UNIVERSITY OF CALIFORNIA, SAN DIEGO

The Culture of Mental Health in a Changing Oaxaca

A dissertation submitted in partial satisfaction of the requirements for the degree of Philosophy

in

Anthropology

by

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University of California, San Diego

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ABSTRACT OF THE DISSERTATION

The Culture of Mental Health in a Changing Oaxaca

by

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Doctor of Philosophy in Anthropology

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Professor Janis H. Jenkins, Chair

This dissertation examines the causes and consequences of the recent growth in Euroamerican mental health practice in Oaxaca, one of Mexico's poorest and most ethnically diverse states with a thriving tradition of indigenous medicine. Based on 18 months of fieldwork in Oaxaca City and the Mixteca region, I explore how and why mental health services have grown so dramatically; what they consist of and what discourses they promote; for what problems they are being utilized; and what impacts they are having in the region.

In so doing, I advance a number of central claims. First and most broadly, I argue that Oaxaca is experiencing a shift in its culture of mental health, one in which globalizing conceptions and practices are taking hold and impacting understandings of illness, self, and social relations. Social problems such as migration and violence are increasingly dealt with in the clinical setting as matters of mental health, and concepts such as trauma, stress, self-esteem, and self-expression are gaining traction throughout the state. Secondly, I argue that mental health professionals themselves are integral to these broader shifts. As conduits of the global attempting to mold the local, practitioners' enterprise goes well beyond the provision of treatment: I show how they are actively attempting to foment culture change in the region. Representations of 'culture'—which practitioners view as incompatible with mental health and with modern forms of subjectivity—are central to this project. Finally, community members do not merely absorb these globalizing concepts; rather, they actively engage with and alter them on the ground. Thus the expansion of Euroamerican mental health practice is not simply a homogenizing process, but one in which globalizing concepts articulate with local meaning systems to generate novel social practices, experiences, and self-understandings.

As a fine-grained ethnographic analysis of social and cultural change, the dissertation (1) advances social scientific theory on the reciprocal relationships between global trends, cultural discourse, professional practice, and individual experience; (2) provides qualitative data on health ideologies, disparities, and access to treatment in marginalized communities; and (3) contributes to anthropological and cross-disciplinary scholarship on culture, mental health, and globalization.

CHAPTER 1

INTRODUCTION: OAXACA IN THE 21st CENTURY

The landscape of mental healthcare in the southern Mexican state of Oaxaca is in the process of dramatic development. Whereas in the early 1990s mental health practitioners were rare, now nearly every neighborhood in the state capital Oaxaca City has several, their practices ranging from biomedical psychiatry to Gestalt therapy to psychoanalysis. Self-help options abound: among other member-run support groups, Oaxaca has 38 centers for Neurotics Anonymous, an offshoot of Alcoholics Anonymous designed specifically to support those self-diagnosed with emotional and/or mental illness. Workshops on themes like "Emotional Intelligence," "Managing Emotions," and "Living in Peace," offered by both local psychologists and foreign gurus, take place nearly each week. Institutional mental healthcare-seeking has become much more common, as well: virtually unused 15 years ago, outpatient services at the public psychiatric hospital are now routinely overwhelmed by the volume of help-seekers from all over the region. According to Oaxaca's Health Ministry (*Servicios de Salud de Oaxaca*, or SSO), there was a threefold increase from 2,551 to 7,433 patients receiving consultations at the psychiatric hospital between 1993 and 2000; in 2009, there were over 9,000.

Television and radio shows, some sponsored by the government, regularly attempt to de-stigmatize mental illness and educate the population about mental health and other psychological and psychiatric concepts such as self-esteem, the expression of emotions, the adverse effects of stress, and the definitions of various mental disorders. This so-

called *psicoeducación* has also made its way into *Oportunidades,* Mexico's cash-transfer poverty alleviation program, for which participants are often required to attend educational sessions about mental health, just as they must attend sessions on cancer, hygiene, and nutrition. More and more elementary, intermediate, and high schools have psychologists on staff. Churches increasingly host psychologist-led family events and include psychological services in their health dispensaries. Several Oaxacan universities now offer degrees in psychology, and local clinics offer certificates in various forms of therapy from neurolinguistic programming to hypnosis. In short, psychological services are visible, actively promoted by practitioners, organizations, churches, and schools, and are increasingly desired by Oaxacans.

Most mental health providers are located in Oaxaca City; however, between 1998 and 2001 SSO began a mental health initiative, The State Mental Health Program (*Programa Estatal de Salud Mental,* or PESM) whose mission is to gather epidemiological data, reduce rates of mental illness, and provide education, training, and preventative programs throughout the state, particularly in lower-income rural, indigenous areas. (Mexico's first institutional program to promote mental health was developed between 1947 and 1951; Oaxaca's was not begun for another 50 years.) PESM coordinates with civil organizations to promote mental health and provide preventative care through educational workshops, courses, video debates, free consultations, conferences, cultural and artistic exhibitions, marches, and radio and TV programming both in and outside the city. In 2007 PESM revamped their program and created an ambitious five-year plan to increase access to services to better deal with the "growing needs of the population, which has suffered constant social transformations that have

repercussions in each individual's life" (Ramirez & Méndez 2007:8).

This dissertation examines the causes and consequences of the recent growth in Euroamerican mental health practice in Oaxaca, Mexico's second-poorest and most ethnically diverse state with a thriving tradition of indigenous medicine. Mental healthcare—such as psychopharmaceutical intervention and psychotherapy—shares some commonalities with indigenous healthcare practices; *curanderas/os* have, for centuries, made use of herbal pharmacological remedies, and community members often go to them and/or religious leaders to unburden themselves. However, the new biomedical and psychological approaches to mental health now flourishing in Oaxaca—as well as the discourses that accompany them—differ from indigenous care in consequential ways relating to understandings of self, illness, and healing. Based on 18 months of fieldwork in Oaxaca City and the indigenous Mixteca region, I explore how and why mental health services have grown so dramatically; what they consist of and what discourses and ideologies they promote; who is providing them; for what problems they are being utilized; and what impacts they are having on broader understandings of health and illness in the region. Overall, the dissertation shows how globalizing Euroamerican psychological and psychiatric concepts are diffused and made meaningful on a local level and how they relate to broader sociocultural transformation.

SIGNIFICANCE OF STUDY

The globalization of Euroamerican psychology and psychiatry is not new, but given its increasing ubiquity, it is essential to understand. This is the case for several reasons. First, medical and psychological anthropology have shown that culture and

social life impact not just understandings and expressions of illness, but also their experiences and outcomes (Jenkins 1998; Jenkins & Barrett 2004; Kleinman 1988a; Kleinman & Good 1985). Thus, in order to both understand and alleviate suffering, we must continue to investigate how emotional distress and disorder are apprehended and dealt with in sites around the world. How are globalizing Euroamerican practices, ideologies, and discourses implemented on the ground? Are they replacing pre-existing means of apprehending, talking about, and treating illness, or are the local and global blending to form new, emergent practices? And what role does culture play in these processes?

Second, the growing dominance of Euroamerican models of and approaches to mental health has raised concerns in a number of fields about medicalization and the reliability of diagnoses, psychopharmaceuticals, and public health interventions across contexts. Critics maintain that biomedical and psychologized approaches to suffering and disorder can pathologize experience, overlook social pathologies, and silence protest by reducing distress to diagnoses treated primarily through pharmaceuticals. This is a matter of great concern, perhaps particularly in poor, marginalized regions like southern Mexico. However, the medicalization process is not inevitable, nor are its impacts uniform across time and space. Additionally, critiques of biological and psychological reductionism stand in tension with increasing global mental health advocacy and efforts on the part of both international organizations and mental health practitioners to reduce the stigma of mental illness and provide increased access to adequate services and medications (Good 2010). In-depth ethnographies of medical and psychological practice are needed to

illuminate what is at stake for patients and healers and what impacts these forms of care have for both individual experience and social life cross-culturally.

And finally, examining the globalization of Euroamerican mental health practice provides a window onto the reciprocal relationships between global process, cultural discourse, professional and institutional practice, and individual experience. It is precisely these complex interactions—between the "structural constraints of society and culture on the one hand and the 'practices'…of social actors on the other" (Ortner 2006: 2)—that social science seeks to understand, in one form or another. The dissertation moves between these distinct but dialectical analytical levels to provide a comprehensive, in-depth account of social and cultural changes in the context of globalization.

In so doing, I advance a number of central arguments. Most broadly, I argue that Oaxaca is currently experiencing a shift in its culture of mental health, one in which globalizing mental health conceptions and practices are taking hold and impacting understandings of illness, self, and social relations. Social problems such as migration and violence are increasingly dealt with in the clinical setting as matters of mental health, and concepts like trauma, stress, and the importance of self-care and self-expression are beginning to gain traction throughout the state. Mental health professionals themselves, I argue, are central in shaping these broader understandings. As 'conduits of the global' attempting to mold the 'local,' practitioners' enterprise goes well beyond the provision of treatment: I show how they are actively attempting to foment culture change in the region. Representations of 'culture'—which practitioners view as fundamentally incompatible with mental health and with modern forms of subjectivity—are central to

this project. Overall, I show how mental health services articulate with and propel broader social and cultural change.

THE CONTEXT

Oaxaca City

My study of Oaxaca began in the summer of 2007, when I traveled there for a summer Mixtec immersion course on a Foreign Language and Area Studies Fellowship. I had visited once before, in 2002, and remembered it as beautiful and vibrant, its capital Oaxaca City (population about 265,000) a small and colorful colonial town. On that trip I recall making my way up one of the city's many hills to a lookout point, where I had a birds-eye view of cathedrals, tree-lined cobblestone streets, the *zócalo* abuzz with activity, and rolling mountains beyond. At the time, the city struck me as quiet and rather peaceful, and—like many visitors to the state—I was taken by its extraordinary diversity and fascinating history. This memory contrasted with my initial impression in 2007, which was of a much larger city, congested and somewhat on edge. It was still a lovely place, but I sensed it was somehow strung more tightly. The tranquil cobblestoned capital in my memory was in part fictional to begin with, but this memory also speaks to the ways in which Oaxaca is, as Murphy and Stepick characterize it, "a set of seeming paradoxes" (1991: 1).

When I arrived in Oaxaca City in 2010 to conduct the bulk of the fieldwork for the present study, I wound up living atop the hill I had climbed eight years before. From one side of the house I could see Monte Albán at a distance, atop another large hill and replete with over 2500 years of history. From the other side of the house I could see

several neighborhoods, or *colonias*, of the city sprawling down the hill to downtown. But what struck me my first morning at the house on *La Loma* ('The Hill,' as my *colonia* was called) were not the serene cathedrals or the stillness of archaeological sites so much as the immense loudness of the muffler-less trucks and buses passing; the near-constant jingles, whistles, bells, and loudspeakers of vendors selling everything from tortillas and fried plantains to propane and water; and the impressive conglomeration of houses built precariously up and down the hill, multi-level concrete mansions alongside corrugated tin shacks and ramshackle wooden structures. I noticed that only some of the streets were paved in La Loma, and people lugging buckets of water home from wells before breakfast suggested they lacked running water in their homes.

This was decidedly not the Oaxaca I recalled from the overlook in 2002. Rather, it was a Oaxaca characterized by increasing urbanization and congestion as well as deep inequality, insecurity, and constrained access to basic necessities—one in which most families are living day-to-day and with great difficulty. Indeed, "[b]ehind its attractive appearance and quaint charm the city and valley are a crucible collecting all the forces buffeting modern Mexico, the forces of change and continuity, conflict and peace, and…rising and falling material standards of living and evolving socioeconomic inequality" (Murphy & Stepick 1991: 1). In this Oaxaca, the *zócalo* is as much the site of perpetual sit-in protests by various groups mobilizing for social justice as it is the site of ice-cream-licking children with their families, businessmen getting their shoes shined, and tourists sampling *mole negro* at pleasant sidewalk cafes. The dozens of vendors with their characteristic sound effects going from street to street peddling their wares are as much a sign of the unequal provision of basic services by the government as they are a

sign of industriousness and local character. The striking façades of centuries-old colonial buildings are as much impressive for their historical significance as they are for the elaborate political graffiti spray-painted on them and then subsequently cleaned off, week after week.

Even the cobblestone streets in Oaxaca City's historic downtown, I was soon to learn, were not impervious to the signs of inequality and political strife. For what seemed like an interminable period of time during my fieldwork, they were all being dug up and replaced—apparently as a scheme the outgoing governor, Ulises Ruiz, had contrived to account for all the money he had embezzled. This was speculation, largely based on hearsay and gossip, but the many angry grumbles the situation provoked spoke to the frustration many Oaxaca City residents feel toward their government, which is frequently characterized as irrevocably corrupt. Of course the cobblestone facelift was infuriating to residents of neighborhoods like La Loma, where so many streets remained unpaved and hardly passable.

It is not my intention to perpetuate stereotypes about a dangerous, bloodsoaked Mexico, and Oaxaca has fortunately been spared from much of the drug-related violence afflicting other parts of the country. However, one of the central themes from my interviews and casual interactions with both mental health practitioners and laypeople was that life in Oaxaca has become more dangerous and characterized by increasing levels of insecurity, instability, stress, and tension. There is a pervasive nostalgia for the days in which you could move freely without fearing assault or robbery. "I remember when it was normal to walk the streets at eleven," one psychologist said, "but now you don't hear anything and people just lock themselves inside, because violence has gotten

much worse here…Ten years ago Oaxaca was considered one of the calmest and most peaceful states, but in recent years all these problems and conflicts have begun." One local psychologist went so far as to conjecture that the "social fabric in Oaxaca has come apart."

Some of this insecurity can be attributed to Oaxaca's 2006 conflicts, in which the former state governor Ulises Ruiz refused customary negotiations with the teachers' union during their annual demonstrations. Tensions escalated, tens of thousands of Oaxacans hoping for political and social change banded with the teachers to create a resistance movement, and both state and national police and military forces were called in to confront them. The clash between the two sides became violent, and an estimated 30 people were killed with many more injured over the course of the seven months the conflict lasted. Dozens of people are receiving psychological and medical care for the effects of torture they suffered during the conflict, and there are allegations of political prisoners still in captivity. The conflict continues to reverberate in Oaxaca City, both through a reduced tourist economy that contributes to unemployment and through a pervasive sense of mistrust and residual anger, which flares up with every reminder of the corruption that characterizes state politics.

Oaxaca State: Poverty & Emigration

Central to these accounts of instability are social and economic inequality, which have characterized the region for nearly the duration of its several-millennia history (Gay 1881/2006; Murphy & Stepick 1991; Williams 1979). This inequality roughly maps on to ethnicity, such that Oaxaca's stunning diversity—it is home to 16 indigenous groups,

each of which is quite internally varied—exists alongside deep-seated patterns of marginalization. Thirty-four percent of the population speaks an indigenous language—a higher proportion than any other state in the nation (INEGI 2012)—and over half the population of the state (39 million) resides in rural communities with fewer than 2500 residents (INEGI 2012).

Oaxaca is Mexico's fifth-largest state by area, and due to its several large mountain ranges—the Sierra Madre Occidental, the Sierra Madre del Sur, and the Sierra de Juárez—it is extremely rugged and difficult to navigate. Many pueblos require treacherous, hours-long drives on dirt roads to arrive at paved roads which eventually arrive at highways to major cities. Furthermore, Oaxaca is divided into eight regions and 570 municipalities—more than any other state in Mexico—many of which are governed according to the laws of *usos y costumbres* in which each pueblo elects its own municipal government through a traditional system of popular assembly. These factors combine to create an incredibly eclectic region, and one that includes quite isolated communities which have developed their own systems of healthcare and healing.

As a state, Oaxaca ranks very low for almost all socioeconomic and human development indicators: according to the most recent census, it has the lowest rate in the country of households with non-dirt floors, drainage, and electricity, and only Guerrero has a lower proportion of households without running water (about 30 percent of Oaxaca's households lack running water and drainage; about 6 percent lack electricity; and only about 30 percent have all three).[1] Per capita income is only about $3,500 USD compared to $20,000 USD in Mexico City, and the state is number three in infant

[1] On the other hand, 75 percent of the population reports owning a television—more than the 60 percent who report owning a refrigerator (INEGI 2012).

mortality rate (17.3 percent) and illiteracy (16.3 percent). According to Mexico's National Council of Evaluation of Social Policies and Development, CONEVAL, nearly 40 percent of the Oaxaca's residents have limited access to healthcare, 30 percent have limited access to education (Oaxacans have on average completed just under seven years of schooling[2]), and 26.6 percent lack access to adequate nutrition (coneval.gob.mx). Only 9.3 percent of Oaxaca's population is *not* categorized as 'poor or vulnerable,' while 40.5 percent live in either extreme or moderate poverty (ibid).

Oaxaca has always been poor, but economic globalization, bolstered by decades of free trade between the United States and Mexico, has contributed to devastatingly high rates of poverty and out-migration. This economic marginalization is most pervasive among Oaxaca's rural indigenous populations, who, therefore, are the most likely to migrate to the United States in search of opportunity. In the 1990s and early 2000s, approximately 150,000 Oaxacans were leaving to seek work in northern Mexico or in the United States each year, and between 1990 and 2004 the number of Oaxacans residing in the United States tripled (CONAPO). In 2009 about 1,203,680 people—34 percent of the state's total population—lived outside of the state (Ruiz Quiróz & Cruz Vasquez 2009:33), many of these in the United States.

Oaxacan Migration

Migration from this southern Mexican state has a long history, but has been particularly intense in the past decade. The progressive loss of indigenous territory

[2] However, 93 percent of the population between 5 and 14 attends school currently (INEGI 2012), so we can anticipate the illiteracy rate will go down steadily.

resulting from land privatization spurred emigration from Oaxaca as early as the 19th century (Velasco-Ortiz 2005). Large waves of emigration did not begin until the early 20thcentury, however, when Oaxacans began leaving for other areas of Mexico to find farm labor work. Some went to nearby communities and cities; others left for coastal areas such as Veracruz where they could earn a living cutting sugar and pineapple. Often this was seasonal work, and these internal (meaning within Mexico) migrants would return to their towns of origin once the crops were picked (Cohen 2004: 57). Still other Oaxacans began migrating to Mexico City, part of the more general trend in Latin America at mid-century, when industrialization caused people to move in droves to urban centers (Velasco-Ortiz 2005: 35). By the late 1970s thousands of Oaxacans had migrated to Baja California as well, where they worked on vegetable farms when Mexico began to send massive produce exports to the United States.

The United States' Bracero Program, a guest-worker program designed to offset labor shortages during World War II, also contributed to migration patterns from Mexico to the United States. The program lasted from 1942 to 1964 and created 4.6 million contracts for seasonal Mexican workers. During that time an average of 209,000 Mexicans crossed the border each year as Braceros, but they were only permitted to stay for a short time. Nevertheless, the program set the stage for more permanent settlement and more permanent migration routes from rural Mexico to the United States (Cohen 2004: 60).

Economic restructuring during the 1980s and up until the present day has also been central to the history of migration from Oaxaca. Crippled by economic crisis and waning confidence in the PRI (the *Partido Revolucionario Institucional*/Institutional

Revolutionary Party), which ruled the country since 1929, Mexico renegotiated its foreign debt and began reforms favoring "export-led industrial growth, general deregulation, cuts to public sector and government expenditures, and an opening of national economies to trade, direct foreign investment, and economic liberalization" (Schmalzbauer 2010: 1861)—often as conditions of aid from the World Bank and the International Monetary Fund. While in 1980 Mexico was "largely closed to foreign trade and investment," its economy "is now open, and goods and capital move freely in and out of the country" (Haber et al. 2008: 1-2). State-owned companies and many aspects of welfare provision have been privatized (ibid: 18).[3] Such policies have undercut some inefficiencies in public and private sectors, but they have also by many accounts exacerbated income inequality and poverty—perhaps particularly in rural areas like Oaxaca.

Economic development in Mexico has generally emphasized industrial expansion through export manufacturing plants, or *maquiladoras*, and has not provided viable alternatives for agricultural communities that could have not been able to successfully compete in the global market (Stephen 2007: 124). In 1994 the passage of NAFTA solidified economic integration between the U.S., Mexico, and Canada, and required Mexico to lower its price supports for farmers and reduce import restrictions. Prices of Mexican crops fell, the prices of feed and fertilizers rose, and by 2001, corn farmers and their families were living on less than one-third what they had earned six years before (Stephen 2007: 127, c.f. Fanjul and Fraser 2003: 17). Indeed, while Mexico's economic growth was concentrated in the southern states between 1970 and 1985, with the

[3] I discuss Mexico's health reforms in more detail in Chapter 5.

implementation of liberalized trade policies and the resultant rapid growth of Mexico's northern economies, growth shifted dramatically to northern states like Chihuahua and Coahuila (Chiquiar 2005). Between 1985 and 2001, growth in southern states like Oaxaca, Chiapas, Veracruz, Tabasco, and Campeche was negligible or negative.

Though the Mexican government has, through its program PROCAMPO, offered some farmer subsidies to offset losses from declining agricultural prices due to NAFTA, it does not seem to have quelled the motivation to emigrate. Despite pro-NAFTA arguments that the trade agreement would ultimately reduce out-migration from Mexico, "NAFTA has not weakened the preexisting incentives and pressures to migrate" and migration rates have risen since the mid-1990s (Cornelius 2002: 293). Cornelius's 2002 prediction—that "NAFTA is unlikely to have much of an effect on the flow of Mexican labor to the United States over the next decade, given the maturation of social networks linking potential migrants with jobs in the United States, the poor quality of many of the jobs being created in Mexico under NAFTA, and the highly skewed spatial distribution of these jobs" (ibid: 296)—proved accurate ten years later.

Central to migration incentives is the enormous wage gap between the United States and Mexico, the proximity of the two countries, and the demand for low-wage laborers in the United States. This demand has ebbed and flowed depending on the state of the U.S. economy, but—as evidenced by the U.S. demand for Mexican and other migrant workers to build railroads back at the turn of the century—has been longstanding in history. Nevertheless, U.S. immigration policy has increasingly criminalized northward labor flows from Mexico and the rest of Latin America. Restrictive immigration policies, the militarization of the U.S.-Mexican border, and a general

emphasis on enforcement has created a population of informal, undocumented workers who not only risk their lives to enter the United States, but whose lives are precarious and characterized by extreme structural vulnerability in the United States (Castañeda 2010; Cornelius 2004, 2006; Holmes 2007; Quesada, Hart, and Bourgois 2011).

With the current economic crisis, migration flows to the United States—both authorized and unauthorized—have slowed dramatically. As a 2010 *Wall Street Journal* article puts it, the "mortgage crisis and ensuing economic slump have slashed jobs in construction, tourism and other sectors that are the mainstay for low-skilled Latin Americans. Immigrants already in the U.S. are struggling, and word of their hardship is dissuading those back home from flocking to the U.S." (Jordan 2010). This slowdown in migration flows is having and will continue to have enormous consequences for both the United States and Mexico. Families in Oaxaca who depend upon remittances or who see migration to the United States as their only hope for economic solvency will potentially face even more dire circumstances than they already do, and migrants currently in the United States will frequently face the prospect of joblessness and of potentially returning to their towns of origin.

The Mixteca Region

Migration is pervasive in the Mixteca region, my other research site in addition to Oaxaca City. The Mixteca region straddles Oaxaca, Puebla, and Guerrero, and is composed of three main parts: the Mixteca Alta (the Mixteca area with the highest elevation; western section of Oaxaca state), the Mixteca Baja (lower elevation, though still quite mountainous; north-northwest section of Oaxaca), and the Costa (coastal

region; south-southwest section of Oaxaca). The region's population is 426,977 (INEGI 2010) and number of indigenous groups live there in addition to Mixtecos, including Triquis, Popolocas, Nahuas, and Chochos (Romero Frizzi 1996). While Oaxaca City is characterized by low migratory intensity (CONAPO 2005), the Mixteca has higher rates of emigration than any other region in the state (*Instituto Oaxaqueño de Atencion al Migrante*).

The history of migration from the Mixteca region mirrors that of Oaxaca in general, and as Laura Velasco-Ortíz puts it, by the 1990s Oaxacan—and particularly Mixtec and Zapotec—migration to the U.S. border regions "was a fact" (Velasco-Ortiz 2005: 39). By the year 2000, "an average of 34 percent of a community's households [in rural Oaxaca] had at least one migrant living across the border" (Cohen 2004: 63). By the year 2004, this estimate rose to 47 percent (Cohen 2004: 19). Granted, the number of migrants varies widely from community to community and is dependent on many factors, from migrant networks to the state of the local economy to ecological erosion, but the sense of desolation is pervasive in the Mixteca. Villages are almost eerily quiet, their dusty streets lined with the boarded-up homes of migrants. Older men and women sit outside their homes weaving palm products to sell at the local market; younger women cook, take care of the children, and work outside in the fields. Nearly everyone in the area has an impressive repertoire of often heart-wrenching stories about either their or their family members' experiences in the United States. In many Mixtec communities, only a fraction of inhabitants remain—most of them women, children, and the elderly.

Before 2009, it was rare to see a man between the ages of 18 and 45. Until the holidays, that is, at which point migrants would return in droves, laden with gifts and

stories from *el otro lado*. Those with documents often would drive back to their hometowns in cars with license plates ranging from California to Utah to Florida. Those without documents would either forego actual presence and watch the festivities on video afterwards, or take the risk and go home anyway, knowing they would have to pay a *coyote,* or professional people-smuggler, upwards of $3,500 USD to smuggle them back into the United States. Although statistical analyses do not find evidence of increased return migration to Mexico during the financial crisis (Rendall et al. 2010), I did notice what seemed to be a growing presence of young returned migrant males in Mixtec towns like San Miguel Tlacotepec and Juxtlahuaca, and local community members and practitioners confirmed that they had seen a growth in this population, as well.

The lives of many Mixtecos are decidedly transnational, or shaped by "multiple relations—familial, economic, social, organization, religious, and political—that span borders" (Glick Schiller 2003: 105). A number of ethnographies have examined such transnational communities, detailing the emergence of new cultural configurations and social practices: transnational identities and forms of citizenship; innovative forms of local governance; syncretic blending of musical, culinary, linguistic, and clothing styles; and creative use of media such as radio programs and live-streaming video as means of communication across borders, to name a few (Cohen 2004; Cornelius et al. 2009; Fitzgerald 2009; Kearney 1986, 1991, 1995; Stephen 2007; Velasco-Ortiz 2005). In these Mixtec communities one hears a disarming mixture of Mixtec, Spanish, and English spoken, often within the course of a sentence. Walls are adorned with graffiti bearing the names of California sports teams, area codes, and gangs. Clothing styles range from the traditional rebozo and apron to miniskirts and American name-brand jeans. Some houses

are made of corrugated tin, and others are multi-level concrete mansions with Americanized decor. While geographically speaking the Mixteca is isolated—a harrowing 6-hour drive from Oaxaca City over the Northern Sierra mountain range—culturally speaking, it is anything but.

* * *

It is within this context of poverty, marginalization, political unrest, and mass out-migration that mental healthcare has thrived. Even with the recent boom in psychology, psychiatry, and alternative therapies (such as self-help groups, reiki, yoga, and acupuncture), mental health practitioners say they cannot keep up with demand. Psychologists and psychiatrists regularly mention that more and more Oaxacans suffer from emotional and psychological distress, that prevalence (along with detection) of psychiatric disorder has increased over the course of recent years, and that in general, life is increasingly stressful.[4] These professionals frequently characterize their patients' lives as lacking in security and plagued by uncertainty and anxiety, which they attribute to factors ranging from lingering fears after the aforementioned 2006 conflicts to migration

[4] Unfortunately there is a paucity of epidemiological mental health data in the state, since such data are only now being collected systematically. Therefore, it is difficult to evaluate claims regarding increasing prevalence of mental disorder. However, both the public psychiatric hospital and general Health Ministry hospitals report dramatic increases in mental health-related help-seeking between the early 1990s and the early 2000s, indicating that people at least may be becoming more likely to identify problems in the framework of mental health and seek specialized services. The studies that do exist are difficult to compare given they use different measures and methodologies, but overall indicate elevated prevalence rates for affective and anxiety disorders in the state. Data from a representative sample of 576 Oaxacans in Oaxaca City indicate a lifetime prevalence rate of 15.8 percent for major depression, a significantly higher rate than the other four cities surveyed (Hermosillo, Mérida, and Guadalajara) (Slone et al. 2006). According to the Oaxacan Health Ministry, from 2003 to 2007 the most prevalent mental disorders in outpatient services throughout the state were (1) major depression, (2) anxiety disorder, and (3) behavioral and learning disorders in children and adolescents (Ramirez & Méndez 2007). During the same period IMSS services reported that 13 percent of patients suffered mood disorders and 11 percent suffered generalized anxiety disorder (ibid). Using records from primary care facilities in Oaxaca City, Bernardino-García and colleagues find that childhood conduct disorders and anxiety disorders are the most common mental health problems reported, while in rural regions affective disorders are more common (Bernardino-García et al. 2010).

to the more general consequences of urbanization, globalization, and economic crises. As one doctor and psychologist put it, "Well, we live in a more violent society; as opposed to twenty years ago Oaxaca is a more violent, more modern city, it's a city with more migration, which puts us in fashion with what's going on with the rest of the world, right? More violence, more anxiety, more depression, and more addiction. Anything new here?"

Walking around Oaxaca City in 2007 and in the years following, I was struck by the visibility of mental health services—it seemed as though everywhere I looked there was another option for care. The winter before, I had written my Master's thesis on displays of empathy in an emotional health workshop for migrant women in San Diego. I had noticed that the women there, most of whom were originally from Mexico, were learning about psychological concepts like depression, self-care, the expression of emotions, personal 'barriers,' and empowerment for the first time. I had assumed that their lack of exposure to these psychologized frameworks was at least partially due to the relative paucity of psychological services and discourse in Mexico compared to the United States. It is true that compared to Mexico's cosmopolitan centers and to most regions of the United States, Mexico's poorer states like Oaxaca, Chiapas, and Guerrero have very few mental healthcare practitioners. However, one could hardly describe Oaxaca City as lacking in options for psychological care. On the contrary, they were obviously proliferating.

When I returned to Oaxaca with the UCSD's Center for Comparative Immigration Studies' Mexican Migration Research and Training Program (MMFRP) to conduct research in the winter of 2007, I was fascinated to find that not only was overall health significantly worse for Tlacotepenses living in San Miguel Tlacotepec than for their

migrating counterparts in the United States, but that both community members and doctors were talking about the mental health impacts of migration in the town. Our study—which included 921 interviews with Tlacotepenses in both Oaxaca and in the United States—showed that women whose husbands were in the United States were more likely to have sought mental health treatment than other members of the community (Duncan et al. 2009). Our qualitative interviews revealed that although they were not trained in psychology or psychiatry, local doctors in Tlacotepec were administering both talk therapy and psychopharmaceutical medications. Most Oaxacans had told me that mental health was uniformly ignored and stigmatized, so I was surprised that it was a topic of considerable interest to doctors and community members alike, and that many seemed to be taking the matter into their own hands.

In the summer of 2008 I returned to Oaxaca for another Mixtec immersion course and began interviewing mental health practitioners, who confirmed that Oaxaca's landscape of mental healthcare had undergone immense changes in recent years. As they described their varied practices—flower essences combined with hypnosis, educational workshops teaching participants how to build self-esteem and cultivate independence, medication management using the most up-to-date psychopharmaceuticals—it became clear that Oaxaca's impressive diversity was manifesting in its field of mental health. But how and why had mental health services begun to take off? Who, exactly was utilizing them, and for what problems? Were they locally inflected, or were they importing global models and approaches wholesale? What impact, if any, were they having on Oaxacans' experiences, conceptions, and treatments of emotional distress? The following chapters pose answers to those questions.

METHODS

The bulk of the research was conducted over the 12-month period of January, 2010 through January, 2011. However, preliminary interviews and observation took place prior to the main fieldwork during my time in Oaxaca in July-August 2007, December 2007, and June-August 2008, to total 18 non-consecutive months of research. The study employed a mixed-methods approach consisting of 145 qualitative interviews (55 with mental health practitioners and other professionals and healers; 50 with patients at the state psychiatric hospital; 40 with community members in Oaxaca City and the Mixteca region); analysis of media materials, advertisements, educational materials, and institutional documents used in Oaxaca's public health efforts; participant observation in communities and at psychiatric and psychological conferences, educational sessions, support groups, and the state psychiatric hospital; and survey interviews conducted in collaboration with the Center for Comparative Immigration Studies.

Professional Sample

In my first weeks of pilot research in 2007, I spent hours walking the streets of Oaxaca City with map, pencil, and notebook, scribbling down names, numbers, and locations for particular practitioners and clinics. I often photographed the signs, which now serve as a colorful collage of the options for care in this rapidly changing city (Figures 1.1, 1.2, and 1.3).



Figure 1.1: Psychologist Signs in Oaxaca City



Figure 1.2: Psychologist Sign in Juxtlahuaca, Mixteca Region



Figure 1.3: Neurotics Anonymous Sign, Teposcolula

I must have seemed a strange sort of tourist, ignoring the beautiful colonial churches, museums, and parks in favor of getting a good close-up of a particularly striking Neuróticos Anónimos sign.

The visibility (and availability) of mental health services outside of Oaxaca City is considerably more limited, but more and more, these services exist. Public health announcements painted on outdoor walls are common throughout Mexico, perhaps particularly in rural regions. In Oaxaca, they increasingly incorporate messages on subjects like the function of a psychologist or the prevention of suicide, drug use, and domestic violence. Others advertise psychological services available in local Centros de Salud. Not all of these displays are sponsored by public health campaigns: once, on a long bus ride to the Mixteca region, I saw a homemade sign fashioned out of a piece of

cardboard nailed to a thin wooden pole. Someone had written *'psicólogo'* on it in crooked letters, with an arrow pointing down a long dirt road. There was nothing else but cornfields in sight for miles.

This visibility was fascinating; although of course I was more attuned to it than people with no interest in the subject, it seemed clear that at the very least, psychologists were not hiding in stigmatized corners or dark back rooms, as I had been led to believe. Despite my growing realization that mental health services were flourishing and the suspicion that this was a relatively new phenomenon, I thought there would still be few enough practitioners that it might be possible to interview all of them. I was wrong: there proved to be an overwhelming quantity and array, far more than I had initially supposed.

Therefore, I decided to focus my efforts on individual practitioners—especially those who seemed to have a strong public influence and who had been particularly active in the field—and various centers, public services, and organizations consequential to the broader landscape of care. I sought as much as possible to conduct interviews and observation in a blend of sites that represented the main options for treatment, which can be divided as follows: (1) institutional, government-subsidized services; (2) private services, including individual private practices and for-profit clinics; and (3) non-profit organizations, some of which provide free care. "The Current Landscape of Mental Health Services" section in the following chapter provides an account of the general services that exist in Oaxaca as well as those featured in my own research.

Overall, the professional sample (N=55) consists of 36 psychologists, 10 psychiatrists, five *curanderos/as*, and four 'others'—general doctors, administrators, 'alternative' medical practitioners (e.g. reiki), and nurses.

I conducted semi-structured interviews with all 55 practitioners; these were audio recorded upon consent. Interviews focused around each practitioner's background, professional training, therapeutic approaches, opinions about emotional and mental health in Oaxaca, changes in Oaxaca's culture of mental health (e.g. opinions about whether services have become more plentiful, whether most Oaxacans are aware of them, whether mental health is more or less stigmatized than it has been in the past), and social problems contributing to mental disorder and/or emotional distress in the state. There was no compensation for participation; when interviews were conducted in cafes, however, I insisted upon treating.

Several of these professionals—particularly psychiatrists at the Cruz del Sur psychiatric hospital—became friends and/or research contacts throughout the course of my research; our conversations were, therefore, ongoing. Of all the professionals I contacted, only one declined participation in the study. As a general observation, I was struck by the frank openness with which mental health practitioners in Oaxaca approached my questioning. With a few exceptions, they seemed eager to share their expertise and to speak about issues which it seemed they thought others dismissed but which they found extremely important.

Patient Sample

The Cruz del Sur psychiatric hospital was not originally included in my list of research sites, not because I didn't know of it, but because of my impression that it served only the most severe cases of mental disorder in Oaxaca. I wanted to examine services that were more readily utilized and widely known. However, my interviews in early 2010

revealed that Cruz del Sur's outpatient center was one of the most popular options for mental health treatment in the region. As discussed in Chapter 7, hundreds of people travel from both the city and rural pueblos to seek help there. The patient sample thus includes Oaxacans from all eight regions of the state and represents a wide range of age, socio-economic statuses, educational attainments, and ethnicities (see Table 7.1 in Chapter 7).

With the exception of one patient with whom I spoke while conducting interviews with psychologists in the inpatient unit and two patients whose initial consultations I observed, all hospital participants in the study were outpatients and were recruited with the help of outpatient psychiatrists. At the conclusion of appointments with patients deemed capable of participating in the study (meaning they were 'stable,' not in the throes of florid psychosis, and able to have conversations), psychiatrists briefly explained the study and asked patients, family members of patients, or both, if they would like to learn more about it. If they agreed, patients and/or family members of patients would join me in a private meeting room where I explained the details of the study and went over the consent forms with them. Upon consent, interviews were audio recorded. As per hospital regulations there was no compensation for participation; however, patients and their family members were given refreshments as a token of appreciation.

The semi-structured interviews, which lasted between 20 minutes and several hours, focused around basic demographic and biographical questions (i.e. age, place of origin, family composition and living conditions, education, migration experience); how participants understood the problem(s) from which they or their family member were suffering; the narrative around the problem (i.e. what happened, when did problems or

symptoms begin, how long they have persisted); how and why they decided to come to the hospital for treatment and where else they sought care (i.e. treatment-seeking pathways); main complaints or symptoms; and how and when participants first heard of mental health care. Oftentimes these interviews involved patients' life histories and accounts of events, opinions, and experiences patients deemed important.

Although most of the hospital psychiatrists were amenable to and highly interested in the study, they are quite overwhelmed with patients during most days and tended to be rushed. There were many days in which I waited for them to refer patients to me to no avail, so I spent my time observing the intake and waiting area, chatting with both patients and hospital staff. One psychiatrist permitted me to observe intake appointments, but this was not a central part of my activities there. Psychiatrists often discussed cases with me, particularly those involving what they deemed 'cultural' issues or those involving migration.

Community Sample

The community sample consists of Oaxacans *not* recruited at Cruz del Sur. Some of the participants were friends with whom I was in touch throughout the course of fieldwork; others were Oaxacans recruited by means of flyers posted in Oaxaca City. Still more were Mixteca residents I met by walking around pueblos and striking up conversations and through conducting survey interviews with MMFRP (see below for details). Because it is not random, I cannot claim that it is representative; however, "the logic and power behind purposeful selection of informants is that the sample should be *information rich,*" consisting of participants who are "experiential experts" and who

"exemplify characteristics of interest to the study" (Morse 1994: 228, c.f. Patton 1990). Like the Cruz del Sur sample, the general community sample represents a wide range of ages, socio-economic status, educational attainments, and ethnicities.

In the Mixteca region, I conducted interviews in San Miguel Tlacotepec (population 1,621 in pueblo, 3,220 in the municipality of which Tlacotepec is the capital), Ixpantepec Nieves (population 1,182), Santiago Juxtlahuaca (population 8,972 in city, 32,927 in the municipality of which Juxtlahuaca is the capital), and Huajuapan de León (population 69,839). In San Miguel Tlacotepec, where my Mixteca-based research was most extensive, I interviewed general community members, healthcare practitioners (both public and private), and *curanderos/as*. I spent time in the community during each of my trips to Oaxaca (in 2007, 2008, 2010, and 2011), including attending the town's patron saint festival and other events; chatting in people's homes and yards; sharing meals; visiting the town clinic, and other activities. In addition, through participation in MMFRP, discussed below, I met and interviewed Tlacotepense migrants in San Diego (though data from those interviews are not included in the dissertation). My interviews and participant observation were more limited in Ixpantepec Nieves, though I have come to know several families there quite well. There, I conducted formal interviews with several community members and a *curandero,* and spent many days visiting more casually with families. In Juxtlahuaca I conducted interviews with several community members and psychologists, and in Huajuapan I conducted interviews with Health Ministry psychologists and doctors.

In Oaxaca City I conducted a number of interviews with (non-patient, non-mental health professional) community members who I either actively recruited or who

volunteered for interviews once we became acquaintances. Their occupations ranged from shop-owner to housekeepers to students to activists, and interviews took place everywhere from homes to cafes to park benches.

Interviews with the community sample covered a range of topics including but by no means limited to life history, general impressions of Oaxaca, immigration, awareness and perceptions of mental health and mental healthcare, conceptions of emotions, and accounts of events, opinions, and experiences interviewees deemed important. Some of these interviews were recorded, and some came about more spontaneously so were not. I offered compensation for the more formal interviews conducted with the community sample, but only two participants accepted the 50 pesos. However, as often as I could I treated interviewees to coffee or refreshments as a token of gratitude.

Participant Observation

Throughout fieldwork I engaged in various degrees of participant observation, defined as "research characterized by a period of intense social interaction between the researcher and the subjects, in the milieu of the latter," in which "data are unobtrusively and systematically collected" (Bogdan & Taylor 1975: 5). Although I lived alone most of my time in Oaxaca City (save for the companionship of Oscar, Güera, and Fernando, two dogs and a cat I helped take care of for the owner of the house in La Loma), I was in constant interaction with Oaxacan friends, neighbors, and project participants whose perspectives gave shape to my analyses. Because it is a city, interaction is not as intensive as it might be in a small village; nevertheless, I was a part of the flow of social life and felt myself to be a member of the community. Everyday activities—shopping at the

market, attempting to procure water for my home, waiting for and riding the bus, eating meals with families, making tamales and mole with friends, going to doctor's appointments, sitting at a *Día de los Muertos* altar waiting for the spirits of the dead to visit with the family of a friend—were incredibly instructive and composed the richest part of my fieldwork experience.

I also conducted participant observation at mental health conferences, workshops, and support groups. For example, I attended the Southern Mexican Psychiatric Association meetings (see Chapters 4 and 5), the Cruz del Sur psychiatric *Jornadas* (a conference in which hospital psychiatrists presented at the local medical school), Neurotics Anonymous events, mental health chats or '*charlas'* at non-profit organizations, and mental health and 'emotional management' seminars (see Chapter 4). Additionally, although I did not participate in clinical activities such as psychiatric appointments or therapy sessions at Cruz del Sur, I was there almost daily for several months, and as such had intensive social interactions with practitioners, patients, staff, and administrators. I attended presentations by pharmaceutical representatives, observed several patient intake sessions, chatted with patients in the waiting area, and regularly visited the inpatient facility.

Finally, in addition to interviews, participant observation, and attendance at mental health-related events, I collected and analyzed a number of media materials and institutional documents from Oaxaca's various public and private health services. These include institutional documents such as National Health Ministry Mental Health Action Plans and State Mental Health Program Plans; epidemiological data from several public health jurisdictions; PowerPoint presentations given at public mental health events;

advertisements (posters, trifolds, handouts), promotional and organizational literature from public, non-profit, and private clinics; and media coverage (radio programs, television programs, commercials, and newspaper articles).

Center for Comparative Immigration Studies Sample and Methods

Along with the independent research I conducted for the present dissertation study, I conducted survey and open-ended interviews in the Mixteca region and in Southern California through my participation with UCSD's Center for Comparative Immigration Studies' Mexican Migration Fieldwork and Training Program (MMFRP). As a group we conducted 921 surveys in 2007 and 910 surveys in 2011 with residents (between the ages of 15 and 65) of San Miguel Tlacotepec and with Tlacotepense migrants in the San Diego area. The research team visited all houses in San Miguel Tlacotepec both years, interviewed all eligible members of each household, and noted abandoned houses. Survey questions covered a range of topics from basic demographic data to migration and employment histories to health profiles, and were supplemented with hundreds of open-ended qualitative interviews. In the 2011 study we administered the short-version Center for Epidemiological Studies Depression Scale (CES-D) to measure depressive symptomatology. Quantitative analyses were conducted in collaboration with MMFRP's statisticians. The results are published in Cornelius et al. 2009 and Fitzgerald et al. forthcoming. I was a member of and contributor to the health team chapter both years (Duncan et al. 2009; Calvario et al. forthcoming), and report on our findings in Chapter 8 of the dissertation.

THEORETICAL ORIENTATIONS

This study is situated at the interface between the anthropologies of mental health, emotion, and medicine, on the one hand, and the anthropology of globalization, on the other. I provide a number of literature reviews throughout the dissertation, but will broadly frame the study theoretically within each of these subfields here. What follows is not intended to be a thorough account of the literature, but rather an overview of historical and contemporary scholarly developments in the study of interactions between culture, emotion, mental health, and globalization. The dissertation contributes to theoretical and empirical understanding of these interactions.

Mental Health in Medical and Psychological Anthropology

Historical Foundations

Ethnomedical studies of health, illness, and psychopathology have a long history within anthropology. As far back as the early 20th century, W.H.R. Rivers, along with contemporaries and near-contemporaries like E.E. Evans Pritchard and Abram Kardiner, was fascinated by what he called "the more or less vague system of ideas which, though not distinctly formulated by a people, yet directs their behavior—their reactions towards those features of the environment which we have classified together under the category of disease" (Rivers 1924: 7). Focusing on the pathological as defined by Papuans and Melanesians, Rivers sought to discover the internal logic of ethnomedical practices and beliefs by examining them in context and across several cultures. Contrary to popular opinion at the time, Rivers proposed that "the practices of these peoples in relation to disease are not a medley of disconnected and meaningless customs, but are inspired by

definite ideas concerning the causation of the disease. Their modes of treatment follow directly from their ideas concerning etiology and pathology" (Rivers 1924: 51)

Although at that time such 'beliefs' were dismissed as irrational and indicative of more primal stages of mental evolution, this work established the tradition of exploring various cultures' understandings of and approaches to health, illness, and pathology as logical systems in their own right. Around the same time, the culture and personality school of psychological anthropology—led mainly by Ruth Benedict and Margaret Mead—theorized psychopathology as a pathological amplification of cultural characteristics or as an incongruity between predominant cultural mores and individual personality (Mead 1928; Benedict 1934; c.f. Kirmayer 2007: 11). In her classic paper "Anthropology and the Abnormal," Benedict made the then-radical claim that "normal-abnormal" categories and notions of deviance are culturally determined and should not be judged according to Western "local normalities" (Benedict 1934/1959: 498, 511). This work began to depart from prior understanding of societal and psychological development as an evolutionary continuum from 'archaic' and 'primitive' to 'modern' and 'rational.'

Irving A. Hallowell continued along these lines to propose that

> …the values stressed by different cultures and institutionalized by them act with selective emphasis with reference to the particular temperaments and personalities afforded maximum of minimum opportunities for complete expression. The breakdown in mental functioning in certain individuals cannot be dissociated, in any ultimate etiological analysis, from a parallel consideration of the particular temperament and personality types which are considered 'normal' in any culture and are consequently developed and nurtured by it. The cultural factor is thus medial in its relationship to the 'normal,' on the one hand, and the 'abnormal' on the other, so that, hypothetically, it would seem that the character and incidence of at least certain classes of mental derangement must bear some relation to the cultural pattern (Hallowell 1934: 2).

Both Hallowell and Benedict stressed the relativity of normality from culture to culture, and the need to be fully familiar with local patterns of behavior, personality, and belief to understand experience and pathology. In this view, the presence of psychopathology was based on emic understanding of culturally sanctioned and culturally deviant experiences and behaviors. Hallowell went on to propose that illness and psychopathology were fundamentally related to theories of and orientations toward the 'self,' which are culturally derived and cannot be understood outside of the local "behavioral environment," or the world of the socially and culturally situated individual (Hallowell 1955).

Culture, Self, and Emotion

Hallowell's work was groundbreaking both because it brought the 'self' into analytical focus and because it took a phenomenological approach. Along with other seminal theorists of self, psychopathology, and ethnopsychology (e.g. Devereux 1961; Field 1960; Hallowell 1934, 1955; Kardiner 1939; Sapir 1938, 1986; Sullivan 1962), Hallowell provided a framework for what was to become an efflorescence of psychological anthropological work on the cultural mediation of the self. These studies have empirically illustrated that the 'Western' notion of the self "as a bounded unique, more or less integrated motivational universe, a dynamic center of awareness, emotion, judgment and action" is by no means universal (Geertz 1979: 229, c.f. Rose 1998: 5). Rather, 'selves'—and their attendant identities and forms of personhood—are created and enacted in relation to broader meaning systems and modes of interaction within specific

sociocultural contexts which may give rise to any number of self-concepts and self-experiences.

At the same time, while selves are culturally constituted, they are not culturally determined nor "simply reflections of culture" (Parish 2008: 185). Rather, the models upon which we draw are "always part of our 'being-in-the-world,' our effort to live. The self is never independent of cultural life, nor ever passively a construction of culture" (Parish 2008: 185). Thus, cross-cultural studies of self seek to determine not only how cultural forms and values produce particular selves, but rather how the 'work of culture' articulates with the 'work of self' as people navigate their personal and social worlds (Obeyesekere 1990; Parish 2008; Csordas 1994a, 1994b). Phenomenological anthropology seeks to bring these navigating selves—their stories, existential dilemmas, and embodied experience—into analytic focus (Csordas 1994b; Desjarlais 1994; Jackson 1996). The phenomenological approach takes as a foundational insight that "no matter what constituting power we assign the impersonal forces of history, language, and upbringing, the subject always figures, at the very least, as the site where these forces find expression and are played out" (Jackson 1996: 22).

In the 1980s, anthropology began to investigate in earnest how local ethnopsychological theories of self and personhood produce particular experiences and expressions of emotion and sentiment. The anthropology of emotions emerged as an important field challenging taken-for-granted models of emotions as internal, psychobiological experiences beyond the realm of cultural analysis. Rather than an add-on to biological, universal phenomena, anthropological work on emotion has emphasized the "*primary* importance of cultural meaning systems in emotional experience" (Lutz &

White 1986: 417) and the ways in which emotion resides not "within hearts or minds of individuals but instead in the mutually transacted terrain of social and political space" (Jenkins 1994: 101). Emotions involve culturally informed, context-based assessments, and serve social, communicative, and moral purposes (Jenkins 1994; Lutz 1988; Rosaldo 1980).

The anthropology of emotions conceives of emotional experience as interpretive activity, "constructed in social situations according to the premises of cultural 'theories'"—about the mind, self, and about social behavior more generally (White & Marsella 1982: 3). The field problematizes *a priori* distinctions between culturally mediated cognition and universal bodily 'feelings' and between body and mind more generally (Jenkins 1996; White 1992); between private experience and "collective representation" (White 1992: 22); and between "intrapsychic mental events" and "intersubjective social processes" (Jenkins 1994: 99). Thus the Euroamerican conception of emotion and mental disorder as internal, physiological, and universal is viewed as an ethnopsychological theory like any other.

This work builds upon but goes beyond social psychological theories of emotion, which typically do take emotion to be socially situated and informed, but only insofar as social context acts as an additional layer on top of emotion's cognitive and physiological components. As Geoffrey White notes in his account of disciplinary approaches to the study of emotion, the social psychological view emphasizes the "interpretive aspects of emotion, such as evaluations or appraisals that process information about social relations and situations" (White 2005: 244). Social psychology thus helps conceptualize emotion's pragmatic function, but fails to account for the ways in which emotion is socially and

culturally constituted. In other words, from the anthropological standpoint, this approach is "limited by the assumption that the relevant aspects of social context are internalized in a person's knowledge or perceptions of social interaction—in emotion schemas and the like," thus downplaying or overlooking "the social scenes and discursive practices that define and shape emotional experience in everyday life" (ibid).

Drawing upon Raymond Williams' concept of 'structures of feeling,' White proposes the analytical framework of 'emotive institutions' to "make connections to the social explicit by locating emotion in recurrent culturally constituted activities, which in turn entail social positions and practices embedded in wider institutional arrangements of power, ideology, and politics" (White 2005: 251-252). Emotive institutions are "doubly social: they generate discourse *about* social relations at the same time as they enable the *enactment* or *embodiment* of identities in ongoing interaction" (White 2005: 248). Analyzing 'emotive institutions' does not discount the potentially psychobiological or cognitive components of emotion, but takes as its object of study the mutual constitution of context and affect, sociality and individual experience, structures and sentiment. The concept of emotive institutions suggests that we must analytically attend to (and question oppositions between): (a) broad "spheres of ideology and political structure" and the 'institutional arrangements' which often define 'structures of feeling' and terms of emotional discourse in a society (White 2005: 243; c.f. Williams 1977); (b) "situations, contexts, and institutionalized activities in which emotions obtain social meaning and force" (White 2005: 248); and embodied feeling and meaning (Csordas 1994b).

The current study views globalizing mental health practice in Oaxaca as an 'emotive institution' which generates discourses and ideology about self, emotion, and

social relations; enables the '*enactment* or *embodiment*' of particular means of interaction and being-in-the-world; and is itself shaped by broader 'spheres of ideology and political arrangements.'

Culture, Psychopathology, and Subjectivity

Medical and psychological anthropology—as well as the so-called 'new cross-cultural psychiatry' outlined by Arthur Kleinman (1977, 1980, 1988a, 1988b)—take a similar approach to the anthropology of emotions in their investigation of psychopathology. These fields have produced a plethora of ethnographies detailing ethnopsychiatric diagnoses, treatments, and experiences from a number of settings. Focusing on illness explanatory systems, their relationship to sociocultural systems and particular views of the self, and their implications for the course of healing in various cultural contexts, these ethnographies have shown that sociocultural life unequivocally impacts mental health: what is considered pathological or deviant to begin with; how symptoms are experienced, identified, and expressed; how illness and distress should be treated therapeutically; and even the outcome of illnesses themselves (Fabrega 1989, 1993; Gaines 1992; Guarnaccia et al. 2003; Good 1977, 1994, 1997; DelVecchio Good & Good 1982, 1988; Jenkins 1988, 1991, 1994, 1996, 2007; Jenkins & Barrett 2004; Kleinman 1980, 1986, 1988a, 1988b; Kleinman & Good 1985; Rubel, O'Nell, and Collado-Ardon 1984; Westermeyer 1976; Marsella & White 1982; O'Nell 1996).

To bridge insights of both anthropology and psychiatry, much of this work takes a middle-ground approach between the pure cultural constructivist and pure positivist standpoints to investigate experiences and meanings of psychopathology. Acknowledging

the phenomenological and biological realness of mental disorder, this approach simultaneously brings the domains of culture, power, meaning, and subjectivity into analytic focus. Both patients and healers are understood to be "embedded in specific configurations of cultural meanings and social relationships…Illness and healing are also part of the system of health care. Within that system, they are articulated as culturally constituted experiences and activities, respectively" (Kleinman 1980: 24-25). Seen holistically, the health care system is, itself, a cultural system—"both a map 'for' and 'of' a special area of human behavior" (ibid: 26)—and can be researched and analyzed as such. Understanding the "logic of knowledge of practitioners and patients" is fundamental to the study of medical systems as cultural systems embedded within wider "institutional power relations" (Connor 2001: 5).

As Mary-Jo DelVecchio Good and Byron Good put it,

> [i]n any episode of major illness, personal meanings are grounded in networks of signification and linked to basic values of a society or subculture. Such networks shape the experience of individual sufferers; they are developed, sustained and changed as individuals use medical language to articulate their suffering. Semantic illness networks thus link conscious and unconscious personal experience to cultural configurations of a society (DelVecchio Good and Good: 148).

From this perspective, the task of the analyst is not to uncover the 'real' biological processes masked by culturally colored complaints, or to subsume popular illness categories under imposed nosologies. Instead, the goal is to analyze the semantic networks, narratives, clinical interactions, and cultural meaning systems within and around which illness meaning gets made.

A turn toward meaning, experience, and subjectivity has been central to contemporary anthropology theorizing on mental health. In his 1938 paper "Why Cultural Anthropology Needs the Psychiatrist," Edward Sapir observed that anthropology until that point had, rather suspiciously, almost entirely eschewed analysis of the individual; as he wrote, it "seemed almost indelicate, not to say indecent, to obtrude observations that smacked of the personal or the anecdotal (Sapir 1938: 2). Anthropology's domain was the public personality and behavior of a society, and it sought to paint portraits of cultures writ large (Benedict 1934). But, Sapir asked, what are social and cultural patterns without the individuals who enact them (or, alternatively, contest them)? He argued that it was "only through a minute and sympathetic study of individual behavior in the state in which normal human beings find themselves, namely in the state of society, that it will ultimately be possible to say things about society itself and culture that are more than fairly convenient abstractions" (ibid: 7). Sapir's comments anticipated what has become a broader move toward subjectivity and experience as central arenas of investigation, particularly in studies of psychopathology.

Janis Jenkins & Robert Barrett argue that this move has three major starting points in culture theory: "(1) the primacy of lived experience over analytic categories imposed by anthropological theory (Kleinman 1988a); (2) the active engagement of subjects in processes of cultural construction; and (3) the irrepressibility of subjectivity as embedded in intersubjectively created realms of meaning and significance" (Jenkins & Barrett 2004: 8). And while a full appreciation of subjectivity requires attention to individuals and "the ensemble of modes of perception, affect, thought, desire, and fear that animate acting subjects" (Ortner 2006: 107), it also requires an appreciation of "the

cultural and social formations that shape, organize, and provoke these modes of affect, thought, and so on" (Ortner 2006: 107). It is the reciprocal relation between these realms that studies of subjectivity seek to capture.

Thus a fundamental basis of studies of subjectivity is an understanding of the person as "existentially complex, a being who feels and thinks and reflects, who makes and seeks meaning," and who actively positions him or herself in relation or opposition to particular discourses and ideologies even while being constrained by them (Ortner 2006: 110). Additionally, this theoretical approach draws attention to the political realm and the connection between subjectivity and subjection. As an analytical lens, 'subjectivity'

> denotes a new attention to hierarchy, violence, and subtle modes of internalized anxieties that link subjection and subjectivity, and an urgent sense of the importance of linking national and global economic and political processes to the most intimate forms of everyday experience. It places the political at the heart of the psychological and the psychological at the heart of the political" (DelVecchio Good et al. 2008: 3).

Indeed and as recent work on psychopathology and subjectivity illustrates, not only do culturally and clinically informed understandings of the self and emotion impact experience of illness and healing, but so too do structural constraints such as social and economic inequality. Medical anthropology and social medicine, among other disciplines, have revealed and interrogated ways in which inequality sculpts the distribution of suffering and illness, affects health outcomes, and impedes access to medical services (Desjarlais et al. 1995; Farmer 1999, 2005; Holmes 2007). These studies have emphasized the "pathogenic roles of social inequalities" and have shown "how large-scale social forces come to have their effects on unequally positioned individuals in increasingly interconnected populations" (Farmer 1999: 5).

The Globalization of Euroamerican Mental Health Practice

Much of the aforementioned scholarship has critiqued Euroamerican psychiatry and psychology for dismissing cultural variation and personal meaning in illness interpretation as something to be translated through and past to get at what's 'really' going on, for medicalizing and pathologizing human experience and protest (Biehl et al. 2007: 240), and for not acknowledging its own culturally created biases. Although apparently scientifically objective, neutral, and value-free, Euroamerican mental health practice is to a large degree a product of cultural process and historical milieu—and is increasingly influenced by the power of pharmaceutical companies (Braslow & Starks 2005; Healy 2002, 2006; Lakoff 2005; Luhrmann 2000; Starks & Braslow 2005; among others).[5] Medicine, psychiatry, psychology, and public health increasingly integrate culturally informed illness interpretation in practice (the inclusion of cultural factors in the DSM-IV in 1999 as well as in subsequent versions is one example of this), but these disciplines generally operate according to the view of psychopathology as a universal, biological disease process treatable through psychopharmaceutical intervention.

[5] Anthropologists, sociologists, and historians of medical knowledge have examined the ways in which psychiatric epistemology has, in the past few decades, shifted "from a focus on psychological processes to classification of symptoms, from a primary interest in affect to and its economy to cognition, and from investments in community psychiatry to biological research and pharmacological treatment" (Good 1992: 181). These changes have produced a focus on "*categories* of disorder, rather than on level of distress, and psychiatric diseases are held to be *discrete* and *heterogeneous,* that is, non-overlapping and distinguishable"; also, "criteria of categories are held to be *symptoms,* rather than etiology" (ibid: 185). Along with reducing illnesses to their signs came an expansion of what counts as illness: the number of psychiatric disorders in the DSM went from 60 in 1953 to 350 in 2000, a 480% increase (Karp 2006). These processes have been tied up with a number of developments in psychiatry, such as the Neo-Kraeplinian movement in the 1960s, which sought to refine the nosological system to make it more valid and reliable (Good 1992). Also important have been shifts in federal legislation in the U.S., including FDA policy (Lakoff 2005) and the de-institutionalization movement, which is itself tied to the development of more effective psychiatric medications.

Taking into account that biomedical psychiatry has developed technologies, medicines, and practices that have significantly improved lives of people who suffer from debilitating mental illness, the current project views both Euroamerican psychology and biomedical psychiatry as one of many "ethnopsychiatric systems"—culturally informed and culturally situated approaches to treating emotional and psychological distress (Gaines 1992). Each ethnopsychiatry has a particular view of the self, the body, and emotions, which in turn shapes what is considered pathological and how pathology should be treated. In addition to particular models of illness, ethnopsychiatries reflect upon and propose models of how to think of and treat oneself and others, and how one should perform the daily work of living (Collier & Lakoff 2005: 23). Indeed, ethnopsychiatries put forth a particular 'regimes of living,' or "elements—techniques, subjects, norms—through which the question of 'how to live' is posed (ibid).

Unlike other ethnopsychiatries, though, Euroamerican psychology, psychiatry, and their attendant 'regimes of living' are highly institutionalized and rapidly globalizing through commodities, markets, technologies, practitioners, and health organizations. Thus, while over the past three decades anthropological theory and ethnography have eloquently demonstrated the socioculturally mediated, context-based, and intersubjective dimensions of self, emotion, and illness in a number of settings, the 'cultural meaning system' implicit in predominant Euroamerican ethnopsychology and ethnopsychiatry have come to saturate self- and illness-understandings in the many regions to which these systems and their accompanying pharmaceuticals have spread. The practices, ideologies, and discourses that characterize these disciplines do not spread evenly across locales, though; rather, different cultures utilize these models in differing ways, and put their

practices (and medicines) to various uses depending on what is considered to be normal and beneficial versus what is pathological and harmful (Ecks 2003). Some actively resist them (Lakoff 2005), while others integrate them into local conceptions and treatments (Biehl 2004; Petryna et al. 2006; Ecks 2003; DelVecchio Good et al. 2008; Skultans 2007).[6]

Although this process can yield increasingly homogenous ideas of mental health and pathology, psychiatric anthropology has shown how the application of diagnoses is mediated by cultural orientations, professional preferences and personalities, and patient understandings. Thus, although psychiatric diagnoses can be homogenizing, the dynamic interactions between the 'global' and the 'local' can also contribute to the creation of new 'imaginaries'—new ways of apprehending self and others; new possibilities for living, speaking, and behaving; and new forms of hope and desire, as this dissertation illustrates (DelVecchio Good 2007; Jenkins 2010).

Illness explanatory models are not static, but rather shift according to global process and the changing sociocultural landscape of given locales and eras. As Arthur Kleinman puts it:

> Large scale changes in political economy and political power, as are taking place right now in our highly globalized world, change the cultural meaning we take for granted and the collective experience we are socialized into, and with them the self also changes, so that what we believe, how we act together, and who we are as individuals also becomes something new. And that change extends to how we regard ourselves and others. The result is that suffering, well-being, and the ethical practices that respond to human problems are constantly changing as local worlds change and as do we, the people in them, become something new and different (Kleinman 2006: 227).

[6] See Chapter 4 for additional discussion of psychiatric and psychological globalization.

As I will show in the following chapters, the intentional diffusion of Euroamerican mental health ideology, discourse, practice, and 'imaginaries' in Oaxaca is part of mental health practitioners' explicit project to change the 'cultural meanings' thought to be taken for granted in Oaxaca. Their goal is explicitly *to* change how Oaxacans regard themselves and others, to help them 'become something new and different.'

Global processes—which are reconfiguring the social and cultural sphere in Oaxaca—can and do change local medical systems, conceptions about what it means to be a healthy, stable self, what therapeutic modalities should be utilized in the case that one is not, and even the subjective experience of emotional distress. Ethnomedical systems "represent movements of historical social and cultural processes including borrowing. Given instances are but moments of a culture-in-the-making, and as such provide one of the many windows in the house of culture into which one might choose to gaze" (Gaines 1992: 19). The current study examines this 'culture-in-the-making' in Oaxaca. It provides an ethnographic account of the cultural context of illness and healing in a particular locale, and advances theoretical understanding of how those aspects of social life and subjectivity change under competing local and global discourses.

The Anthropology of Globalization

The past several decades have seen a proliferation of social scientific work on globalization, or "the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa" (Giddens 1990: 64). This work has centered on a number of different aspects of social, economic, political, and cultural life, and has emerged over the

past several decades in response to three main sets of interconnected phenomena: (1) an increasingly globalized capitalist economy and its attendant modes of production, distribution, finance, and consumption; (2) the various cultural flows and exchanges that such a system encourages and accommodates through media and movements of products and populations; and (3) "global political process, the rise of new transnational institutions, and concomitantly, the spread of global governance and authority structures of diverse sorts" (Robinson 2007: 125).

Much anthropological work on globalization has sought to understand transnational flows of media (Larkin 2008; Boellstorff 2008; Juris 2008), money (Ho 2008), companies (Caldwell 2008; Tsing 2005); people (Kearney 1995; Ong 1999; Rouse 1998; Suárez-Orozco & Suárez-Orozco 2001), images (Appadurai 1996), and ideas (Sylvain 2008; Appadurai 1996), and how these flows contribute to particular linkages, forms of hybridity, and modes of relating to one's everyday world. Time, space, and social experiences are in many senses reconfigured and recast through these flows and interconnections. While some work on globalization has emphasized the ways in which social life and representations have become unhinged and 'deterritorialized,' or detached from specific locations, anthropological studies of cultural globalization have drawn attention to the ways in which "cultural subjects and objects" are also 'reterritorialized.' Inda and Rosaldo use the formulation "de/territorialization" to capture this ongoing articulation between the 'local' and the 'global' (2008: 14-15) in which goods, ideas, markets, and so forth are detached from particular locations through processes of globalization while they are at the same time received, utilized, and re-planted in particular locales by particular actors in "a process of "mutual imbrication" (ibid: 25).

Thus, while fears of "cultural imperialism and the homogenization of the world" have been common—and, in some cases, warranted—nuanced studies of globalizing processes reveal more complexity on the local level (Inda & Rosaldo 2008: 15). Rarely is globalization a one-way process of monolithic, uniform, 'global' Western and/or American cultural forms and worldviews taking over and flattening cultural forms and worldviews in the 'local' 'periphery.' First, people do not passively absorb globalizing material and ideas; rather, they tend to engage with, actively transfigure, and sometimes strategically mobilize them in ways appropriate to the local setting. Local cultural orientations, social dynamics and tensions, and political circumstances play into the particular ways in which globalizing content is adopted, 'domesticated' (Caldwell 2008), 'creolized' (Friedman 1994), or rejected.[7]

As Friedman notes, however, social scientific analyses of globalization often tend to catalogue the existence of various cultural items and ideologies in different places, thus raising the question of whether hybridity is just "the other for-us," from the perspective of the Western observer (Friedman 2000: 640).[8] When we say that cultural forms and practices are mixed, blended, creolized, and hybrid, "[a]re not such hybrids defined as such because they seem to be betwixt and between our own 'modern Western' categories,

[7] A related and somewhat self-evident point is that cultural globalization does not act as a one-way flow from 'center' to 'periphery' or from the "west to the rest" (Inda & Rosaldo 2008: 20); from cuisine to music to people, the movement has just as frequently gone in the other direction such that "the periphery has set itself up within the very heart of the West" (Inda & Rosaldo 2008: 21). This has resulted in increased cultural heterogeneity within the 'West,' as well.

[8] With regard to social and cultural analysis in the global context, Friedman contrasts *globalization* approaches and *global systemic* approaches; the latter refers "to the analytical or theoretical properties of processes that are posited by the researcher, that is hypotheses concerning the way in which social formations are constituted and transformed over time" (Friedman 2000: 639), while the former "is about something that has happened," a proposal that "the world has changed" (ibid: 640). Global systems approaches attempt to theorize and uncover underlying structures shaped by global relations, while the latter concerns itself with "observable or experienced realities" (ibid).

i.e. hybrids for us?" (ibid: 641). Often studies of 'hybridity' produce objectified knowledge, obscuring what hybridity might actually mean in people's lives, transforming informants and their activities in to cultural texts (texts now viewed as excitingly pastiche and post-modern) whose meaning is predetermined. Friedman argues against such a notion of culture-as-text, emphasizing the need to combine studies of discourse and representation with studies of actual social practice and meaning-making (Friedman 2000: 642, c.f. Wikan 1990). We need to examine "the nature of cultural production itself rather than simply assuming that culture is a substance of thing in itself that can, as a result, move in global flows" (Friedman 2000: 645). In this light, globalization may be understood as a type of cultural process which is produced and reconstituted on the ground by social actors.

While global processes can represent increasing uniformity across contexts, therefore, they can also "present opportunities for localities not only to assert and affirm themselves, but also to recast the global according to particular and meaningful ways" (Caldwell 2008: 241). As a result, increasing heterogeneity may emerge in some areas (e.g. the types of 'selves' that might be possible in a given locale) even as homogeneity might prevail in others. In other words, increasing homogeneity and increasing heterogeneity are not necessarily mutually exclusive (Anderson-Fye 2003: 62, c.f. Suárez-Orozco 2001); more often, they coexist in global cultural flows and are negotiated by actors in particular social practices and interactions on the ground.

At the same time, the relative power, cachet, and institutionalization of 'Western' (e.g. American and European) cultural forms within the global cultural economy cannot be denied. Indeed, processes of globalization are often theorized as the various means by

which the conditions and values of modernity are becoming universalized, including elements of 'Western' "Enlightenment worldview such as freedom, welfare, human rights, democracy, and sovereignty" (Inda & Rosaldo 2008: 5). In many ways "biomedicine has become a metonym for modernity," and its expansion has been a main means by which "modernity has laid claim on people's lives" (Connor 2001: 7). Many have viewed this process as a form of neo-colonialism or Eurocentric "global coloniality" subordinating the "knowledge and cultural practices of many non-European groups throughout the world" (Escobar 2008: 3-4) in hegemonic fashion. As Escobar points out, globalization—as the extension of various aspects of modernity and subordination—raises questions like, "Whose knowledge counts? And what does this have to do with place, culture, and power?" (Escobar 2008: 4).

As analysts and ethnographers of globalization, I argue that we must simultaneously orient ourselves to agency, social practice, and production, on the one hand, and the ways in which globalization activates, entrenches, and/or assuages particular configurations of power and dominance, on the other. Bringing power relations and political economy to the fore, it is difficult to take a celebratory tone in reference to globalization's contributions to hybridity, fluidity, interconnectedness, and transcendence of borders (c.f. Hondagneu-Sotelo & Avila 1997: 549-550). Globalization is not always—or even usually—an equalizing force. The world is increasingly interconnected, but global flows are "structured and regulated, such that while certain objects and subjects are permitted to travel, others are not. Immobility and exclusion are thus as much a part of globalization as movement" (Inda & Rosaldo 2008: 29). Further, and crucially, while the spread of global capitalism and its associated structural reforms, programs,

institutions, and projects have brought gains to some and can be argued to have improved overall quality of life in particular locales, so too has it in many cases contributed to an increasing economic inequality and divides between the 'haves and have nots.'

* * *

Overall, the dissertation examines the ongoing articulation of the 'local' and the 'global' in the context of mental health practice. Consistent with the aforementioned literature, Oaxacans—practitioners, patients, and community members—do not simply absorb globalizing concepts around health, self, and pathology; rather, they actively engage with and alter them on the ground. In other words, globally expanding mental health practices and ideas impact local understandings, but are at the same time reconfigured by the local context. As the following chapters illustrate, professional and institutional representations of 'culture' are central to how this happens—and to how the articulation of the local and the global simultaneously reveals and contributes to societal tensions on the ground.

PLAN OF THE DISSERTATION

In the eight chapters that follow, I provide an ethnographic account of Oaxaca's 'culture of mental health,' culture here taken to be a particular context of "symbols and meanings that persons dynamically create and re-create for themselves in the process of social interaction…a medium of experience, interpretation, and action" (Jenkins 1994: 99-100). Cultures of mental health are by no means bound or static, but are rather emergent and historical, "a set of polyvalent practices, texts, and images that may, at any time, be contested" (Comaroff & Comaroff 1991: 17). These 'practices, texts, and

images'—as well as the ideological concepts upon which they are based and the discourses through which they are regimented and circulated—define a particular "range of possibilities for iterable speech and disciplined acting—and by extension thinking and emoting" (Zigon 2011: 15).

Oaxaca's culture of mental health as emerging on a professional and institutional level constitutes a set of discourses, ideologies, and practices "from which hegemonic forms are cast" (Comaroff & Comaroff 1991: 21). However, this culture is not universally "taken-for-granted as the natural and received shape of the world and everything that inhabits it" (ibid: 18); in other words, it is not fully hegemonic in the general community. Rather, to borrow Comaroff & Comaroff's (1991) distinction between hegemony and ideology, Oaxaca's culture of mental health is still in the realm of ideology, or "an articulated system of meanings, values, and beliefs" (Williams 1977: 109) which have not yet necessarily become naturalized as unselfconscious habit or subjectivity. Indeed, it is the shift from ideology to hegemony that many mental health practitioners hope to accomplish and which I argue is beginning to occur.

To probe these processes, I examine and attempt to bridge several analytical levels: (a) globalizing mental health discourses, ideologies, and practices; (b) local professional mental health practice; (c) local mental health discourses, ideologies, and practices, including representations of culture; and (d) individual and community understandings, experience, and practices.

In **Chapter 2**, "Oaxaca's Changing Culture of Mental Health," I propose a model through which to understand Oaxaca's growth in services. Using a Oaxaca City psychotherapy clinic as an illustrative example, I argue that the growth can be attributed

to the following interrelated factors: (1) the local and global visibility of mental health ideologies, discourses, and practices, along with general ideas about how to treat emotional problems (aspects of (a) and (c) above); (2) 'Supply' of mental health services ((b) above); (3) experience of emotional and mental distress as well as social and economic strife which may contribute to distress (aspects of (d) above); (4) desire and 'demand' for mental health services (an aspect of (d) above); (5) mental health conceptions or interpretations of distress (aspects of (c) and (d) above). I theorize that these factors interact through an ongoing feedback loop. After describing the model and the relationships between its various components, I provide an overview of the mental health services currently available in Oaxaca.

In **Chapter 3**, "Historical Foundations," I situate the current changes in Oaxaca's culture of mental health within a historical framework. Beginning with pre-Hispanic Mesoamerican medicine and tracing psychiatric developments through Mexico's independence, the chapter discusses how mental health and emotional distress have been treated both in indigenous and clinical contexts. Indigenous medicine has highly elaborated concepts and treatments around the maintenance of emotional well-being, which is conceptualized as part and parcel of one's social, cosmic, and physical well-being. As such, though indigenous practices both historically and in the present day share some commonalities with Euroamerican mental health care, they are based upon fundamentally different understandings of the self. My account also explores the historical bases for tensions between contemporary Euroamerican mental healthcare and traditional indigenous medicine—tensions which persist in the contemporary moment.

Chapter 4, "Managing Emotions & Taking Pills: Global and Local Discourse, Ideology, and Practice," examines which globalizing mental health ideologies and discourses are circulating in Oaxaca and, using several ethnographic examples, begins to outline how they are locally mobilized. I argue that there are two related processes of globalization taking place with regard to mental health, self, and sentiment: psychological globalization and psychiatric globalization. The former is based around what Nikolas Rose (1998) has termed the 'regime of the self,' or "the technologies and techniques that hold personhood—identity, selfhood, autonomy, and individuality—in place" (Rose 1998: 2). I show how psychological globalization contributes to the formation of a 'psychological imaginary' premised upon the cultivation of self-knowledge, self-expression, responsibility, and empowerment. This psychological imaginary—which is spreading through a number of means in Oaxaca—posits a view of the self as vulnerable and prone to pathology, on the one hand, and capable of agentive transformation and liberation, on the other.

For its part, psychiatric globalization is based upon universalizing notions of mental health and pathology as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) and the World Health Organization's *International Classification of Diseases* (ICD), as well as the transnational spread of the many pharmaceuticals developed to treat those pathologies. Psychiatric globalization is facilitated by global health governance organizations like the WHO and multinational pharmaceutical companies and markets, but the psychiatric imaginary it produces is not as widespread in Oaxaca as the psychological imaginary. I theorize that this is in part because psychiatric globalization deals explicitly with pathology rather than with the

more quotidian project of self-cultivation, but also because Mexico lacks direct-to-consumer pharmaceutical marketing. As such, psychiatrists take it upon themselves to spread the psychiatric imaginary in both clinical and non-clinical settings.

In **Chapter 5**, "Creating Consciousness, Changing Culture: Oaxaca's Mental Health Practitioners," I continue my analysis of Oaxacan psychological and psychiatric practice by examining the conflicted role of culture in the professional ethos of mental health. To do so, I examine the interactions between three interrelated domains: (1) the transmission and diffusion of new psychological and psychiatric ideologies in Oaxaca; (2) discourses around culture, tradition, and mental health; and (3) the role of mental health practitioners as 'conduits of the global' who are actively attempting to mold 'the local' and produce subjects commensurable with not only mental health, but modernity more generally. I show how Oaxaca's growing field of mental health services is linked to forms of neoliberal governmentality; as such, mental health is framed in the context of democratic human rights, on the one hand, and economic development, on the other.

By dispelling so-called 'cultural' practices and by providing *psicoeducación* in local media, schools, health institutions, development initiatives, and clinical practice, practitioners are engaged in a widespread project of 'emotional modernization,' or the cultivation of subjects consistent with globalizing notions of self, health, and sentiment—the 'psy-imaginaries' I presented in the previous chapter. Practitioners promote, teach, and 'diffuse' these notions with the explicit goal of making them a part of Oaxacans' everyday commonsense reality. Mental health practitioners' enterprise therefore goes well beyond the provision of treatment: I argue that they are explicitly attempting to foment culture change in the region. Mental health practice in Oaxaca is, I contend, a

'device of meaning production' (Rose 1998: 25) which not only provides means of self-understanding and technologies for self-cultivation in the context *of* modernity, but which actively seeks to produce the psychological conditions *for* modernity.

Chapter 6, "Gendered Trauma and its Effects: Domestic Violence & PTSD," homes in on the particular ways in which psychiatric diagnoses are locally understood and applied. Specifically, I analyze how post-traumatic stress disorder ('PTSD') has recently emerged in Oaxaca as a salient diagnosis in cases of migration and political violence, while the psychological impacts of domestic violence are diagnosed in the framework of mood and personality disorders. This is particularly striking given the visibility of widespread anti-gender violence campaigns in the region emphasizing the traumatic effects of such abuse. I show how the growth of trauma discourse in Oaxaca has generated new ways of thinking about the effects of violence, yet the clinical use of the PTSD diagnosis has been circumscribed by the notion that domestic violence is a routinized 'cultural problem' too ingrained to generate the disorder. This chapter therefore continues to explore the centrality of cultural representations to the local incorporation of globalizing psychiatric categories and practices. Clinical practice is, in this context, a "key site for managing difference" (Ticktin 2011: 150).

At the same time, as I show in **Chapter 7**, "Narrating Illness at the Psychiatric Hospital," clinical practice is also a site for the alleviation of extreme suffering and the generation of hope. In this chapter, I provide an ethnographic account of the Cruz del Sur psychiatric hospital and present a series of six patient case studies. These case studies illustrate how patients see their afflictions as deeply rooted in social crises and familial conflicts—particularly violence, loss, relationship breakdowns, poverty, and migration—

highlighting the pervasiveness of social suffering in Oaxaca as well as an understanding of the self as constituted in and through relationships. Patients maintain several explanatory frameworks for their illnesses simultaneously; at the hospital, they integrate psychiatric 'bionarratives' (Carpenter-Song 2007) and begin to emphasize the central importance of psychopharmaceuticals to recovery. Patients thus become 'pharmaceutical selves' (Jenkins 2010), but the degree to which selves are "oriented by and toward pharmaceutical drugs" (ibid) are contingent upon the degree to which medications create spaces for hope and the ability to participate in the ebbs and flows of social life.

This chapter also discusses my finding that approximately one-third of the outpatients at Cruz del Sur are returned migrants, many of whom attribute their illnesses to unexpected and bewildering mental health crises brought on by the migration experience. These findings have important implications for the literature on undocumented migration and health, particularly recent work on the structural conditions of vulnerability in which many undocumented migrants live (Holmes 2007; Horton 2009; Quesada, Hart & Bourgois 2011; Willen 2005, 2007). Stressors intrinsic to the condition of 'illegality' can contribute to distress and prompt migrants to return to their towns of origin for help and support; however, returning home—sometimes in states of confusion and usually in states of despair—these migrants face yet more barriers in their struggles to communicate with family members and healthcare practitioners on the Mexican side.

Chapter 8, "Mental Health in Migrant Sending Communities," I explore the theoretical and evidential link between migration, mental health, and the growth of mental health services in Oaxaca. The chapter focuses on mental health practitioners' perceptions of migration and its effects, particularly with regard to familial separation

and return migration. I argue that migration is viewed and treated as a pressing matter of mental health and as a source of social and moral decline. From practitioners' standpoint, migration-related family separation instigates a cycle of abandonment, family separation, and social role abnegation. Because this cycle is understood to produce resentful, emotionally unstable women and alienated, deviant children, both women and children are viewed as prime candidates for mental health intervention. For their part, returned migrants are frequently perceived as moral 'Others' further eroding the social fabric and contributing to violence and unrest. Put together, practitioners' discourse around migration frames it as a pressing moral and public mental health emergency contributing to societal and individual 'imbalances' as well as increased demand for mental health services.

In **Chapter 9,** "Transnationally Shaped Sentiments," I continue my analysis of migration's role in Oaxaca's culture of mental health. This chapter examines experiences of migration-induced distress—particularly family separation—and contributes to the critical phenomenology of migration and illegality (Willen 2005, 2007; Horton 2009) by applying that theoretical framework to the case of non-migrants in migrant-sending communities. Specifically, I argue that emotional health and well-being in this context must be conceptualized as transnational—rooted in sociopolitical processes, emotional experiences, and movements occurring on both sides of the border and beyond—particularly among community members with close relatives residing in the United States. I show how 'transnationally shaped sentiments' compose an important aspect of non-migrants' mode of being-in-the-world—and how they contribute to the spread of 'psy imaginaries' and the desire for mental health services in the region.

I close the dissertation with a final case study in the **Conclusion**, which illustrates how self and subjectivity are changing in tandem with Oaxaca's changing culture of mental health.

CHAPTER 2

OAXACA'S CHANGING CULTURE OF MENTAL HEALTH

Paula Aragón, psychologist and Health Ministry administrator: Psychologists have worked very hard to raise awareness about psychological services. People are starting to learn…that they don't only have to take care of their bodies but also their—their minds, their emotions. So demand is increasing. People now know that if you have relationship problems, problems managing your kids, family problems you can go to a psychologist, while before, they would never have considered it.

José Luis Arias, psychotherapist: …I think that in the past nine years [psychology] has grown a great deal here. There are more psychologists, and people are more open to psychology. Before, it was very rare; people felt uncomfortable, like 'I must be crazy,' or 'what are they going to say about me if I go to the psychologist?' But now it's more and more common, the taboo around only *locos* going to psychologists has been broken. There are more and more workshops that have to do with psychology and human development, and for the last nine years many styles and traditions [of therapy] have emerged…When I arrived here [ten years ago] there was hardly anything.

Lara Hernández, psychologist: I think that yes, [the openness] has to do with more centers, more psychologists, more group workshops. So they are adding up, people are telling others, 'I already went [for treatment], I already went,' so it becomes something more common…The fact that there is more movement [in the field] makes people seek treatment more. It becomes something more normalized.

Dra. Mariana Pérez, medical doctor, psychologist: Things have changed a lot; the panorama has opened up dramatically. Eighteen years ago you really had to put your nose to the grindstone in this sense. There was a small group of psychiatrists and psychologists, and…it took a great deal of work to pave the way. Whereas currently, people are much more sensitized…and they accept the help much more... Back then, there were social cues that if you went to a psychologist or psychiatrist you were kind of crazy, or really crazy. Now, no. Now it's a resource for whatever type of issue. People are very open. There has been an increase in psychological attention at schools—it's very different than it was before…From a social point of view, as a society we are much more willing, much more open.

One morning in June, 2010, I forgot I had decided to stop answering my landline and picked up the phone. I had been making a point not to, because nine times out of ten

it was an automated message from one of the competing political parties in the gubernatorial elections. They were dialing and redialing local numbers, punctuating residents' days with campaign propaganda. In the month before elections, one could expect to receive up to five calls a day with automated messages about 'transforming Oaxaca' or 'peace and progress,' urging Oaxacans to vote for one party or another. When I heard the automated voice I almost hung up, but then realized that the voice was offering me "free psychological help," "because we need to transform Oaxaca" ('*atención psicológica gratuita,' 'porque necesitamos transformar a Oaxaca'*). I was so taken aback by the offer that, much to my regret, I hung up at the end of the message rather than pushing '1' to see what the psychological help would have entailed.

If the lesson had not been driven home before this moment, it was now clear: mental health care had 'arrived' in Oaxaca, and was living a moment of highly visible cultural cachet. The necessity of psychological care and the importance of attending to one's emotions was an idea that had permeated not only the upper echelons of Oaxacan society and its growing middle class, I realized once again as I hung up the phone, but the public imaginary more broadly. It was a campaign slogan, another aspect of change and transformation that political candidates pledge to enact. As I argue throughout the dissertation, the project of both providing mental health care and teaching about mental health is intimately bound up with explicit projects to change and transform Oaxaca, to rescue it from the backwaters in which it is perceived to exist, and to modify its culture at a basic level.

Although a wide assortment of mental health services is perhaps to be expected in a cosmopolitan city such as Oaxaca, their growth over such a short period is striking even

to local mental health professionals. Nearly every practitioner interviewed explained that until relatively recently, few options existed for mental health care in the state, much less an array. From their perspective, until about 15 years ago mental health was marginalized and neglected on every level: institutionally, mental health was not prioritized and therefore very few public health services included psychological or psychiatric care; professionally, doctors neglected mental health as an area of concern and rarely made referrals to mental health specialists; and socially, Oaxacans viewed mental health as a domain pertaining exclusively to "crazy people."

Practitioners still express struggling against suspicion and hostility (indeed, this sense of stigmatization is a central characteristic of their professional ethos, as I explain in Chapter 5), but—as the interview excerpts at the outset of the chapter illustrate—they emphasize that overall, there has been a dramatic increase in the number of psychological and psychiatric services, growing readiness among Oaxacans to accept such services and their accompanying ideas, and increasing desire and, to use their phrasing, 'demand' for such services. However, exactly how these factors and others have come together to produce an emergent 'culture of mental health' is unclear. Has the increase in services been a response to 'demand' for such services on the part of Oaxacans? If so, to what can such demand be attributed? Are more people suffering and thus in need of mental health services? Alternatively, has the visibility of mental health on global level created broader 'awareness,' itself contributing to an increase in desire for services? What role do practitioners themselves have in the change?

To begin answering these questions, I will describe the history and current composition of one locally operating clinic, the *Centro de Atención y Formación*

Humanista (CAFHAC), whose story illuminates some of the processes at hand in Oaxaca's changing culture of mental health. Using CAFHAC as an example, I then propose a theoretical model which both delineates the levels of analysis with which the dissertation engages and illustrates how particular factors within these levels interact to create a context in which mental health services are flourishing. Next, I provide an overview of the current composition of mental health services in Oaxaca.

CENTRO DE ATENCIÓN Y FORMACIÓN HUMANISTA

The Center for Humanist Treatment and Training [*Centro de Atención y Formación Humanista*, or CAFHAC] is a private psychological clinic and training program located on one of Oaxaca City's main thoroughfares, a road perpetually congested with buses, trucks, and cars. Riding a bus from one of Oaxaca City's outlying *colonias* into the center of town, it is hard to miss CAFHAC's office building: though small and unassuming, it is covered with logos and advertisements for CAFHAC's extensive therapy and training offerings. Painted in shades of yellow, brown, and green, the building's façade reads (in Spanish):

Center for Humanist Treatment and Training, A.C.
*Psychotherapy Clinic * Specializations * Certificates * Master's Degrees*
** Creating spaces for personal growth since 1996**
http://www.cafhac.org

On one side of the entryway, a vinyl sign asks, "Do you want to improve your physical and emotional quality of life?" and advertises their psychotherapy clinic, which serves children, adolescents, and adults in both individual and group modalities. The other side

of the entryway more specifically delineates the Center's offerings: specializations in Human Development, certificates in Neuro-Linguistic Programming[1] and Gestalt psychotherapy, a psychotherapy clinic, "organizational development", courses and workshops, and a master's degree in Ericksonian psychotherapy.

One of CAFHAC's founders and leaders, a medical doctor and psychotherapist from Mexico City whom I will call Miguel Sarmiento, recounted how the center came to be founded in Oaxaca 15 years ago, a time when there were "few means of surviving [as an organization] because…the culture of psychotherapy was something very, very little solicited" in Oaxaca. Miguel, who is energetic, dedicated, and rather intense, did not take the absence of a 'culture of psychotherapy' in the state as an indication that psychological services were not needed. On the contrary, he perceived a "serious necessity" for practitioners who could begin to address Oaxaca's "social and familial structures," which generate "conditions contributing to more and more problems every day." In Miguel's view, these 'conditions'—reinforced through processes of "social learning" [*aprendizaje social*]—are authoritarian social and political structures; marginalization, inequality, and poverty; gender; emigration; and violence, all of which contribute to grave "emotional conflicts" and "stress" for the people of Oaxaca.

Though a medical doctor and epidemiologist by training, Miguel expressed disillusionment toward medicine's ability to address such problems. In his view,

[1] Neuro-Linguistic Programming™ is, according to neurolinguisticprogramming.com, "the study of the structure of subjective experience and what can be calculated from that and is predicated upon the belief that all behaviour has structure." Developed by Americans Richard Bandler and John Grinder in the 1970s, the therapy is based upon "formal models" of "linguistic and behavioural patterns" and was "specifically created in order to allow us to do magic by creating new ways of understanding how verbal and non-verbal communication affect the human brain. As such it presents us all with the opportunity to not only communicate better with others, but also learn how to gain more control over what we considered to be automatic functions of our own neurology" (ibid).

biomedicine and particularly psychiatry "medicalizes" its users by ignoring the social roots of their problems. "Problems of mental health," Miguel told me, "are caused by the social environment…Mental health is fundamentally a matter of learning, and the main problems have to do with communication, with complex social environments, with what we call 'social teachings' [*enseñanzas sociales*] that are incongruent with the needs of individuals."

What Oaxaca needed, in Miguel's view, was an approach addressing both the whole social environment [*entorno social*] and its effects on individuals and families. With a colleague, he formed CAFHAC as a humanistic psychotherapy center, a training center for professionals, and an educational center for members of the community at large. The structure of the organization would facilitate "mental health" on a number of levels: emotional and psychological issues resulting from social breakdowns could be dealt with in therapy; more mental health professionals could be trained to offer such services; and non-professional members of the broader community could use the skills and knowledge gleaned from various workshops [*talleres*], seminars, and training sessions to resolve problems in their personal lives, workplaces, and communities—and, in the process, help circulate a particular understanding of mental health.

According to their website, CAFHAC "trains professionals who are able to promote, in groups and among individuals, processes of meaningful learning, generating a global perception of the challenges facing the modern world," of which Oaxaca is presumably a part. This "global perception" likely refers to the international (e.g. non-Mexican) and interdisciplinary nature of CAFHAC's programs and philosophies. In addition to Neuro-Linguistic Programming (founded and developed in the United States),

Gestalt psychotherapy (Germany), and Ericksonian hypnosis (U.S.), CAFHAC also offers workshops (for example, a "*Taller Re-Conociéndome*" [Re-Knowing Myself Workshop][2]) and "theoretical-experiential" courses ranging from Ancient Greek mythology to Native (North) American history, culture, and "spiritual legacy." Hundreds—if not thousands—of Oaxacans have taken these courses over the past 15 years, and Miguel thinks they have had an impact. "There has been a lot of change," he said. "[Now] there is more of a culture of psychotherapy, and there are many more formally trained people. There's more offer and more demand, I think. Now, the idea of going to a psychologist is relatively normal."

Like Miguel, CAFHAC co-founder Concepción Díaz recounted a history in which CAFHAC—itself strongly influenced by foreign philosophy and treatment modalities—has "had an effect on the population" of Oaxaca. In her view, as one of Oaxaca's first institutes to provide humanist psychological treatment and training, CAFHAC has helped to make mental health visible as a legitimate area of concern. In so doing, Concepción told me that they have helped spur a change in Oaxacans' understanding of mental health and its appropriate treatment. "People begin to think differently," she said. "As a society we are in this process of creating awareness that mental health is important, that emotional work is important, that attending to the mental and the emotional can contribute to improving our quality of life, our relationships with others."

Concepción and others explained that CAFHAC was having an impact not only by providing treatment and thus resolving problems for individuals, couples, and

[2] As CAFHAC's website put it, "Re-knowing myself means touching myself without fear, looking inside myself and discovering what I am, beyond the disguises I use to present myself in the outside world, beyond obligations, beyond fear, beyond emotions." The workshop was offered in the summer of 2011.

families, but by gradually changing conceptions on a societal level. They attributed CAFHAC's success to the explicit mission of "creating consciousness" and awareness [*crear conciencia*] of psychological services and promoting a psychologized view of individual experience and broader social relations. Since CAFHAC began, Concepción said, universities have begun to incorporate humanist training into their curriculum, a generation of humanist psychologists have been trained, countless Oaxacans have received treatment and educational sessions at CAFHAC, and—as a result of these efforts combined with pre-existing social problems in Oaxaca—desire for such services has grown considerably.

Miguel and Concepción are by no means the only practitioners to note the rapid change at hand in Oaxaca's 'culture of mental health,' and nor are they the only to take partial credit for it. Indeed, CAFHAC's approach to mental health is one of many circulating in Oaxaca. However, I suggest that some of the themes in Miguel and Concepción's account of their own success can be considered emblematic of the processes by which mental health services have flourished more generally in the state.

GROWTH IN SERVICES: THEORETICAL MODEL

In particular, to understand the complex environment in which mental health services and a more general 'culture of mental health' have begun to thrive, I argue that the following factors must be considered and analyzed:

(1) The local and global visibility of mental health ideologies, discourse, and practices, as well as general ideas about how to treat emotional problems [V];

(2) The 'supply' of mental health services [S];

(3) Experience of emotional distress and illness as well as social and economic strife, which may contribute to and/or become embodied as mental health problems; in other words, the social determinants of illness and distress [EXP];

(4) Desire and 'demand' for mental health services [D]; and

(5) Lay (i.e. non-professional) mental health conceptions or interpretations of distress [MH].

To illustrate the particular relationships between these factors (which I will explain in more detail below), I propose the theoretical model presented in Figure 2.1.

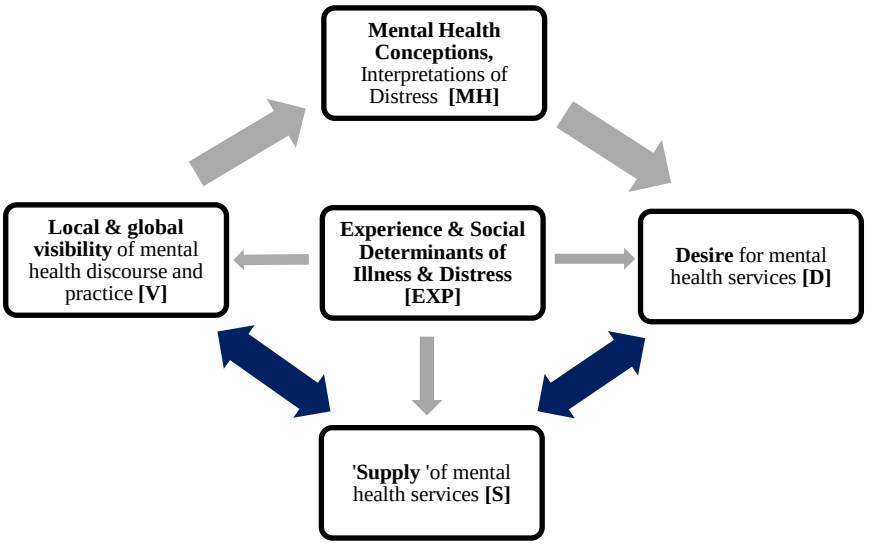


Figure 2.1: Theoretical Model: Change in Oaxaca's Culture of Mental Health

The model theorizes all of the factors as related, and some as dialectical (see blue arrows) in an ongoing feedback loop which drives the growth in mental health services and the overall changes in Oaxaca's 'culture of mental health.'

This model is grounded in anthropological theories of the relationship between structural factors (global trends, culture, society, politics, and institutions) on the one hand, and individual or community experience, action, and agency on the other (Ortner 2006). From the view of contemporary culture theory, the relationship between "the structural constraints of society and culture on the one hand and the 'practices'…of social actors on the other," are dialectical, rather than in opposition to each other (Ortner 2006: 2). In the current project, structural 'constraints'—including the economic policies and processes contributing to the globalization of mental health discourses, ideologies, and practices—are theorized as not only constraining, but also productive of social practices and particular forms of self-understanding (Parish 1996; Comaroff & Comaroff 1991).

The reciprocal relations between structural factors and individual and community factors highlighted by culture theory have proven indispensable to theories of globalization, as well (see Chapter 1 and Chapter 4). In his call for a "global anthropology," Friedman (1994) emphasizes the need for anthropologists to examine the "ongoing articulation between global and local processes," which, because they mutually shape each other, cannot be considered in isolation (12). The dissertation attempts to illuminate this mutual shaping of the local and global as it is taking place in Oaxaca. To do so, I engage various levels of analysis and seek to draw attention to the places and spaces in which they overlap.

The model serves two purposes: it delineates the particular levels of analysis with which the dissertation engages, and illustrates how particular factors within these levels interact. What follows are definitions of each of the factors and a brief explanation of the model, with CAFHAC as an illustrative example. The definitions I provide are

intentionally simplified to clarify the model; however, I will elaborate upon and further complicate them as the dissertation progresses.

Experience and Social Determinants of Illness & Distress [EXP]

By 'experience of illness and distress,' I am referring to suffering on the part of community members. By the 'social determinants of illness and distress,' I am referring to social and economic strife which may contribute to and/or become embodied as emotional and health-related problems and suffering.[3] More precisely, the social determinants of illness and distress encompass the following domains:

(1) The *material conditions characterizing the lives of Oaxacans,* including poverty, marginalization, and inequality, as discussed in Chapter 1. These conditions have contributed to a context of widespread emigration in Oaxaca's rural communities; in turn, migration has become an important matter of mental health in the region. Practitioners explain it is one of the main reasons more mental health services are needed in Oaxaca, and community members experiencing migration-related distress express the desire for additional means of psychological and emotional support (see Chapters 7, 8, and 9).

(2) *Social problems characterizing the lives of Oaxacans,* including (but not limited to) gender inequality and domestic violence, political violence and impunity, the marginalization of indigenous peoples, lack of access to education and healthcare, and an increasing sense of insecurity and alienation. These problems, too, can generate

[3] Of course, a number of factors can potentially contribute to illness and distress, including biological and genetic ones. However, this is not intended as a model of illness, but rather a model of the interaction between the factors contributing to a changing landscape of mental health in Oaxaca.

emotional distress and contribute to higher rates of diagnosed mental disorder. As Desjarlais and colleagues point out in their 1995 *World Mental Health* volume, "mental, social, and behavioral problems represent overlapping clusters of problems that, connected to the recent wave of global changes and new morbidities, interact so as to intensify each other's effects on behavior and well-being" (Desjarlais et al. 1995: 6).

Perhaps even more than poverty, rapid social change and resultant erosion of social support are important determinants of distress which can contribute to elevated rates of psychiatric symptomatology and disorder. This is related to the degree of insecurity that globalization and social change can provoke, insecurity defined here according to Patel and Kleinman's definition: "stability and continuation of livelihood, predictability of relationships, feeling safe, and belonging to a social group" (Patel & Kleinman 2003: 611). In contexts like rural Mexico, where it is seldom feasible for small-scale farmers to compete in the global economy, 'continuation of livelihood' is severely at risk.

Using Paul Farmer's (2005) term, itself borrowed from liberation theology, the social determinants of illness and distress can be considered as conditions both engendered by and contributing to "structural violence": "a broad rubric that includes a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestably human rights abuses" (Farmer 2005: 8), as well as "social and economic inequalities that determine who will be at risk for assaults and who will be shielded from them" (ibid). Not only are experience of illness and its social determinants important to understand in their own right, but social and economic problems—perceived

by many in Oaxaca to be worsening—were also raised time and time again by professionals, patients, and general community members as an explanation for both the growth in services and Oaxacans' increasing desire for them. Miguel and his colleagues at CAFHAC noted myriad problems in the *entorno social* [social environment], including authoritarianism, gender and income inequality, and violence. From CAFHAC's view, these factors contribute to experience of stress, emotional conflict, and personal/familial problems, which in turn are thought to be best addressed in therapy. It was the perception of social problems and their emotional impacts that provided the impetus for CAFHAC's establishment in the first place. At the same time, experience of such problems feeds ongoing desire for CAHFAC's services.

In the model, experience of illness and distress as well as the social determinants of illness and distress [EXP] contribute to desire [D] for services which aim to address suffering and pathology. Would-be professionals perceive illness and distress—again, exacerbated by social and economic strife—and interpret this as a need for mental health interventions and education. Seizing this opportunity for both employment and altruistic community engagement, they become trained professionals and offer services; thus, [EXP] also contributes to Supply [S].

In a similar fashion, the ubiquity of 'mental health' as an area of concern and intervention [V] is driven by [EXP]. The theory that mental health problems are universal, exacerbated by social and economic problems, and essential to bring to light drives both global and local campaigns, media attention, and educational efforts [V] which themselves promote particular understandings of mental health.

Supply of Services [S] refers to the actual mental health services and professionals that exist in Oaxaca (see "The Current Landscape of Mental Health Services" section below). In the CAFHAC example, [S] is the psychotherapy center and the individual CAFHAC practitioners.

Desire & Demand for Services [D] refers to: *perceived need* (on the part of practitioners) for such services due to debilitating illness and distress among community members; community members' *desire for access* to these services; *propensity* to utilize such services when they exist; and *actual utilization* of such services. Desire for mental health services and access to psychologists was—despite practitioners' feeling that many Oaxacans still spurned them and stigmatized their services—an important theme in my interviews with both patients and general community members in Oaxaca City and especially the Mixteca region, as Chapter 8 discusses.

[D] according to Miguel and Concepción would be their perception that services were and are needed by Oaxacans; Oaxacans' propensity to utilize CAFHAC's psychotherapeutic services; and their actual utilization of such services.

In the model, [S] and [D] are reciprocal. The existence of services—as well as people's success with them, which they tell others about—contributes to continuing utilization and to more people desiring such services.[4] Desire for services in turn contributes to more professionals seeing opportunity and offering such services.

[4] Of course not everybody has positive experiences with mental health services, and dissatisfaction could contribute to negative accounts spread through word of mouth—which in theory could hinder the growth of services. Since services were so clearly spreading, however, I theorize that mental health service-users [*usuarios*, to use the language of practitioners] were more likely to 'spread the word' after having had success with treatment (see Chapter 7).

Global and Local Visibility of Mental Health Issues & Services [V]

This category refers to two related factors:

(V1) Globalizing discourses and ideologies of "mental health" as conceived of by Euroamerican psychology and biomedical psychiatry, which are increasingly salient in a number of cultural settings. I elaborate upon these ideologies and the discourses and practices which accompany them in Chapter 3, and discuss precisely how practitioners and campaigns in Oaxaca promote and teach them in Chapters 4, 5, and 6.

(V2) Local and global institutions, organizations, campaigns, media coverage, conferences, and educational efforts meant to circulate the above concepts and promote the utilization of psychological and psychiatric services and psychopharmaceuticals. These will be discussed throughout the dissertation. Practitioners themselves ([S]) often form a component of [V2] in the sense that they actively promote particular ideologies, discourses, and practices as they provide services. As Chapter 5 discusses, they often do so by means of so-called *psicoeducación.*

[V] can be summarized as the local and global visibility of mental health ideologies, discourses, and practice, as well as particular ideas about how to treat emotional problems. [V] is in turn tied to broader forms of globalization, such as economic globalization and the power of international governance organizations such as the World Bank and the World Health Organization to set local agendas with regard to health and development (see Chapter 4). Often, development projects require psychosocial treatment programs (Pupavac 2001); more broadly, particular configurations of state-provided care are required by the terms of loans from the World

Bank and the IMF, and these often include imperatives for mental healthcare. Economic globalization also contributes to the conditions under which—for example—multinational pharmaceutical companies market to Mexican mental health professionals (again, see Chapter 4).

In the CAFHAC example, [V1] are the globalizing discourses and ideologies around mental health as conceived of in the therapeutic traditions of Gestalt psychotherapy, Ericksonian hypnosis, and Neuro-Linguistic Programming, among others which CAFHAC explicitly utilizes and promotes. [V2] are CAFHAC's educational initiatives which train new professionals to provide these services (contributing to [S], therefore) and which aim to 'create consciousness' of them—and their attendant discourses and ideologies—in the broader public (thus contributing to [MH]).

In the model, [V] impacts mental health conceptions and interpretations of distress [MH] in that [V] promotes particular understandings of and practices around mental health. I theorize that global and local visibility of mental health issues, discourses, and ideologies contributes to more psychologically and psychiatrically oriented understandings of emotion, pathology, and distress, but that these do not necessarily replace or fully usurp pre-existing understandings (see Chapter 7).

[V] also contributes to a growth in the supply of mental health services [S] in that would-be practitioners are exposed to campaigns, media attention, and educational efforts (in other words, the prevalence of psychological and psychiatric practice and ideology) which emphasize the importance of mental health and the need [*necesidad; demanda* in the words of many practitioners] for access to services. Exposure to [V] therefore

theoretically drives an increase in the number of mental health professionals offering services.

Mental Health Conceptions/Interpretations of Distress [MH]

This construct refers to culturally shared lay theories about the mind, psyche, emotions, and pathology. The questions of whether and how people conceive of emotion; what types of experiences they deem pathological; how distress is interpreted; and what treatment(s) should be utilized in the case of distress and pathology (see Chapter 1) would all fall within the domain of mental health conceptions and interpretations of distress. In this definition, the question of whether emotions themselves are experiences that can and should be identified and understood is itself an aspect of 'mental health conceptions.' Distress may or may not be conceptualized as 'emotional' or as an aspect of 'mental health' to begin with; the label 'mental health conceptions' does not intend to presume such theories. Rather, it is meant to convey the manifold ways in which a person—or a people—think of and talk about the mind, psyche, emotions, and pathology.

Along with addressing the experience and social determinants of illness and distress [EXP], Miguel and Concepción's main goal at CAFHAC was purposefully changing [MH]. Repeatedly they discussed "creating consciousness," promoting "meaningful learning," and "modeling" certain conceptions, behaviors, and approaches to mental health, thus circulating them in the broader population with the express purpose of generating change. First, they said, they must promote the idea that mental health and emotions are valid and important concerns to begin with; then, they provide tools to interpret and express psychological and emotional experience in a particular way. The

vision is that CAFHAC patients and students undergo “a process of individual change” which they then “model” in social interaction. Their social interlocutors are affected in turn, in a kind of snowball effect, such that the particular ideologies and practices promoted by CAFHAC diffuse and reverberate throughout the society.

In the model, and as stated above in the explanation of [V], [V] can affect mental health conceptions and interpretations of distress [MH] in that [V] promotes particular understandings of and practices around mental health which are in turn taken up by members of the community. I theorize that global and local visibility of mental health issues, discourses, and ideologies contributes to psychologically and psychiatrically oriented understandings of emotion, pathology, and distress. In turn, such conceptions contribute to an increase in desire and demand for psychological and psychiatric services [D]. However, [D] is not necessarily dependent upon psychologically and psychiatrically oriented mental health understandings; as I will discuss in Chapter 7, people may maintain several interpretations of their distress while utilizing mental health services. Also, they may utilize mental health services concurrently with other types of care. In other words, one’s understanding of distress and one’s treatment-seeking decisions are related, but not determinative, and frequently, various treatment preferences and conceptions of distress are utilized concurrently.

Table 2.1. Summarizes the relationship between each of the factors in table form.

Table 2.1: Theoretical Model: Growth of Mental Health Services

Unidirectional Processes (Grey Arrows in Visual Model)	
Local & Global Visibility of MH [V1 & V2)→Mental Health Conceptions [MH]	*Local and global visibility of mental health issues, ideologies, and discourses + ideas about how to treat emotional problems contribute to changing understandings of emotions & mental health in the local context*
Mental Health Conceptions [MH] →Desire/Demand for Services [D]	*Particular lay conceptions of emotional health (e.g. psychologically/psychiatrically-oriented understandings) contribute to people seeking psychological/psychiatric care when they experience distress or illness*
Experience and Social Determinants of Illness & Distress [EXP] →Desire/Demand for Services	*Social problems and distress lead people to seek services – few would seek services if they felt fine*
Social Determinants of Illness & Distress [SD]→Supply of Services [S]	*Would-be professionals perceive strife & suffering, a need for health interventions & education, as well as opportunity for employment; become trained practitioners and offer services*
Experience and Social Determinants of Illness and Distress [EXP)] →Local and Global Visibility of MH [V1 & V2]	*Theory that mental health problems are universal and must be brought to light; that distress is prevalent and untreated; that social problems can be detrimental to mental health contributes to global & local public health campaigns, media coverage, educational efforts*
Bidirectional Processes (Blue Arrows in Visual Model)	
Local & Global Visibility of MH [V1 & V2] ←→Supply of Services [S]	*More campaigns, TV/radio shows, and educational efforts (prevalence of psychological and psychiatric practice, discourse, & ideology) contributes to more people becoming professionals, offering services. More professionals contributes to more campaigns and TV/radio shows, educational efforts on a local and global level.*
Supply of Services [S]←→Desire/Demand for Services [D]	*Existence of services and people's success with them leads to continuing utilization and to more and more people desiring them. Demand for services leads to more professionals seeing opportunity and offering such services*.

Several caveats to this model are in order. The schematic is not meant to be exhaustive; as I will show throughout the dissertation, there are various other factors at play in the growing salience of mental health practice, ideology, and discourse in Oaxaca. Perhaps most important to note is that Oaxacans' conceptions have not switched from one model to another in any simple manner; rather, they tend to manage several explanatory frameworks simultaneously. However, I do argue that understandings are increasingly incorporating psychological—and sometimes biomedical—models. Also, the supply of services has not grown equally in all locales: there continues to be disparities in access among urban (usually *mestizo*) and rural (usually indigenous) residents, despite the apparent desire for such services among rural residents (see Chapters 7 and 9). In this sense, treatment *preferences* and *options* are at odds, such that many who would seek Euroamerican treatment if it were available either seek alternative treatment or forego treatment altogether.

There are several other noteworthy factors not explicitly included in the model, particularly the importance of word of mouth and social interactions in the spread and reproduction of psychological and psychiatric 'imaginaries' (see Chapters 4, 7, and 9). As we will see in Chapter 7, patients at the public psychiatric hospital are likely to spread the word about the efficacy of psychiatric care once they have experienced symptom relief with the use of pharmaceuticals. Many patients mentioned that they themselves heard of the hospital's powerful ability to 'cure' through relatives, friends, and local authorities who either knew someone who had sought treatment there or who had sought treatment there themselves. We can think of these patients as 'early adopters' who frequently

embark on personal projects of 'spreading the word' and attempting to de-stigmatize mental health conditions in their communities.

Related to word of mouth and social interactions are migration and tourism, which arguably contribute to the spread of 'psy imaginaries.' I initially theorized that migration would play an important part in Oaxacans' awareness of psychological and psychiatric services, but this hypothesis was not borne out in the data. No one I spoke to said they became aware of psychological services, discourses, or practices by means of a migrant who had been exposed to Euroamerican psychology or psychiatry in the United States. It seems Oaxacans in Oaxaca may have better access—or at least *perceived* access—to such services than do Oaxacan migrants in the United States, despite the fact that mental health services are much more widespread and well-established in the U.S. The quantity of returned migrants at the psychiatric hospital attests to this possibility (see Chapter 7 for further discussion).

The presence of Americans and Europeans in Oaxaca, on the other hand, may well be an important factor in the spread of services, ideologies, and discourses. Many Americans and Europeans visit Oaxaca as tourists, and there is a sizeable population of ex-patriots who live permanently there and who are frequently involved in the non-profit and development world—which is itself important to both the provision of psychological and psychosocial services and to spreading particular discourses around psychological well-being, 'empowerment,' self-esteem, and human rights.

Before contextualizing the changes underway in Oaxaca by providing a historical account of Mexican medicine and mental health in the following chapter, I will provide an overview of the services which currently exist (the 'supply' [S]).

CURRENT LANDSCAPE OF MENTAL HEALTH SERVICES

What follows is a partial account of the mental health services that exist in Oaxaca. My intents in this section is to (a) provide the foundation for analyses of these services in coming chapters, (b) document the extent of such services in the current historical moment, (c) elaborate upon with which of these services I conducted fieldwork and interviews, and (d) more generally paint a picture of the diverse array of mental healthcare now available in Oaxaca. Starred services (*) are those which will reappear throughout the dissertation and which will be more extensively described and analyzed in forthcoming chapters. Only services explicitly targeting "mental health" are detailed here; I distinguish these from indigenous medicine, which (as discussed in the following chapter) does not necessarily differentiate mental health from overall well-being. Additionally, while indigenous medicine has existed in Oaxaca for hundreds of years, mental health services have only become available in Oaxaca in the past fifty, and have only begun to thrive in the past fifteen. It is these new services—almost all of which are based on healing approaches and ideologies imported from the United States and Europe—to which I will now turn. I will focus my account on services available in Oaxaca City and the Mixteca region, the project's two field sites.

Institutional Services

According to Mexican Social Security Laws, all employed workers are guaranteed health coverage through either the *Instituto Mexicano del Seguro Social* (The National Institute of Social Services, known as IMSS) or the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (Institute for Social Security for State

Workers, known as ISSSTE) (Finkler 2001: 51). These institutions provide coverage for approximately half of Mexico's citizens, while the unemployed as well as those working in the informal economy are eligible for *Servicios de Salud* (the Health Ministry, or Department of Health, known as SS).

In Oaxaca, the IMSS, ISSSTE, and SS all offer some mental health services. I will discuss them each in turn.

IMSS

Established in 1943, the IMSS is Mexico's social security system for workers employed in the formal sector. It is the largest of the three institutions (Laurell 2007) and costs of the system are split between the federal government, the state government, employers, and an income-based premium for workers.[5] In Oaxaca City, the IMSS hospital staffs two psychiatrists and a number of psychologists; however, practitioners complained that there were too few to serve the large patient population. The IMSS hospital in Juxtlahuaca has a special psychological and youth services building, but it is staffed with only one psychology intern [*pasante*] at a time. They rotate every six months, so continued psychological care with one therapist is not an option (this is an issue with psychology interns in the SSO system as well). A psychiatrist at the Oaxaca City IMSS hospital was the only mental healthcare practitioner to decline participation in

[5] The IMSS was reformed in the mid-1990s in relation to World Bank requirements for adjustment loans. The reform was supposed to entail what Asa Cristina Laurell (2007) calls a "sweeping corporate reorganization of IMSS health services to achieve cost containment and to introduce market logic into the assignment of health resources," a process which Laurell argues contributes to the commodification of health in its "equal pay for equal services" and "managed competition" logic—as opposed to the previous "services according to need" logic (Laurell 2007: 517). However, such reforms proved much more difficult in practice, and have not been fully implemented. There are ongoing debates and protests around the privatization of IMSS and ISSSTE services.

the study. I did, however, interview the current psychologist at the IMSS hospital in Juxtlahuaca, as well as patients who had been referred to the psychiatric hospital from IMSS hospitals and clinics. A number of rural Centros de Salud in the Mixteca region are IMSS facilities.

ISSSTE

The ISSSTE was founded in 1960 and provides low-cost care to government employees throughout the state. There is a large ISSSTE hospital in Oaxaca City which staffs one psychiatrist and a number of psychologists. I did not have the opportunity to interview patients or practitioners at ISSSTE, but I did interview patients who had been referred to the psychiatric hospital from ISSSTE hospitals.

SSO

Servicios de Salud de Oaxaca (SSO)* is Oaxaca's Ministry of Health (MoH) service and provides services regardless of employment in the formal or governmental sectors. As Kaja Finkler (2001) points out, these services are not as highly subsidized as the IMSS and ISSSTE services, and patients—many of whom are the poorest citizens—often have to pay high fees relative to their incomes. However, Mexico's 2004 health reform created People's Health Insurance, or *Seguro Popular*, a

> voluntary family health insurance program for the uninsured that was designed by the federal government and financed through conditional grants offered to the states by the federal government for its implementation. It was promoted as a program to provide free insurance to the poorest of the poor and contained a firm commitment that services would be publicly provided (Homedes & Ugalde 2009: 4).

Families are to pay based on a sliding scale, and poorer states like Oaxaca are to receive additional subsidies ("solidarity supplements") from the federal government to insure the large population of citizens not covered by IMSS or ISSSTE. Despite these lofty commitments, *Seguro Popular* is permitted to contract and compete with the private sector, which may have the effect of weakening the public sector (Homedes & Ugalde 2009; Laurell 2007). Further, critics have pointed out that the system exacerbates health inequalities by putting extra burdens on poorer states with higher proportions of poor families (ibid).

Mexico's public health expenditure is quite low compared to other high- to middle-income countries in Latin America (about 3 percent of GDP (Laurell 2007: 519)), and allocation for state health services have been historically unequal, with states like Oaxaca and Chiapas suffering chronic underfunding. All public health services suffer this problem, but the Ministry of Health (again, primarily for the poor) receives much less of the federal health budget than does, for example, IMSS (Finkler 2001: 52). In Oaxaca as elsewhere, there are frequent complaints by staff, physicians, and patients about poor administration of SSO services, lack of funds for equipment, staff, and basic necessities (like sufficient running water at the psychiatric hospital, a Health Ministry facility).

Health Ministry services are divided into First- Second-, and Third-level attention, roughly corresponding to degree of specialization. First-level services are primary care services provided by *Centros de Salud*, community health clinics. These services tend to be non-specialized and low-cost, and often do not include mental healthcare. However, in accordance with SSO's state mental health program, or *Programa Estatal de Salud Mental* (PESM; see below), more and more Centros de Salud are staffed with *pasantes*,

recently graduated psychologists-in-training who conduct their social service in communities around the state for a tenure of six months. According to SSO's statistician, 120 SSO Centros de Salud are staffed with psychologists for half the year, 76 Centros de Salud are staffed with psychologists "most of the time," and 23 are permanently staffed. SSO's goal, however, is to staff the majority of Centros de Salud all year round—or to staff general practitioners with mental health training. In the Central Valley region of which Oaxaca City is a part, 67 Centros de Salud had psychologists in 2009 and 54 had them in 2010 (there are 217 total Centros de Salud in the Central Valley region). The numbers change yearly according to the number of psychology students graduating and which region they are assigned.

The psychology interns not only offer individual therapy but also give educational chats, or '*pláticas*' in the communities, some of which community members are required to attend to obtain their *Oportunidades* stipends.[6] These pláticas discuss different aspects of psychological health and self-care, and promote general awareness of emotional problems and risk factors, including domestic abuse. Pláticas and counseling with psychological interns at Centros de Salud are often a community's first exposure to psychological services.

Second-level attention consists of general hospitals, such as the *Hospital Civil Aurelio Valdivieso*, known as the *Hospital Civil*, SSO's main hospital in Oaxaca City, notable for huge crowds of people waiting wearily outside its doors at all hours of the day and night. Permanent vendors have set up shop outside due to the reliable stream of

[6] *Oportunidades* is a federal cash-transfer social welfare program that provides stipends to families if they comply with various requirements, like sending kids to school, getting regular health checkups, helping to maintain health facilities in the communities, and attending *'pláticas.'*

clientele. The hospital has one psychiatrist and eight psychologists who provide emotional support for patients hospitalized for non-mental health-related issues. There are no psychiatric inpatient services at the Hospital Civil. I interviewed the Hospital Civil psychiatrist several times.

Third-level services are specialized hospitals, many of which are located just outside Oaxaca City. There is a *Hospital de Especialidades* with various specialized services, including one psychiatrist; a children's hospital; and an HIV clinic, which (in addition to medical attention) provides psychological services in the form of both group and individual therapy for HIV-positive patients, among others.

I interviewed a number of SSO psychologists both in Oaxaca City and in the Mixteca region, as well as the psychiatrists at the Ministry of Health psychiatric hospital, Cruz del Sur. Psychologists at the Huajuapan SSO Mental Health Program said there had only been SSO-provided psychological services in the Mixteca since 2006.

*Cruz del Sur Psychiatric Hospital**

The state's only public psychiatric hospital, *Cruz del Sur,* is third-level Health Ministry (SSO) facility and thus may be utilized by anyone, regardless of employment. Founded in 1963 as a '*granja*,' or farm hospital (in which patients would have livestock and grow their own food as part of their treatment), Cruz del Sur is now a standard psychiatric hospital based on Mexico's so-called '*Modelo Hidalgo,*' in which treatment focuses on reintegration of the patient (see Chapters 4 and 7 for additional discussion) into society.

The outpatient facility has been functioning since the hospital's inception but very few patients utilized it until 1994, at which point psychiatrists replaced general doctors. Now the hospital has eight psychologists on staff (two in the men's inpatient dormitory, two in the women's dormitory, two in outpatient services, and two offering group and occupational therapy), eight to ten psychiatrists depending on the day (usually six in the outpatient and two in the inpatient facilities), and a number of nurses and social workers. There are 120 hospital beds, 70 for men and 50 for women, but the intake psychiatrists only hospitalize the most serious cases, such that the facilities are usually only at 60 percent capacity. Although first-time patients receive a standard hour-long interview, subsequent appointments are typically only 30 minutes long and consist largely of medication management (according to outpatient psychiatrists, 99 percent of people who come to the hospital receive a diagnosis and a medication prescription). Relatively few outpatients report receiving psychological attention or therapy from the outpatient psychologists.

Cruz del Sur is the main affordable option for psychiatric care in Oaxaca, and patients often travel extraordinarily long distances to seek treatment there. When it was founded it served the entire 'south-southeast' region of Mexico, including Oaxaca, Chiapas, Veracruz, part of Tabasco, and part of Guerrero. Veracruz and Tabasco now have their own facilities, but Cruz del Sur continues to serve patients from Chiapas and Guerrero, as well as patients lacking services in Central America (or who sicken while emigrating from Central America to Mexico or the United States, a rather common occurrence). I conducted several months of fieldwork at Cruz del Sur, and provide a more detailed account of the facility, psychiatric practice, and patients in Chapter 7.

*State Mental Health Program**

SSO also has a *Programa Estatal de Salud Mental* [State Mental Health Program, or PESM], formed between 1998 and 2001 as part of its Preventative Medicine Department of Non-Transmittable Diseases. The PESM is the result of national legislation on mental health which serves to "incentivize efficient programs for the prevention and treatment of mental illnesses," preserve "the human rights and dignity of users of mental health services," and to "foster research within an ethical framework for gradually increasing awareness of mental health problems and their impact" (Ramirez & Méndez 2007: 4; translation mine). The program is also linked with the 2007-2012 National Program for Development, which emphasizes the need to "strengthen integral or biopsychosocial care through establishing psychological services in each urban Centro de Salud as well as consolidate the regionalization of mental health services in second-level hospitals" (ibid: 5).

PESM's specific objectives are the following:

> Prevent, detect, attend to, and treat mental illness at the level of the individual, the family, the group, and the community.
>
> Implement training actions and ongoing updates to health personnel in first- and second-level services for the detection and appropriate referral of patients with disorders to the corresponding service level.
>
> Inform and educate the general population about mental health problems, so that they achieve the timely identification of these illnesses and refer patients to the appropriate services, eliminating discrimination and mismanagement of the [patient's] family.
>
> Promote healthy lifestyles that favorably affect the overall health of the Oaxacan population through permanent communication campaigns and social diffusion.

> Establish a network of municipal participation in high-risk areas, with plans for preventative mental health work" (Ramirez & Méndez 2007: 14).

Between 2002 and 2003 the PESM trained 200 general doctors to conduct valid diagnostic interviews, and the program has reinforced training of social service psychologists "in all areas of intervention" (Ramirez & Méndez 2007: 10). When Centros de Salud do not staff psychologists, PESM often provides a mental health module to help staff identify and deal with psychological and psychiatric issues, conduct prevention-related activities, and provide the appropriate referral services. (These materials use the International Classification of Diseases (ICD-10) criteria for the purposes of diagnosis.) The PESM's activities and professional training focus on "[illness] prevention and promotion of healthy lifestyles, such as recognition of risk factors, though intensification of courses, conferences, talks and workshops directed at the general population, the high-risk population, teachers, health personnel, and schools" (Ramirez & Méndez 2007: 10). Video debates, free consultations, cultural and artistic expressions, marches, and radio and television promotion, have also played large parts in the PESM. I will return to a discussion of these goals and efforts in Chapter 5. I interviewed a number of psychologists and one psychiatrist involved with the PESM.

The DIF Oaxaca

The DIF Oaxaca, or the *Sistema para el Desarrollo Integral de la Familia del Estado de Oaxaca* (System for the Comprehensive Development of the State of Oaxaca), is a decentralized public assistance program which works in conjunction with municipalities, state and federal agencies, NGOs, and private businesses to support

"disadvantaged populations."[7] The DIF has numerous programs. The Unit for Family Development, for example, includes an Office for Attention to the Elderly, a Program for the Prevention of Adolescent Pregnancy, a Prevention of Psychosocial Risks program for adolescents, and a program called "Learning to Be" (*Aprender a Ser*), which provides workshops, social work assistance, medical attention, and psychological consultations.

Centros Asistenciales de Desarrollo Infantíl (CADIs) are DIF clinics in 'marginalized' urban and rural areas which provide low-cost maternal and pediatric services, nutritional programs, general medical, dental, and psychological attention, workshops (martial arts, crafts, dressmaking, aerobics, and more), nutritional programs including food allocations to prevent malnutrition, and clubs for the elderly. These services are provided for low fees; a psychological consultation is usually on the order of 10 or 15 pesos (75 cents to a dollar) for an hour-long session.

DIF services often include psychological attention and educational sessions in elementary, middle, and high schools. These sessions can cover everything from building self-esteem to prevention of domestic and gender violence to and drug awareness. Visiting psychologists or psychologists on staff also provide counseling, behavioral interventions, and psychological testing for disorders and learning disabilities. I interviewed one CADI psychologist and a number of psychologists involved with DIF violence-prevention activities. All of these public services (ISSSTE, IMSS, SSO, DIF) have anti-domestic violence and anti-gender violence campaigns, initiatives, and centers (see Chapter 6) which usually provide psychological support and counseling for victims of domestic violence.

[7] http://www.dif.oaxaca.gob.mx

The IMO

The *Instituto de la Mujer Oaxaqueña,** or Oaxacan Women's Institute, is part of the federal Mexican Women's Institute and is not affiliated with public health services. It is, however, highly visible in Oaxaca through media attention in the newspaper, on the radio, and on television—not to mention their huge billboards in Oaxaca City. They have a Center for Attention to Female Victims of Gender Violence which provides medical, legal, and psychological attention free of charge to all female sufferers of violence. I interviewed the director of the Center as well as two staff psychologists; I describe their services in Chapter 6.

CEPAVI

There are a number of anti-domestic and anti-gender violence programs in Oaxaca; CEPAVI, or *Centro Especializado Para la Prevención y Atención de la Violencia Intrafamiliar Sexual y de Género* is one of the most visible of these. An SSO psychologist in Huajuapan said that CEPAVI violence treatment centers are administered by a combination of public services including the SSO, ISSSTE, and the Sub-Attorney General's office (*Subprocuraduría*). I interviewed several psychologists who collaborated with or worked within CEPAVI to attend to situations of domestic violence.

Private Services

Psychiatry

There are an estimated 30 psychiatrists* in Oaxaca state; about 12 of these work in the institutional settings mentioned above (some of those supplement their institutional positions with private practices). Of the 30, 23 practice in Oaxaca City, two practice in smaller towns in the Valle Central [Central Valley] region (of which Oaxaca City is a part), four practice in the Istmo [Isthmus] region, one practices in Tuxtepec (part of La Papaloapan region), and none practice in the state's five remaining regions: La Mixteca, La Costa, La Cañada, La Sierra Norte, and La Sierra Sur. No Oaxacan medical schools offer psychiatric specialization; therefore, all psychiatrists in the state have been trained elsewhere (most commonly in Puebla or Mexico City).

Private psychiatric care is extremely expensive by Oaxacan standards. A typical consultation in Oaxaca City costs between 500 and 800 pesos, or about $35-70 USD. Given that the minimum wage in Oaxaca is under 60 pesos a day, these prices are exorbitant for many residents. Despite this, psychiatrists report that their practices are thriving and that there is overwhelming need throughout the state for more practitioners. Patients I interviewed often said they saved money and/or received remittances from migrant in the U.S. expressly for mental healthcare, particularly psychopharmaceutical medications.

There is one private psychiatric clinic in Oaxaca, the *Clínica Hacienda San Dionisio* located about an hour outside of Oaxaca City near the town of Ocotlán (also part of the Central Valley region). As 'Hacienda' implies, the clinic is housed in a converted colonial estate in a quiet, pastoral setting which was once a ranch. Originally created for addiction treatment and detoxification only, San Dionisio now offers general inpatient mental health services. A weeklong stay at San Dionisio costs 6000 pesos per week (over

$500 USD). This price includes room and board plus the following services: a medical exam; a psychiatric exam; "multidisciplinary" treatment; a personal therapist assigned to each individual; individual, group, and family therapy; *psicoeducación*; film screenings and debates; pool and gym use, including spinning and yoga classes; sports coach; nutritional consultations, and laundry and cleaning services. The clinic provides separate services for mental health patients and addiction patients. I visited *San Dionisio* several times and interviewed the hospital psychiatrist, a hospital psychologist, and several patients.

Psychology

Most of the signs visible throughout the city are for private psychological practices,* which range from Gestalt psychotherapy to hypnosis to psychoanalysis. Prices for individual therapy range widely, depending on the experience and reputation of the therapist. Private psychologists sometimes integrate homeopathic medicine or *Flores de Bach*.[8] Most of these practitioners are Oaxacan, though there are a number of therapists from other Mexican states and from abroad (in my sample of 50 professionals (not counting *curanderos/as*, who were all Oaxacan), 38 were Oaxacan, eight were non-Oaxacan Mexican, two were from other Latin American countries, one was Spanish, and one was American).

There are a number of private psychotherapy clinics in the city; here I will describe several of the more prominent ones.

[8] Flores de Bach, or Bach Flower Remedies, are a set of 38 flower essences that, according to their website, correct "emotional imbalances: negative emotions are replaced with positive" (bachflower.com) developed in the 1930s by British physician Dr. Edward Bach. Bach Flower remedies were quite popular in Oaxaca City, and many psychologists reported using them in conjunction with psychotherapy.

The *Centro de Atención y Formación Humanista,* or CAFHAC,* described at the beginning of the chapter, is a private psychology clinic and training program founded in Oaxaca City in 1994. CAFHAC has a considerable presence and was one of the first therapy centers in the state, offering private psychotherapy for about 500 pesos ($35 USD) as well as group sessions, which tend to be a bit more affordable. CAFHAC therapists utilize a blend of various types of humanistic therapy, including Gestalt psychotherapy, Ericksonian hypnosis, and Neuro-Linguistic Programming. To promote mental health and emotional stability in the broader population, they offer not only individual therapy and group workshops [*talleres*], but also extensive certificate programs open to the general public (they refer to these as '*maestrias*' (master's degrees) but there are no required prerequisites). One may become certified in Neuro-Linguistic Programming, Humanistic Education and the Facilitations of Groups, Gestalt psychotherapy, and Ericksonian hypnosis, and the expectation is that participants will utilize these skills in their everyday work and social interactions. In this manner, CAFHAC explicitly attempts to promote mental health and particular versions of globalizing psychological ideologies in the general community (see the beginning of this chapter for more detailed discussion). I conducted several private interviews with the *Centro's* director, as well as a group interview with a roomful of psychologists and trainees at the *Centro.*

Founded in 1993, the *Centro de Desarollo Humano y Psicoterapia Gestalt* [Center for Human Development and Gestalt Psychotherapy] is CAFHAC's predecessor and quite similar in that it offers individual and therapy, trains professionals in particular types of therapy (in their case, Gestalt, Flores de Bach, Human Development, and Family

Development), and teaches intensive workshops on subjects such as *Comprendiendo el destino* [Understanding destiny] and *Aprendiendo a manejar mis sentimientos* [Learning to manage my feelings]. I did not conduct interviews with members of the Gestalt Center.

The more recently established (2008) *Colectivo Terapia Narrativa y Trabajo Comunitario* [Narrative Therapy and Community Work Collective] provides group, family, couples', and individual therapy based on the tradition developed by Michael White and David Epston from the Dulwich Centre in Adelaide, Australia (one of the *Colectivo'*s founders was trained at the Centre). They approach individual and community change beginning with a view of "people as the experts of their own lives" (c.f. Morgan 2000) whose identities are "a weave of stories which we are constantly 'writing and re-writing' in negotiation with other stories from the cultures we inhabit" (colectivotn.org; my translation). They see their endeavor as a politically charged attempt to give voice to marginalized 'stories' and identities. During my time in Oaxaca the *Colectivo* facilitated a support group—*Tejiendo Relaciones* [Weaving Relationships] for women who had experienced violence. They also provide certificate courses, though far less frequently than the other centers described above. I conducted interviews with several psychologists from the *Colectivo*, as well as an attendee of *Tejiendo Relaciones.*

In addition to individual practitioners, clinics, and training centers, Oaxaca City is home to numerous forms of spiritually oriented Eastern care and practices such as reiki therapy, yoga and meditation courses which often advertise themselves as paths to well-being and means of stress management. Acupuncture seems to be increasingly popular, as well.

In the Mixteca, Juxtlahuaca, Tlaxiaco, and Huajuapan have private psychologists and psychologists in at least one public hospital or clinic (as a bigger city, Huajuapan has much more than Juxtlahuaca or Tlaxiaco). However, many residents of the Mixteca region were either unaware of such services or perceived them to be prohibitively expensive (Calvario et al. forthcoming).

Non-profit Organizations

Various non-profit organizations offer psychological care and/or psychological education as part of their overall services, and churches and schools are both beginning to integrate psychological services, as well. La Merced, one of the larger churches in Oaxaca City, offers psychologist-facilitated family gatherings on various topics relating to emotional health, as well as "treatment for different psychological problems" provided by an on-site psychologist at the church's medical dispensary.

Development organizations, many of which emphasize women's 'empowerment' as a technique to promote sustainable economic growth, sometimes offer self-esteem building workshops and other psychologically oriented events and talks. Some organizations focus explicitly on the detection and prevention of gender violence or political violence (see Chapter 6 for more detailed discussion of these initiatives). USAID funds an organization called *ProDerecho* to do 'restorative justice' work in Oaxaca, and recently hired a program called "Strategies for Trauma Awareness and Resistance" (STAR) from Eastern Mennonite University in Pennsylvania. STAR's goal is to break "cycles of violence" (specifically political and gender violence) and to promote reconciliation between victim and perpetrator by training local professionals in

psychological techniques to detect and treat trauma. Similarly, a Canadian non-profit called Partners in Rights and Recovery was recently invited by Oaxacan human rights organizations to provide community leaders with workshops on human rights documentation and psychosocial support. They focus on political violence and torture. I interviewed a Oaxacan psychologist trained by *ProDerecho* and STAR, as well as one of the Partners in Rights and Recovery psychologists.

The *Clínica de Atención Psicológica y Terapias Alternativas* [Clinic for Psychological Care and Alternative Therapy, or CAPTA] is an *asociación civil*, or non-governmental/non-profit organization providing various services in both Oaxaca City and rural indigenous communities around the state. Founded in 2002 to attend to cases of sexual and domestic violence, the center used to be known as the *Centro de Atención Integral del Valle*, or The Valley Comprehensive Care Center. It provided medical, legal, and psychological attention, and continues to do so. However, due to patient desire for other types of psychological and alternative care, the *Centro de Atención Integral* split into two centers in 2009, one of which kept the original name. CAPTA now offers psychological attention, alternative medicine (including Flores de Bach, reiki, aromatherapy, and body expression with art and meditation) to people of all ages, as well as legal advice in cases of domestic or sexual violence. CAPTA also provides talks or *pláticas* on a number of subjects (from "Self-Esteem and Emotional Intelligence" to "Violence Against Women, a Power Game That We No Longer Want to Play") in Oaxaca City and in rural towns throughout the state. I interviewed one psychologist and one general doctor at CAPTA.

The *Casa de la Mujer** forms a part of the *Grupo de Estudios Sobre la Mujer "Rosario Castellanos,"* or Gesmujer, and is both a research institution and a grant-giving organization which helps low-income girls from indigenous communities attend school and pursue careers. The *becarias*, or students with grants from Gesmujer, travel into the city once a month for workshops and educational talks, often on health topics. "Expressing Emotions" was one of the modules in their 2010-2011 program; in that class, students learn to both identify and talk openly about emotions in front of the group. Each week the *Casa de la Mujer* hosts *Charlas de Miércoles*, or Wednesday 'chats' about various topics related to women's equality, oftentimes centered around mental and emotional health issues. These chats are open to the public and are facilitated by psychologists. I attended and participated in *charlas* on depression, stress, and domestic violence and interviewed two psychologists, one staff member, and a *becaria* at the Casa de la Mujer.

*Neuróticos Anónimos,** or Neurotics Anonymous (NA) is by far the largest and most visible non-profit organization for mental health issues. Oaxaca State has 39 NA centers, more than any other state in Mexico (Mexico City has 32 centers and Mexico State has 34; the state with the next most after these is Veracruz, with 13). Oaxaca's NA centers are concentrated in Oaxaca City, which is home to 22 plus an inpatient 'villa'; the other 16 are spread throughout the state. Run entirely by volunteers and unaffiliated with any organization, business, political party, or religion, NA provides free member-run group therapy in the 12-step tradition of Alcoholics Anonymous. They also provide a 24-hour phone hotline and a program for teens, called 'Neuroteen.' The organization was founded in Mexico City in 1977, and Oaxaca's first center opened in 1986. Anyone is

permitted to attend meetings because according to NA, anyone is susceptible to emotional illness—and the most important step is accepting it so that one can begin the healing process. Like an alcoholic, a neurotic cannot be 'cured,' only 'controlled'; thus, it is recommended that members continue attending meetings and providing service indefinitely.

'Neurotics' can self-diagnose using NA's diagnostic tool, "*Es Usted Neurótico?*" [Are you Neurotic?] and the criteria are extremely broad, from being 'supersensitive' to 'disorganized' to having frequent headaches to 'feeling sorry for oneself' (see Chapter 4 for further discussion). I interviewed one spokesperson for NA; visited and received a tour of the outpatient villa, spoke to members, and attended several NA events, or *juntas,* in which members gave testimony.

CONCLUSION

There are undoubtedly other mental health services in the state of which I did not become aware, particularly in regions where I spent little or no time, like the Isthmus and the Sierra Norte. However, because I spoke to dozens of practitioners—both public and private, in and outside of Oaxaca City—all of whom gave similar accounts of the landscape of services, I feel confident that the above summary is quite thorough. It is also worth mentioning that in the absence of mental health practitioners, general doctors in the Mixteca region reported playing the part of psychiatrists and psychologists by prescribing psychopharmaceutical medications and providing informal psychotherapy to distressed patients (Duncan et al. 2009).

My review of existing mental health services and my overall argument concerning their growth is not meant to imply that access to such services is universal in Oaxaca. On the contrary, both practitioners and community members mentioned repeatedly how more mental health services—particularly affordable public services—were sorely needed in the state. At the same time, this array of clinical mental healthcare is a relatively new development, and represents a historical departure. The first part of this chapter presented a model for how and why these changes are occurring; I argue that the growth of mental health services in Oaxaca can be attributed to a combination of various 'supply and demand' factors on a local level combined with the rapid globalization of mental health discourse, ideology, and practice. Then, I outlined the services which are currently available in the state. The following chapter will situate these changes by providing an abridged history of approaches to 'mental health' in Mexico, from Pre-Columbian Aztec medicine through Mexico's independence.

CHAPTER 3

HISTORICAL FOUNDATIONS

To understand contemporary changes in Oaxaca's culture of mental health, it is important to situate the growth of mental health services within a historical framework. How have mental health and emotional distress been treated in Mexico historically, and to what degree do Euroamerican (allopathic, biomedical, cosmopolitan) psychological and psychiatric approaches represent a departure from more 'traditional' forms of care?[1] While their philosophies and treatments appear to be considerably different and often at odds, these forms of care co-evolved beginning at the time of the Conquest, through the Colonial period, and up until the present. The co-evolution has not been without conflict, though, and sheds light on the complicated dynamic between indigenous and Spanish populations in Mexico. This dynamic as it has played out through the years reveals the ways in which medicine can be political and medical knowledge an ideological battleground.

I begin with a general discussion of pre-Hispanic Mesoamerican medicine, which emphasized the primacy of the supernatural realm and which boasted a complex herbal taxonomy for the treatment of ills. Focusing on Aztec medicine, I discuss how—despite the lack of a Cartesian mind-body duality—there were highly elaborated concepts of emotional well-being and what contemporary psychiatric practice would refer to as

[1] I put 'traditional' in quotations to acknowledge that while indigenous medical approaches to health in Latin America certainly have a long history, they evolve in dynamic fashion and are by no means static. As we will see in this account, the distinction between 'traditional' and 'modern' medicine has been a hazy one throughout history, though it has also been fraught with conflict. From this point on, the quotations will be implied.

psychopathology. The concept of 'losing one's heart' (*in yollotl*) and the healing approaches developed to address that loss resemble some aspects of Euroamerican mental health practice.

The second part of the chapter discusses colonial medicine and the process by which *curanderismo*—a syncretic blend of pre-Hispanic, European, and African medicines—came to be. Generally speaking, indigenous medicine was marginalized and to a large degree obliterated by the Conquest; however, some important aspects remained and blended with non-native conceptualizations and forms of care. Christian thought was central to colonial medicine, which did not have specific practices for the treatment of mental illness but which did develop religiously sponsored halfway houses providing refuge for the poor, marginalized, and mentally ill. It was not until independence from Spain that Mexico's field of psychiatry began to develop. As I discuss in the third part of the chapter, the country began to establish psychiatric institutions in the late 19th century and by 1950 had developed its first federal mental health program. Oaxaca's institutional mental health program was not established until 2001.

The chapter concludes with an account of contemporary indigenous medicine and ethnopsychiatry. Focusing on Mixtec approaches to well-being and healing, I discuss the centrality of equilibrium, supernatural forces, and nature, as well as the various healing practices which have been developed to maintain equilibrium.

PREHISPANIC MESOAMERICAN MEDICINE

Our historical understanding of Mesoamerican medicine is based on a patchwork of documents created by Spanish missionaries and chroniclers, combined with the aspects

of Mesoamerican medicine that have been discovered archeologically (i.e. cranial molding, dental encrustation), in codices, and that have endured and so have been catalogued in more recent ethnography. What we now know as 'Pre-Hispanic Mesoamerican' medicine, therefore, is in many ways a product of colonial dominance. This is not only because the colonizers chose what to value and what to discard in terms of indigenous practices—both in practice and in chronicles—but also because those practices combined with Spanish and African medicine to create what we now know as indigenous medicine and sometimes refer to as 'Pre-Hispanic medicine.' Because of this historical co-evolution and gradual blending of traditions, it is difficult to disentangle which specific aspects of Pre-Hispanic Mesoamerican medicine are, indeed, Pre-Hispanic.

This being said, it is possible to distinguish several aspects of Mesoamerican medicine that seem, according to the historical record, to pre-date the arrival of the Spaniards in the New World.[1] When Cortes and his men arrived in Mexico's interior in 1519, they found "a well-developed system of public health, botanical gardens designed for conducting experimentation of a medical nature, involving plants from all over Mexico and Central America, a royal library for housing codices pertaining to medicinal recipes and their prescribed uses, and a public sanitation and sewage disposal system" (Padilla & Salgado de Snyder 1988: 56). From those Aztec libraries and their codices, we know that nature and deities were central to Pre-Hispanic medicine and that illness

[1] I will return to some of these aspects in more detail later in the chapter, when I discuss Mixtec medicine in particular. This section is based on accounts of Colonial documents, which—because Aztecs were the most populous indigenous civilization at the time of the conquest—mainly chronicled Aztec (Mexicano) medicine to the exclusion of other Native American groups. The current discussion, therefore, is based mainly upon what is known about Aztec medicinal practice.

causality was not purely biological as it was in the European conception (Quijada 1991: 151-152; Ocaranza 1934/1995: 38; Padilla & Salgado de Snyder 1988). There were many deities associated with specific illnesses and treatments, and illness was, generally speaking, thought to be either divine punishment or a result of "harmful influences of human enemies" (Somolinos 1983: 63; translation mine). Diagnoses and etiology were, therefore, based on divination, and many curative practices—such as sacrifices and ritual dances—were focused on appeasing the gods. Nature was (and is) a central aspect of indigenous Mexican medicine—the environmental circumstances, weather, phases of the moon, direction and velocity of the winds, the rainy periods, eclipses, and motions of the stars were all central to preparing medicine and healing (Ocaranza 1934/1995: 49).

Mesoamerican cultures had highly developed herbal taxonomies, with different plants and combinations of plants used to treat specific maladies. Indeed, their various formulas comprised a complex pharmaceutical knowledge used to treat everything from *susto* to rheumatism to *la locura* (Flores y Troncoso 1992: 209). Medicinal herbs were sold in Mesoamerican markets long before the arrival of Europeans, and continue to be sold in markets today (Somolinos 1983: 69). When the Spanish did reach Mexico, they exploited indigenous herbology for economic gain, and these medicines soon were exported to Spain as an alternative medical treatment (Somolinos 1983: 91).

Medicine was not taught in temples by religious priests (as were other arts like painting, dancing, and singing) but was generally passed along from father to son and mothers to daughters (Ocaranza 1934/1995: 46). Healers were specialized in everything from surgery to midwivery, herbology to internal medicine.

Mesoamerican Psychiatry

It is problematic to speak of a "Mesoamerican psychiatry," because "psychiatry" as currently understood is based upon a model of the mind and the human organism quite different from that embraced by Mesoamerican culture, which did not typically distinguish between the physical and the emotional/mental/spiritual. Indeed, the healthy balance of the human organism in all its complexity is the aim of most indigenous medicine, and one aspect of the person is rarely addressed without taking into consideration all the others.

As Rubel and Browner put it,

> Indigenous traditional medicine is characterized by the lack of a body-mind concept and an understanding of the human body as homeostatic and self-regulating…Causal explanations about disease, whether physical, emotional, or mental, are attributed to a variety of imbalances the body may suffer. That is why it is believed that when an individual experiences loss of balance from a fright, from a strong anger, from interpersonal conflicts, from sexual passion, or from cold winds, these factors can cause illness. Consequently, indigenous peoples spend a great deal of time trying to avoid exposure to circumstances that might provoke imbalances, fearing that they might impact health (Rubel & Browner 1999: 86; translation mine).

However, the absence of a mind-body duality does not make null a discussion of emotional health or ethnopsychiatry in Mesoamerican medicine. Emotions were and are considered extremely important in the maintenance of equilibrium, and thus it is possible to identify the ways in which emotional ills, mental disturbances, and ills of the spirit—those ills usually treated in Western medical culture by psychiatrists, psychologists, psychotherapists, and psychoanalysts—have been treated by indigenous healers (Somolinos D'Ardois 1978).

Although their illness explanatory system was not based on a mind-body duality, there was a distinction between different parts of the body thought to control different aspects of functioning. In Mexicano (Aztec) medicine, the top of the head (*cuaitl*) was thought to be the seat of consciousness, reasoning, and *tonali,* or 'soul' (as interpreted by the Spanish upon their arrival in the New World). The heart was the seat of a person's vital functioning, imagination, and divination powers; the liver was the seat of emotional life (Rodríguez-Landa et. al 2007). All these aspects of the person are inextricably linked in indigenous medicine, but it has always distinguished between different types of pathological experience and has included a complex notion of emotional health and treatments to address what Western medicine might refer to as mental/emotional imbalances. Historians have gone so far as to say that in Aztec culture there "flourished highly advanced forms of psychiatry and psychotherapy," including "developed concepts about ego formation and psychic structure not unlike Freudian ones" (Belsasso 1969: 32).

In their essay "Psychology in Pre-Columbian Mexico," Padilla and Salgado de Snyder argue that the Aztecs had a mode of philosophical inquiry into psychology and the nature of self. Through education, the Aztecs believed, a person went from their original state as "faceless" and "unfinished" to an individual with "distinctive characteristics"—a "self" (Padilla & Salgado de Snyder 1988: 60). The face, it seems, represented the moral aspects of the human being (Somolinos D'Ardois 1978: 26). According to Aztec philosophy, education provided the opportunity to develop one's 'face'; it provided equilibrium, "well defined features," a "strong heart," and a "healthy, harmonious…personality" (Padilla & Salgado de Snyder 1988: 60).

Losing one's heart, losing one's head

'Personality' was encompassed by the Aztec concept of *ixtli-in yollotl*, which "is one of the most important concepts in Pre-Columbian Nahuatl culture because of its relevance to emotional well-being" (Padilla & Salgado de Snyder 1988: 57). *In ixtli,* Padillo and Salgado de Snyder contend, refers to the 'ego': "that which most intimately characterizes the intrinsic nature of each individual" (ibid: 57), and *in yollotl* means "heart in movement." The authors write, "according to Nahuatl medicine the origins of all illnesses of body and mind were localized in the heart" (ibid: 58, c.f. Viezca Treviño & Peña Paéz 1976; Rodríguez-Landa et al. 2007). Like the ancient Greeks, then, the Aztecs believed the heart to be the center of emotional and psychological life. A person suffering from an emotional disturbance was known as a *yollopoliuhqui*, or "the one who lost his heart" (Padilla & Salgado de Snyder 1988: 62; Somolinos D'Ardois 1978: 27).

Somolinos D'Ardois suggests that 'losing the heart' as it was understood by the Aztecs is similar to what is now often referred to as 'losing one's mind' or 'losing one's head.' One Nahuatl text by the Franciscan friar Bernardino de Sahagún (to whom Aztec indigenous healers dictated their medical practices) describes a *yollopoliuhqui* as follows: "You do not understand, you do not see, you do not hear; you do not notice things, you do not learn. Your heart is twisted, you work in fits and starts. Your head is drunk…your head is unscrewed…you walk around as though you've eaten hallucinogenic mushrooms…" (Somolinos D'Ardois 1978: 27). Although the translation from the Nahuatl to Spanish to English likely loses some of its original significance, this does paint a more vivid picture than do lexical studies that simply reveal Mesoamerican cultures had words for states to which we would now refer as psychiatric. Indeed, the

above description suggests that there were very particular ways of acting that were considered pathological and that were related to having 'lost one's heart' and treated by a healer who used talk therapy, invocations, and exorcisms to restore the patient to equilibrium.

Even the Aztec codices suggest that Pre-Hispanic physicians "knew how to recognize persons who were manic, schizoid, hysterical, depressive, or psychopathic. Such persons were treated at Calmecac [an Aztec temple] by a variety of methods, including trephination, hypnosis, and specific herbal potions for specific disorders" (Belsasso 1969: 32). In the *Códice de la Cruz-Badiano*—or *Libellus de medicinalibus indorum herbis*—a medical treatise written by Aztec physician Martin de la Cruz and translated into Latin by Juan Badiano in 1552, the author apparently identifies and lays out treatments for disorders that resemble those now known as schizophrenia, epilepsy, and mental retardation (Somolinos D'Ardois 1978, Padilla & Salgado de Snyder 1988: 61).

One psychiatrist has suggested that in *La Leyenda de Quetzalcóatl* there is indication that feelings and behaviors consistent with what the DSM-IV now labels depression were also recognized and treated in Mesoamerican medicine:

> …in the myth of Quetzalcóatl one can identify depressed mood, which is characterized by loss of interest and ability to enjoy things; diminished attention and concentration; feelings of inferiority and loss of confidence in oneself; ideas of guilt and uselessness; a negative outlook on the future, and, finally, the act of suicide (Rodríguez-Landa et. al 2007: 378; c.f. Montesinos Balboa 2004; translation mine).

Melancholy and other emotional illnesses were thought to be based in the heart (*yollotl*) of the afflicted and caused by evil spirit possession, divine punishment for sin, breaking

of taboos, disobedience of gods, and/or delinquency in religious duties and rites (Padilla & Salgado de Snyder 1988: 62). Diagnoses of "psychiatric" problems were, therefore "deeply imbedded in…mystical and supernatural concepts" and "treated by 'techniques for transformations of hearts'" (Belsasso 1969: 32). These disturbances were often interpreted as omens or auguries, and led to threatening imbalances in not only the individual, but also the community at large, and thus the community at large participated in the restoration of health for the patient (Somolinos D'Ardois 1978: 19).

Another historical account argues that "Aztec 'psychiatrists' divided mental diseases into two main categories, passive insanity and active insanity, which they called, respectively, *tlahuilocayotl* and *xolopeyotl*" (Schendel 1968: 49). These insanities, the author claims, were thought to be caused by abuse of narcotic plants and fungi—including marijuana, the jimson weed, hallucinogenic mushrooms, and peyote—used for medico-religious purposes, and were treated with purgatives and herbal anti-toxins (ibid).

Ethnopsychiatric Treatments

Though diagnoses and etiological explanations were "religio-magical," treatments for emotional disturbances and other illnesses were highly empirical, consisting of curative pharmaceutical concoctions and, importantly, a type of talk therapy provided by a physician called a *tonalpouqui*.

With regard to the extensive pharmacopoeia available to treat heart-related ills ('heart' here referring to the emotional seat of the person, as it was understood by the Aztecs), for *yollopoliuhqui* the most effective treatment was the flower of Yolloxóchitl. Additionally, the Aztecs would use a stone called *quiauhteuciutlatl* blended with other

elements into a liquid, given to those "who seem to be beginning to go crazy [*enloquecer*], and which would increase phlegm in the heart" (Somolinos D'Ardois 1978: 31; translation mine). These, however, are but two of the many hundreds of concoctions Aztecs and other Mesoamerican cultures (including the Mixtec, as we will see below) developed using the naturally growing herbs and plants in Mesoamerica. Somolinos D'Ardois estimates that there were at least 2,500 plants utilized in therapeutic settings that we would now label as psychiatric (Somolinos D'Ardois 1978: 32). There exist tomes and tomes of ethnobotanical encyclopedias laying out the pharmacological treatments developed pre-Conquest, and the Spanish wasted no time in integrating that knowledge into their own medical knowledge and exporting it back to Europe.

In addition to herbs, the Aztecs utilized cacao, chocolate, aguardiente, and other alimentary cures to treat melancholy, and some documents suggested that Aztec physicians recommended lifestyle changes such as walking in the shade, refraining from sexual relations, singing, and playing music (Rodríguez-Landa et. al 2007: 379).

With regard to therapeutic interaction, the *tonalpouqui* acted as a middle man between Aztec gods and the afflicted patient, and could restore the patient's emotional balance with the power of words:

> The *tonalpouqui* was equivalent to a current-day psychotherapist. He made use of psychotherapeutic methods to reestablish the emotional equilibrium of the individual. It was believed that the *tonalpouqui* had the knowledge and moral authority to assist patients by means of lengthy conversations designed to liberate then from the possession of evil spirits. Personal characteristics such as empathy and reassurance comprised a healing language which served as the major determinants for a successful outcome (Padilla & Salgado de Snyder 1988: 63).

In the talk therapy he provided, the *tonalpouqui* would not only use 'psychotherapeutic methods,' but would also interpret the divine omens his patient had experienced. Once

the offended god was made known, the *tonalpouqui* would advise his patient on what types of offerings to make in order to appease the offended god, restore his or her favor, and "liberate the patient" (Somolinos D'Ardois 1978: 18).

The healer's goal in these instances was essentially to rid the patient's mind of obsessive ideas regarding the dangers that have befallen him. Somolinos D'Ardois argues that such fear would often lead to what we would now label as psychosis. Healers cured this paralyzing fear verbally—by interpreting omens, performing exorcisms, and by offering "the spoken word with sufficient authority to modify the patient's thinking and action" (Somolinos D'Ardois 1978: 23; translation mine). Language, therefore, was central to healing, and words themselves—if uttered by the proper authority—were thought to have curative powers. (Of course, such practices were not unique to Mesoamerica, and are an important part of many cultures' healing rites.)

To sum up, based on what is known of pre-Conquest medicine—primarily Aztec medicine, since Colonial doctors, friars, and historians had most contact with them in their chronicling activities—it is clear that Pre-Hispanic Aztecs did recognize and treat ills related to emotions, mental function, and the spirit, which themselves were highly connected to other aspects of body, social, and cosmic function. They did so in highly elaborated ways, using a blend of empirically derived medicines and a type of medico-religious talk therapy, not entirely dissimilar from present-day psychiatric methods.

COLONIAL MEDICINE & PSYCHIATRY

The Spanish conquest and colonization of Mexico left Mesoamerican medicine in a state of disarticulation—not only was the majority of the indigenous population

destroyed, but the Conquest and colonial state also represented an extreme ideological marginalization—and perhaps more often, obliteration—of indigenous practices. When the new economic and social order was established in Mexico, Pre-Hispanic medical practices were often considered primitive and discriminated against—except indigenous herbology, which, as mentioned above, turned out to be important economically and commercially for Spaniards (Somolinos 1983: 81). It seems the Spanish had a deep respect for Mesoamerican herbal knowledge and practice, given that Colonial figures devoted a great deal of energy to establishing taxonomies and collecting indigenous accounts of medical conditions and treatments.

Such efforts led to mestizo medicine, a blend of two approaches to health and healing that persist to the present day, usually referred to as *curanderismo* (Quijada 1991: 152). The process of cultural blending and syncretism characterized the whole of the Colonial period, as the Spanish imposed upon the indigenous populations not only European medical approaches, but also their language, political institutions, religion, and cultural practices. The overwhelming Colonial trend was, of course, domination, and subsequent marginalization—and indigenous medical practices became associated with witchcraft and ignorance (Quijada 1991). The book *Malleus Maleficarum*, finished in 1489, served as the Inquisition's handbook for identifying and persecuting witches, and many of those who may well have suffered from mental illness were—rather than treated medically—brought before the Inquisition tribunals and often killed (Somolinos D'Ardois 1978: 94; Narváez 2002: 36).

At the same time, however, as Somolinos D'Ardois points out,

> …the strong personality of the conquered people and the rapid physical fusion of both races prevented the destruction of the autochthonous element and, thus, just after the Conquest, when the sword and crossbow had to yield to the religious leaders and jurists who were to lead the new country, we see a cultural melting pot emerge in which indigenous elements infiltrate the dominant mentality, modifying it in many ways (Somolinos D'Ardois 1976: 38; translation mine).

Therefore, although many indigenous practices were (and continue to be) looked down upon, they were by no means extinguished entirely. As I will show in my discussion of Mixtec medicine, indigenous medical culture—albeit a blend of pre-Conquest Mesoamerican medicine, Spanish/European medicine, and African medicine (as introduced by slaves later on)—continues to thrive.

As for medicine and psychiatry in the early Colonial years, both were inseparable from Christian thought and practice. The 'good' was considered that which was encompassed by Christian moral thought: piety, charity, self-abnegation, and loving one's neighbor; the 'pathological,' on the other hand, was behavior that veered from the 'good,' and was often treated in religious rites without medical goals or procedures. Although some authors argue that Spanish colonial medicine was "directed toward the rational and academic" (Belsasso 1969: 32), Spanish doctors did treat illness as "a punishment for sins caused by devils who had taken possession of the patient's body and spirit," so "a basic diagnostic problem was to determine whether the disease was natural or preternatural—insanity or witchcraft, epilepsy or diabolical possession" (Belsasso 1969: 32). Illnesses of the heart treated in Mesoamerican medicine were not recognized by official Colonial medicine (Quijada 1991: 153).

The early Colonial era was, therefore, lacking in (officially sanctioned) healers and doctors specializing in emotional distress, and those who were thus afflicted either

lived in disgrace or had the good fortune to receive care and charity from monastic institutions and individuals (such as Bernardino Álvarez and José Sayago) who devoted their lives to helping the ill and alienated. This brings up an interesting point: before the arrival of the Spaniards, Mexicanos (and likely also the other cultural groups in Mexico at the time, including the Mixtec) had a developed medical culture attuned to psychological and emotional ills. With colonization, the mentally ill seem to have been marginalized and demonized—and sometimes killed by tribunals in the Inquisition. It took several centuries for psychiatry to become an important field in Mexican medicine again.

Institutional Colonial Psychiatry

Although there was not an official psychiatry, per se, there were several institutions that sought to help the mentally ill. According to historian Germán Somolinos Somolinos D'Ardois, Bernardino de Álvarez was the first to recognize the need for such an institution in Colonial Mexico; in 1566 he formed the Hospital General de Convalecientes y Pobres Desamparados (often referred to as San Hipólito, the church next to which the convalescent hospital was located), which treated those who Álvarez described as "living stones" [*piedras vivas*]: "innocents, as they have no free will, no understanding; they are like living stones who do not know how to function. In terms of eating, they are living stones, who—if their food is not prepared—will die of hunger. Therefore, they have the most necessity for those who will care for them (Somolinos D'Ardois 1978: 49; translation mine).

The Hospital General de Convalescentes, Somolinos D'Ardois argues, was the first institution in the Americas devoted to the mentally ill; however, it should be mentioned that this hospital does not seem to have offered psychiatric treatment.[2] Instead, it functioned more as a halfway house, in which the poor and ailing, the perhaps mentally ill and certainly socially disenfranchised could recuperate and receive humane treatment and some skills training. It was a religious, not a medical, institution. Such institutions already had a history in Spain, where in 1409 the friar Juan Gilberto Jofre gave a sermon on Valencia's need for a hospital serving the "locos e inocentes" (Somolinos D'Ardois 1978: 56). Jofre's congregation responded, and began a long tradition of such hospitals—a tradition upon which Álvarez built when he established San Hipólito.

Although not necessarily identified as a 'mental illness,' melancholy was a commonly treated condition in 16th and 17th century Spain. Its treatment and interpretation varied; some believed melancholia to be caused by preternatural or diabolical forces, and some took a more Hippocratic stance and believed it was an illness of the liver (Somolinos D'Ardois 1978: 75). The cures for melancholy in Spain during that time ranged from eating particular foods, having pleasant conversation, and listening to music to bleedings and purgatives (Somolinos D'Ardois 1978: 88). Some of these medical approaches reached Mexico by way of institutions set up by the Spanish crown to promote science and medicine. These institutions, usually universities, began appearing in the 16th century and were modeled after European universities. So too were

[2] Somolinos, in contrast, writes that Mexico's first hospital devoted to treating mental illness was el Hospital del Divino Salvador, known as 'Hospital de la Canoa', created at the end of the 18th century (Somolinos 1983).

their medical studies, which were devoted to studying Hippocratic and Galenic philosophy.

During the beginning of the 17th century, Mexican medicine reached its apex, but then became paralyzed and did not undergo notable changes for quite a while, likely because of Spanish controls on what knowledge and information could be imported to Mexico at that time (Somolinos 1983: 169). In the 18th century there were more advances—mostly surgical, due to increased understanding of anatomy—perhaps because the last Austrian king of Spain died and Spain experienced an ideological shift (Somolinos 1983: 182). There was "increased tolerance for the introduction of modern texts and books into the country; the Spanish government began to create in their colonies more awareness of training and study" (Somolinos 1983: 183; translation mine).

With regard to psychiatric medicine in Mexico during that period, there is a paucity of historical documentation. Several doctors wrote about cases that could be considered psychiatric, describing patients experiencing conditions such as dementia and melancholy (Somolinos D'Ardois 1978: 109). In Juan Somolinos Palencia's history of Mexican medicine he claims that the late 18th and early 19th century were some of the most fruitful for Mexican medicine, as vaccines were developed to combat the epidemics that were claiming thousands of lives (44,000 in the most fatal year, 1769) (Somolinos Palencia 1983). However, it seems as though there were few advances in the treatment of emotional ills or in institutional psychiatry, besides a few notables imported from Europe based on the theories of European doctors John Brown and Broussais. 'Brownism' reached Mexico in 1801; based on that approach, depending on the illness either stimulants or depressants were prescribed—the stimulant being alcohol (given to

epileptics) and the depressant being opium (given to those in states of mania hysteria, and hypochondria) (Somolinos D'Ardois 1978: 117). Broussais' theories regarding bleeding cures also reached Mexico, and during the 19th century that was a popular means of treating psychiatric issues.

MEXICAN PSYCHIATRY SINCE INDEPENDENCE

In the 19th century the majority of Mexican doctors studied abroad, particularly in France (Somolinos Palencia 1983: 195). One in particular, Martínez del Río, returned to Mexico and wrote about the French advances in treating the mentally ill, inciting his fellow Mexican physicians to follow suit. However, it was not until several decades later that new psychiatric hospitals began springing up such as Hospital de la Canoa (also known as el Divino Salvador) and Hospital Civil. These hospitals apparently put San Hipólito—which had fallen into disrepair and was known for its inhumane treatment of patients—to shame.

The late 19th century saw Mexico develop its psychiatry and make advances influenced by those taking place in Europe in the same era. Mexico founded its Academia Nacional de Medicina in 1864, and established it its journal *Gaceta de Médica de México.* From the years 1891 to 1909 in that journal there were 18 articles devoted to psychiatric and neurological disorders, including alcoholism, hysteria, and epilepsy. Many more articles about those disorders and also psychosis appeared in other publications, suggesting that though its output was not prolific, during the late 19th and early 20th century Mexico did begin contributing to the growing psychiatric literature.

During those years the country also developed its own institutions at a climbing rate (Somolinos D'Ardois 1978: 147): in 1860 a psychiatric wing was added to the Hospital Civil in Monterrey; in 1898 the Manicomio Estatal de Veracruz was founded; in 1906 the Hospital Psiquiátrico Leandro Ayala was created in Mérida, Yucatán; in 1910 the Manicomio General was founded in Mexico City and the hospital de Nuestra Señora de Guadalupe was founded in Puebla; and in 1916 Enrique O. Aragón founded the *cátedra de psicología* in the Facultad Nacional de Filosofía y Letras (Somolinos Palencia 1983: 255; Narváez 2002: 45, 50).

The 1930s saw a number of advances in Mexico's psychiatric discipline, including the creation of la Sociedad de Psiquiatría, Neurología y Medicina Legal, the Sociedad para Estudios de la Neurología y Psiquiatría, and the Sociedad Mexicana de Neurología y Psiquiatría, all of which had their own scholarly journals (Narváez 2002: 57). In those years the most common treatment for mental illness was shock therapy—insulin shock, cardiac shock, and electroconvulsive shock (Narváez 2002: 65).

Governmental Mental Health Programs

The country's first institutional program to promote mental health services was developed during the period between 1947 and 1951, and was coordinated by the Departamento de Neuropsiquiatría e Higiene Mental, a department of what was then called the Secretaría de Salubridad y Asistencia (Ramirez & Méndez 2007: 5). From 1984 to 2006 there have been five mental health programs in the country, and the Consejo Nacional de Salud Mental (CONSAME) was created in 2004 as part of the Secretaría de Salud Federal. Its aim is to reform Mexico's psychiatric system, particularly

its psychiatric hospitals. Reform has focused primarily on de-institutionalization and the re-integration of psychiatric patients into their communities, as well as promoting community-based treatment in primary care facilities [*tratamiento comunitario*]. Mexico is now home to 33 public psychiatric hospitals within the Ministry of Health (MoH). Oaxaca's institutional mental health program, PESM (see previous chapter), was not established until 2001.

According to Mexico's and Oaxaca's most recent institutional mental health plans (*Programa de Acción en Salud Mental*; *Programa de Acción Específico, Acción en Salud Mental; Programa Estatal de Salud Mental*), which themselves are tied to state, national, and international public health and development plans, reform of institutional psychiatry must also include spreading awareness about mental health among the professional healthcare community such that adequate referrals may be made and accurate epidemiological data collected. In addition, Oaxaca's State Mental Health program aims to train all personnel at primary care centers (*Centros de Salud*) to recognize psychopathology and provide psychotherapeutic intervention, counseling, and basic psychopharmaceutical interventions (Carreño 2009).

Spreading mental health awareness in the community at large is also central to mental health initiatives in the country, partially due to perceptions of widespread stigma against mental illness, the mentally ill, and the mental health profession. Also important to the goal of spreading mental health awareness have been the findings that only 2.5 percent of those who suffer severe mental illness in Mexico receive adequate treatment and that only one out of every ten people with three or more serious psychiatric symptoms seeks medical help (Secretaría de Salud 2008, c.f. Medina-Mora 2003).

CONTEMPORARY INDIGENOUS MEDICINE AND ETHNOPSYCHIATRY

Although indigenous, 'folk,' or 'traditional,' medicine has thrived for thousands of years in Mexico, it has perhaps always vied for legitimacy with 'Western' medicine. At the time of the Conquest, indigenous and Western forms of care blended—along with African elements introduced through slavery—to create *curanderismo;* however, the blending largely took place according to the terms of the colonizer, and many aspects of pre-Hispanic medicine were marginalized. Now, although indigenous healers frequently integrate biomedical and psychological practices into their services, there is little blending on an institutional level. As the following chapters will discuss, mental health practitioners' attitude toward traditional forms of care is, by and large, quite dismissive. To use Csordas' model of medical pluralism, the relations between traditional medicine and mental health care in Oaxaca are *contradictory* on an institutional level, even though to many patients they are complementary and/or coordinating (Csordas 2006).

Because I will be referring to traditional indigenous medicine throughout the dissertation, here I will provide an overview of this system as it currently exists. For this discussion I focus specifically on Mixtec medicine because it is the most pertinent to the dissertation research, given that I conducted fieldwork in the Mixteca region. However, much of Mixtec medicine resembles Latin American 'folk' or 'traditional' medicine more broadly.

It is worth repeating that although many current Mixtec medical practices date back to Pre-conquest times, there are very few Mixtec documents surviving from that era—and those that do exist are primarily in the form of codices. As mentioned above,

the Spanish focused their energy on chronicling Aztec practices at the expense of other indigenous groups. There are many similarities between Aztec and Mixtec medicine; however, as Rubel & Browner (1999) point out, different indigenous groups (and even sub-groups within indigenous groups) have different practices according to the climate in which they live, the plants and various botanical options available, the illnesses they have suffered, and the socio-historical circumstances they have encountered. These adaptations contribute to the formation of different medical approaches and specializations; at the same time, the general philosophy upon which these medicines are based is similar across communities.

Like other indigenous groups in Latin America, Mixtecos practice syncretic forms of medicine (not to mention syncretic forms of religion and other aspects of social life), a blend of pre-Hispanic Native American and 15th-century Spanish, as well as beliefs and treatments brought to the New World with the conquest (Sandstrom 2001; Viezca Treviño 2001; Bade 1994; Hernández 2001; Mak 1959; Diego 2002). Sandstrom asserts that "[f]or a majority of the population of Mesoamerica, the most important influence on healers was the European invasion in the early sixteenth century" (Sandstrom 2001: 314). The authors of the *Instituto Nacional Indigenista de México* [National Indigenous Institute of Mexico] study of medicine in the Mixteca Baja region, based on the testimonies of a Mixtec healer, corroborate Sandstrom's claims:

> According to the existing research, what is understood as traditional medicine today is a mixed product of Mixtec worldview. This is to say, [a product of] the relationship of man to the earth and the elements, labor, heaven, and the environment…On the other hand, the composition of traditional medicine shows European influence and thus gave way to the syncretism we see now. Practice is centered on the objective of maintaining equilibrium, both internal and external (Hernández 2001: 35; translation mine).

As mentioned above in my discussion of Aztec medicine and the conquest, given the extent to which these various medicines have mixed, it is difficult to parse out which aspects of indigenous illness explanatory systems and healing practices come from which original source.

Such blending was not always peaceful, of course; the label *curanderismo* referring to indigenous Latin American (and now also Mexican American) medicinal practices is a term colonial powers used to discredit indigenous medical practitioners. Upon entering the New World, they referred to indigenous healers as doctors, and—operating on the premise that indigenous peoples were naturally different from Europeans and so could not be effectively treated by them—afforded those doctors special privileges. Before too long, though, they lost their status because they did not practice Hippocratic and Galenic doctrine (Viezca Treviño 2001: 54). These healers were thus relegated to the non-medical title "*curanderos*"—still used today—implying a lack of scientific authenticity and integrity.

In terms of illness labels and explanations, concepts like evil eye (thought to be from Europe, called *mal de ojo* in Latin America) and the Mediterranean division of foods, illnesses, and herbs into metaphorical "hot" and "cold" categories blended with more characteristically Native American concepts and experiences like *susto* (fright or fright sickness) and soul loss; tonalism (also known as nagualism, discussed below); possession; object intrusion; and witchcraft.[3] Though these beliefs and practices are varied and have diverse origins, there are several fundamentals which unite them and

[3] These concepts are also found in other non-American cultures across the globe, including Persian, African, Turkish, and others.

which are also intimately related to Mixtec worldview and way of life. These are (1) the concept of equilibrium in all aspects of being: the social, spiritual, alimentary, emotional, and physical; (2) the ubiquity of and connection with supernatural forces or spirits, which can act upon individuals and cause illness; and (3) the pervasiveness nature in all aspects of life (Mak 1959; Diego 2002; Bade 1994). For the sake of clarity, I will discuss these three highly interrelated aspects one by one.

Equilibrium

The concept of equilibrium may derive from the Greek humoral system, in which both foods and curative substances are classified according to a division of 'cold,' 'hot,' and 'neutral' qualities (though *which* quality each food/substance has varies from town to town (Bade 1994: 32; Mak 1959). To be healthy, an individual must balance her intake of hot and cold substances, thus "maintaining a dynamic equilibrium in all ingested items, as well as to other activities related to livelihood" (Whiteford 1995: 220). Illness "results when an excess of either [cold or hot qualities] destroys this equilibrium" (Bade 1994; c.f. Foster & Anderson 1978: 59; Rubel 1960: 808). Thus, diet is central to health in Mixtec medical culture, not only with regard to nutrition but also to the metaphorical qualities that different foods represent.

The emphasis on equilibrium extends to other aspects of life and, as will be discussed below, to healing; in effect, it "orders social and spiritual relations" (Bade 1994: 34). As illustrated in community *tequio* (reciprocal systems of exchange) and *cargos* (required community service) as well, Mixtec culture generally tends to emphasize the balance of giving and receiving:

> When one asks a favor, one returns a favor; when one is fed, one feeds; when one is blessed, one gives thanks; when one is threatened, one seeks to protect. The dialectic between the self and the other seeks at once to eliminate and cultivate debt or obligation. Illness, therefore, is more than an impersonal physical assault, but is also an event in which debt—spiritual and psychological—must be paid (Bade 1994: 34).

Further, it is inadvisable to fall out of favor with members of the community because some illnesses are attributed to witches practicing *brujería* (*taji* in Mixtec[4]), who can be hired in some towns by those seeking to settle a score or act out a grudge (Romney & Romney 1966; Diego 2002).

With regard to emotional and psychological health it is also very important to maintain equilibrium and to avoid extremes. In the 1960s Romney & Romney observed that Mixtecos in Juxtlahuaca were "not given to overexpression of emotions though they can on occasion give bent to their emotions in an explicit way" (Romney & Romney 1966: 22). They attribute this to a desire for "personal security" accomplished by staying "within the framework of his culture" and being "able to follow the pathways without a great deal of deviation." They do point out that Juxtlahuacans do not "show an extreme of flat emotional reaction. The *abrazo* or semiritual embrace is given, for example, although not with a great show of enthusiasm. Joking is characteristic, but somewhat constrained…" (Romney & Romney 1966: 22).

Although the Romneys do not attribute the taciturn nature of Mixtecos to an avoidance of illness, per se, other ethnographies indicate that strong emotions like jealousy (*envidia*), anger (*bilis* or *coraje* in Spanish, *ndaa tyuchu* in Mixtec), fear (*susto*, or *nayi'vi* in Mixtec), and aggression are likely to cause illness, particularly among

[4] All Mixtec translations are provided by my former Mixtec professor, Angelina Trujillo, in the variant spoken in her hometown of Ixpantepec Nieves.

children. Therefore, mothers must be vigilant about managing their own emotions and protecting their children from *mal de ojo* (*kue'e nuu* in Mixtec, caused by menacing looks from jealous or admiring others) and from *sustos* (Mak 1959; Romney & Romney 1966; Bade 1994). *Sustos* are often tied to encounters with hostile supernatural spirits who seize the soul, and must be appeased before the victim can be cured.

Perhaps more frequently, *susto* results from either bodily ills or social conflicts and stressful experiences. It is difficult to know, though: *susto* has been extensively theorized in the anthropological literature as everything from a "cognitive paradigm" that provides meaning for problematic realities (Castro & Eroza 1998) to a gloss for depression, hysteria, a nervous breakdown (Gillin 1945), to pesticide poisoning (Baer & Penzell 1993) and other illnesses like anemia and cancer. In their study of *susto* in three communities (one Chinanteca, one Zapotec, and another mestiza) Rubel, O'Nell, and Collado Ardon (1984) argue that *susto* is a response to inabilities in conforming to gender roles, and *not* a psychiatric ill:

> On the contrary, individuals ill with *susto* were considered victims of social 'stress' created by the inability to meet expectations for fulfilling social roles. For example, men who were *'asustados'* were unable to harvest enough corn to feed their families, and these same men were unlikely to fulfill their *cargo* obligations and were unlikely to own their own animals for agriculture. For their part, women who were *asustados* had difficulty breastfeeding their children. Both men and women who were *asustados* suffered from more biological illnesses than their neighbors. In this sense, and even more surprising, is that *asustado* individuals in these three communities died younger than their neighbors who, even though they had been ill, did not suffer from *susto* (Rubel & Browner 1999: 87-88; c.f. Rubel, O'Nell, & Collado Ardon 1984; translation mine).

It seems that overall, *susto* is not analogous to any single disease according to biomedical nosologies (Rubel, O'Nell, & Collado Ardon 1984). It can result from a constellation of

problems, and whether we consider it a psychiatric problem depends upon its expression and, of course, what type of healer happens to be treating it.

Balance in social and familial life—and ability to fulfill one's expected roles and duties in relation to both the living and the dead—are central to understandings of health according not only to Mixtec medicine, but to Latin American folk medicine more generally. As Kaja Finkler argues in her ethnography of medical practice and patient experience in Mexico,

> the emotional discharges resulting from conflicts in which people are engaged and that are singularly significant etiologically in Mexico are instrumental not only in producing sickness but also in impeding perceived recovery. Individual patients are wrapped in contradictions whose templates are economic deficits, concepts of social justice, and cultural understandings of proper human conduct, including obligations of men to women and parents to children; in short, how men and women *ought* to behave under given circumstances (Finkler 2001: 12).

Social and familial conflict is frequently understood as illness-causing in Mexico; as such, the realm of illness and healing is profoundly moral. As we will see in Chapter 7, patients at the psychiatric hospital almost unanimously invoke social breakdowns in describing the etiologies of their illnesses, and they express struggling with how to re-establish equilibrium in their lives. Though psychological and psychiatric understandings of well-being and mental health do acknowledge social factors and attempt to restore the patient to a type of psychological and biochemical equilibrium (e.g. correcting so-called 'chemical imbalances'), this approach and its underlying philosophy is clearly quite different than the one common to indigenous medicine and runs counter in many ways to Mexican ethnopsychological understanding of self and social relations.

Nature and the Supernatural

> The basic assumption of the Indian Man about the world in which he lives seems to be that it operates according to certain rules or laws ultimately controlled by that part of the universe which we would call the supernatural. He also believes that the general plan of things is ongoing and immutable and therefore that man must learn certain patterns of action and attitudes to bring himself into conformity with this scheme of things; that if he does so, he will receive the minimum amount of punishment and the maximum reward. There is the feeling that some suffering or misfortune is inevitable, but there are certain ways of avoiding it or mitigating it once it has fallen. In the Indian scheme of things in the barrio [Juxtlahuaca], the individual seems to be somewhat submerged in the group, that is, the individual exists as a member of a group that is adjusted to nature, and by following its pattern, he survives and prospers (Romney & Romney 1966: 20).

As its tone suggests, the above quotation is taken from a culture and personality ethnography written nearly 50 years ago; since then not only has the "Indian Man" changed but so too has anthropology's treatment of and theorizing about indigenous groups. However, the basic point resonates: God, or the supernatural, is ever-present and ever at work in the lives and minds of most Mixtecos, perhaps especially when it comes to illness and misfortune. The Romneys and others posit that this orientation toward the supernatural contributes to a fatalistic approach to life, the belief that 'the general plan of things is ongoing and immutable' and 'the feeling that some suffering or misfortune is inevitable.'

Also fundamental to the Mixtec illness explanatory system is "the idea that hostile forces lurk everywhere, ready at the slightest provocation to cause illness or death" (Mak 1959: 127; Hernández 2001; Bade 1994; Diego 2002). When a human or her non-human counterpart (*nagual* or *tona*, discussed below) becomes vulnerable by letting down her "psychological or physical defenses" (Bade 1994: 26) or when she offends a spirit (*tachi* in Mixtec), breaks a social or religious taboo, or is cursed by another person, outside forces or spirits can attack. Such attacks can cause the victim to become ill, 'beaten,' or

bruised, to have an accident, and/or to suffer a *susto*. If left untreated (and sometimes even when treated), *sustos* can lead to soul loss, where the soul leaves or is taken from the body—usually by an offended spirit (Mak 1959: 158; Bade 1994: 26). As discussed above, soul loss can lead to grave illness or death.

Spirit and/or object intrusion, where offended spirits either possess a victim or insert objects like "stones, green or roasted chile, needles, small coins, lizards, sheep and dog dung, bones and candle stubs" can also cause illness. These conditions must be treated by a *curandero/a* (*tyii kixi tata*, in Mixtec) by sucking it from the skin of the afflicted or by rubbing him/her with an egg, which soaks up the illness (Mak 1959: 130; Bade 1994: 28). To avoid offending human spirits, Mixtecos frequently venerate the dead with candles, altars, prayer, ceremonies, and offerings (Bade 1994: 27). *Mal aire* is another indigenously-defined illness treated in the Mixteca, resulting from breathing the air that "emanates off the body of a dead person," from walking in night air, or from encountering "a dark shape" at night. *Mal aire* can lead to dizziness, fainting spells, "absence of breathing", and half-consciousness (Romney & Romney 1966: 74).

Generally speaking, Mixtec culture is inextricably tied to spirits and nature not only through everyday life and work (characterized by a direct and reciprocal relationship with natural objects, landscapes, and animals), but also through tonalism (*tonalismo* also called nagualism, or *nagualismo*). Common throughout Mexico and Guatemala, tonalism is a system of belief which intimately connects men and animals and in which "the whole world is animate and there are spiritual beings in all places and natural objects. They can be beneficial or harmful for people; if one does not demonstrate respect for the spirits they can cause physical harm and sometimes death" (Hernández 2001: 33; translation

mine). The *tona* is a "non-human counterpart, usually an animal but sometimes a 'thunderbolt,' to which [a person's] life is intimately tied," usually from the time of birth (Mak 1959: 131; Bade 1994: 28). When one's *tona* is injured or dies it can cause illness or death in its human counterpart. One's life and health are therefore dependent upon equilibrium; the well-being of the non-human counterpart; and spirits, which reside everywhere—on the ground, in stones, in sweat baths, in the fields, in the forest, and with the dead.

Healing

How can such illnesses be prevented or cured? This brings us to the Mixtec healer (*tyii kixi tata*) and his or her healing practices (*kixi tata*). Whereas a biomedical practitioner usually focuses on symptoms, the Mixtec healer focuses on the causes of illness in the patient's social and personal life, as well as occurrences "that may have disturbed his or her physical, spiritual, or cosmic balance" (Bade 1994: 36). When an illness is supernaturally caused, the healer "must possess divinatory or prophetic skills to determine the cause and appropriate treatment for illness" (ibid: 35). The healer therefore often has a religious role, in which

> healing implies animal sacrifices, edible plants, flowers, and incense…steam baths [*temescales*], suctions, decontamination with copal incense, prayer and objects blessed by the church, *limpias* with flowers, spitting *aguardiente* on the body of the sick person, as well as healing through modern medicine (Hernández 2001: 34; translation mine).

If the patient's soul has been separated from her body, in the case of *susto* and its often-ensuing soul-loss, the healer must know how to call the soul back to the body—unless, of

course, the patient herself knows the appropriate rituals with which to do so (and this is often the case) (Mak 1959: 129-130; Castro & Eroza 1998; Rubel et al. 1984).

While some healers are called upon for all maladies, other are specialized as *sobadores* (massage therapists, *tyi xaxi* in Mixtec), *hueseros* (bonesetters), *parteras* (midwives), and *tisateras* (herbalists). If a patient's equilibrium has been disrupted, the healer must restore it by using plants, foods, and medicinal substances (*yuku tata*, in Mixtec) that represent the ailment's opposite quality. For example, swelling is a "hot" ailment, and so could be treated using "cold" substances, like valerian root or tubers ground and used as a poultice (Mak 1959: 138). Mixtec healers, like many other types of healers around the world, must therefore have an intimate knowledge and understanding of "the physical, symbolic, and religious attributes of medicinal plants and their proper preparation," most of which come from the natural surrounds and many of which are combined with modern pharmaceuticals (Bade 1994: 36).

In summary, Mixtec medicinal culture is central to and inseparable from life in general. Illness, health maintenance, religion, and social relations are all intimately interwoven; with illness, "one's spiritual, social, and cosmic positions are considered to affect both cause and cure" (Bade 2004: 234). Equilibrium, supernatural forces, and nature are the three most crucial aspects of health in this explanatory system and its healing practices.

* * *

While I have argued that it is important to understand the Mixtec medical culture, it is no less important to acknowledge that this culture—like the culture of which it is a part—is not a static artifact, frozen in time. It is "traditional medicine" in the true sense,

given that aspects of it have been practiced for centuries. However, like biomedicine, it undergoes transformations with time, trial and error, and under the influences of other explanatory systems and practices.

As I have pointed out, many Mixtec healers blend their treatments with modern pharmaceuticals and some biomedical practices, leading to a new type of syncretism comparable to the original syncretism that created what is now known as *curanderismo* (Bade 1994; Whiteford 1995; Diego 2002). Even in 1966 when Romney & Romney published their ethnography of Mixtecos in Juxtlahuaca, they report the use of "patented" medicines in indigenous healing practices: "Mejoral, a patent pain-killer, is considered refreshing and may be given in small quantities to children with colds" (Romney & Romney 1966: 75). They also report widespread use of Aspirin along with herbs, and write that *curanderas* treat patients with both "home remedies" and "store-bought medicines" (Romney & Romney 1966: 76). Patients, too, often utilize a number of healing options, depending on their own assessment of the malady, its severity, who they believe would be the most efficacious type of healer, and what resources are available (Whiteford 1995; McGuire 2001; Bade 2004).

CONCLUSION

As the above discussion indicates, social and familial life, spirituality, nature, the animal world, and overall well-being have not been traditionally parceled out and treated as separate phenomena according to pre-Columbian Mesoamerican medicine or indigenous medicine as it is practiced in the present day. Rather, they are intimately intertwined, and emotional well-being has been viewed as part and parcel of the broader

whole of which humans are a part. Finkler argues that it is precisely the Mexican ethnopsychological importance of interconnectedness and interdependence that has doomed psychiatry in the country:

> Psychiatry failed to gain a foothold in Mexico arguably because of its prevailing notion of the autonomous individual rather than the autonomous family of which the individual forms a part. The notion of the autonomous individual goes against dominant cultural understandings in all sectors of Mexican society, where…the family and not the individual is the fundamental unit of society. Importantly, too, Freudian notions regarding a relationship between sexual deficits and emotional disturbances, voiced by some Mexican psychiatrists, flow counter to traditional cultural etiological notions of emotions that emanate from social interaction and the life world… (Finkler 2001: 72).

Indeed, both psychology and psychiatry posit a profoundly different view of self and social relations, one which emphasizes the primacy of individual experience and internal pathology. However, I contend Finkler's declaration that psychiatry 'failed to gain a foothold in Mexico' was premature. Though psychiatry's 'notion of the autonomous individual' may indeed be contrary to dominant Mexican understandings of family and society, the case of Oaxaca suggests that individuals may be coming to see themselves and their emotions in terms of 'mental health' and psychological intervention. This does not necessarily indicate a waning of 'etiological notions of emotions that emanate from social interactions and the life world'; however, as I show in Chapter 7, patients often utilize psychiatric technologies for the express purpose of resolving social conflict and rejoining social life.

While mental health services in Mexico still suffer stigmatization and suspicion in some corners, they are enjoying growing cultural cachet in others. This chapter has provided a historical backdrop against which their rapid proliferation may be understood. The following chapter examines the specific nature of globalizing mental discourses,

ideologies, and practices, arguing that they create particular psy-imaginaries which practitioners actively attempt to promote in their project of broad-based cultural change.

CHAPTER 4

MANAGING EMOTIONS, TAKING PILLS: GLOBAL & LOCAL DISCOURSE, IDEOLOGY, AND PRACTICE

INTRODUCTION

What globalizing mental health ideologies and discourses are circulating in Oaxaca, and how are they mobilized on a local level? How are they involved in Oaxaca's ongoing social and cultural changes? Based on participant observation at conferences, self-help groups, motivational speeches, and Oaxaca's public psychiatric hospital; analysis of media coverage and institutional documents; and interviews with mental health practitioners and public health administrators, this chapter seeks to answer the forgoing questions and, in so doing, contribute to understanding of the transnational flow of ideologies around emotional and psychological well-being and pathology.

In the first part of the chapter, I provide a literature review on anthropological and other work addressing the globalization of Euroamerican mental health discourse, ideology, and practice. I argue that in the case of Oaxaca, there are two distinct but interpenetrating processes of globalization taking place with regard to mental health, self, and sentiment: psychological globalization and psychiatric globalization. Psychological globalization is, broadly speaking, composed of a 'regime of the self' (Rose 1996) and its concomitant 'technologies of the self' meant to cultivate self-knowledge, self-expression, responsibility, and empowerment. Based on a view of the self as fundamentally vulnerable to imbalance and disorder yet capable of agentive self-transformation and psychological liberation, this 'regime of the self' is spreading through a number of means in Oaxaca.

Psychiatric globalization, on the other hand, refers to the transnational spread of universalizing notions of mental pathology as codified in the *DSM* and the *ICD*, as well as the many psychopharmaceutical medications developed to treat those pathologies. International pharmaceutical markets, professional conferences, and exhortations on the part of the World Health Organization and other international health governance bodies to prioritize mental health are central to the rise of psychiatric globalization. In Oaxaca psychiatric globalization is not nearly as widespread as psychological globalization; I theorize that this is the case because psychiatric globalization explicitly regards pathology rather than the more mundane project of self-cultivation (as per psychological globalization), and because direct-to-consumer psychopharmaceutical marketing is prohibited in Mexico. I examine the content of both psychological and psychiatric globalization using several ethnographic examples in the second part of the chapter.

Here and in subsequent chapters, I show how these forms of globalization produce particular 'psy-imaginaries.' Using Jenkins' formulation, I take 'imaginary' to connote "that dimension of culture oriented toward conceivable potentials of or possibilities for human life" (2010: 23).[1] Psy-imaginaries facilitate the acceptance of and desire for mental health services in Oaxaca, but—due to the unequal spread of mental health services—can also create disjunctures between the types of selves people imagine and access to the experts and medications which promise to help them actualize those imaginaries. Further, and as I will elaborate in Chapter 5, the professional dissemination of these imaginaries involves problematic claims about the nature of culture and its place

[1] See Jenkins 2010, Note 6 (pp. 39-40) for helpful discussion of Lacan's, Castoriadas', Strauss', and Taylor's uses of 'imaginaries.'

in mental health practice and experience. Overall, I seek to illuminate the dynamic interactions between the 'local' and the 'global' as manifest in mental health practice—and the tensions these interactions engender on the ground.

GLOBALIZING HEALTH, SELF, & SENTIMENT

I argue that in the case of Oaxaca, there are two intimately related yet distinguishable globalization processes occurring with regard to mental health, self, and sentiment: 'psychological globalization' and 'psychiatric globalization.' The separation of these two processes is a reflection of how they are conceptualized, mobilized, and talked about in Oaxaca; there is both a disciplinary and discursive separation between the two. Though there is overlap and practitioners often integrated aspects of each set of ideologies (e.g. psychologists acknowledging the importance of diagnoses and psychopharmaceutical medications or psychiatrists discussing the importance of expressing emotions and building self-esteem), more common was a strong disciplinary tension. On the community level, psychological ideology and discourse was prevalent among a wide range of study participants in several communities, while psychiatric ideology and discourse was much less widespread, arising only tangentially in my discussions with community members.

Before moving on to my analysis of how these two globalization processes are unfolding in Oaxaca, I will first discuss both in relation to theoretical and ethnographic literature.

Psychological Globalization & Therapeutic Governance

I borrow the term 'psychological globalization' from Anderson-Fye (2003), who uses it to refer to the "transcultural material" which becomes "psychologically salient in any given culture" (2003: 59). Her study of Belizean adolescent girls examines globalizing content around gender violence and body image with the goal of understanding why ideas around the former have been embraced and internalized while ideas around the latter have not gained traction. She theorizes that local ethnopsychology mediates what and how transnational material becomes incorporated; as she puts it, "the better the 'fit' between the local ethnopsychology and the power-laden psychologically related Western media, the more influence the material will have" (ibid: 60). Anderson-Fye's examination of globalization's psychological content focuses on how particular concepts are spread through exposure to American media and American tourists in Belize; although she discusses how this globalizing psychological content articulates with Belizean ethnopsychology, she does not explore its underlying ideology. In other words, while particular notions of gender violence and body image are loosely attributed to the United States, she leaves unexamined the broader model of the self, emotions, and pathology that such notions are based upon.

I use the term 'psychological globalization' to refer more generally to the transnational flow of ideologies, discourses, and practices around psychology, emotion, and general well-being which derive from European and American 'psy' disciplines, and which, in Nikolas Rose's terminology, compose a particular 'regime of the self' (Rose 1996). This 'regime' refers to "the ways in which the contemporary apparatus for 'being human' has been put together: the technologies and techniques that hold personhood—identity, selfhood, autonomy, and individuality—in place" (Rose 1996: 2). Rose traces

the emergence of the 'regime of self' in the United States and Europe and argues that the growth of psychology and other 'psy' disciplines has been historically linked with

> transformations in the exercise of political power in contemporary liberal democracies…The growth of psy has been connected, in an important way, with transformations in forms of personhood—our conceptions of what persons are and how we should understand and act toward them, and our notions of what each of us is in ourselves, and how we can become what we want to be (Rose 1996: 11).

For Rose and others, Foucault's concept of governmentality provides a theoretical lens through which to understand the ways psy disciplines and their concomitant ideologies, practices, and techniques play a crucial "regulatory role" in the subjectification and governance of populations. Governmentality refers to the ways in which power is yielded not by overtly restrictive, coercive, or repressive means but by diffuse and productive means "often guided by expert knowledges that seek to monitor, observe, measure, and normalize individuals and populations" (Clarke et al. 2005: 165, c.f. Foucault 1975, 1980, 1988, 1991). The 'psy' disciplines compose one such expert knowledge, and they contribute to the formation of particular types of subjects: those who essentially discipline and govern themselves. Yielded by means of biopower and technologies of the self (Foucault 1988), psy exercises power by defining the ways we should know and act upon ourselves. As Adele Clarke and colleagues put it, "[t]his kind of power relies not upon brute coercion, but instead upon diffuse mechanisms such as discourse that promote the pursuit of happiness and healthiness through certain modes of personal conduct, including self-surveillance and self-regulation" (Clarke et al. 2003: 165).

Rose argues that in 'advanced liberal' democracies, governance—understood in the Foucaultian sense of the tactics for determining 'the conduct of conduct'—has been accomplished through the particular discourses of *freedom* which 'psy' disciplines espouse and promote, freedom here meaning "the realization of the potentials of the psychological self in and through activities in the mundane world of everyday life" (Rose 1996: 17). As proper subjects and citizens in contexts of 'advanced liberalism,' we come to see ourselves in light of particular ideologies of individuality, liberty, "responsibility, accountability, risk, and freedom of choice" (Richard & Rudnyckyj 2009: 60, c.f. Rose 1999).[2] Because 'psy' emphasizes the fundamental role of inner psychological processes in human existence—one's inner psychology *is*, in this model, one's self and basis for personhood—the cultivation of a unique and authentic self and identity through self-inspection, self-realization, self-esteem, self-expression, and self-actualization are fundamental to 'freedom,' autonomy, and understandings of healthy functioning.

It is through these forms of self-discipline that "government of the self and government of the collectivity become a part of a single, seamless order" (Rudnycjyj 2011: 72). We not only voluntarily submit to various 'techniques' and 'technologies' of the self and the authorities who prescribe them for us, but we understand them to be reflections of our own desire for freedom and fulfillment. As Rose puts it, "a range of

[2] As opposed to the absolute exercise of power by sovereign monarchs who could discipline, punish, and kill at will, 'democratization' "made it possible to superimpose on the mechanism of discipline a system of right that concealed its mechanisms and erased the element of domination and the techniques of domination involved in discipline," thus creating "a public right articulated with collective sovereignty . . . heavily ballasted by the mechanisms of disciplinary coercion" (Foucault 1976/2003: 37, cited in De Genova 2010: 64). Biopower, or the "set of mechanisms through which basic biological features of the human species became the object of political strategy" (Foucault 1978/2007: 1) is central to this modern form of governance: power is exercised through the surveillance and control of populations by managing and intervening upon life, risk, and behavior (Rabinow & Rose 2006; Comaroff and Comaroff 1992; Ferzacca 2002).

psychotherapies…aspire to enabling humans to live as free individuals through subordinating themselves to a form of therapeutic authority: to live as an autonomous individual, you must learn new techniques for understanding and practicing upon yourself. Freedom, that is to say, is enacted only at the price of relying upon experts of the soul" (Rose 1996:17).

Like Rose, Pupavac (2001), Nguyen (2010), Duffield (2007) and others have taken a Foucaultian approach to show how the 'regime of the self' and particular 'technologies of the self' have spread beyond services explicitly offered by 'experts of the soul' to compose a form of therapeutic self-governance both in so-called liberal societies and through international conflict resolution, humanitarian aid interventions, and development projects initiated by these liberal societies. Based upon an understanding of humans as inherently vulnerable and insecure (as opposed to "the 19th-century archetype of the robust risk-taking, self-made man" (Pupavac 2001: 360)) and a belief that the current historical moment is characterized by "general moral, social and even emotional crisis" (ibid), therapeutic ideologies and techniques underlie social and governmental policy in a number of realms.[3] Along with Lasch (1984), Pupavac argues that citizens' relationships to their governments and state institutions are increasingly characterized by a 'politics of feeling' and "the redefinition of political authority in therapeutic terms" (Lasch 1984: 49, quoted in Pupavac 2001: 360). Governance and social control increasingly occurs through both domestic and international biopolitics, or "the specific strategies and contestations over problematizations of collective human

[3] It is beyond the scope of the chapter to thoroughly review the literature on the role of psychology in modern forms of politics, governance, citizenship, and democracy; however, there is a rather extensive literature on the topic. See Duffield 2007; Herman 1995; Lasch 1995; Nolan 1998; Sennett 1976.

vitality, morbidity and mortality; over the forms of knowledge, regimes of authority and practices of intervention that are desirable, legitimate and efficacious" (Rabinow & Rose 2006: 197).

According to this logic, citizenship—as a mode of moral personhood and as a legal status guaranteeing particular rights—requires the successful cultivation of self through a variety of practices ranging from self-disclosure through confession and illness narratives (Nyugen 2010) to building self-esteem through participation in the global market (Kabeer 1999) to taking pharmaceuticals in compliance with psychiatric and medical regimens (Jenkins 2010; Lakoff 2005; Petryna, Lakoff, & Kleinman 2006). Through such 'technologies of the self' we fashion ourselves "in accordance with prevailing moral codes" and expectations (Nguyen 2010: 8). Health, in this context, becomes a matter of "ongoing moral transformation" (Clarke et al. 2003: 172).

Many critiques highlight the ways in which emphasis on personal responsibility and self-cultivation take the place of collective organization and the acquisition of political rights and social recognition and help to ensure the private management of social inequalities, meanwhile relieving the state of such responsibilities to its citizens (Pupavac 2001; Zigon 2011).[4] As such, and often as mandated by the terms of aid from international institutions such as the World Bank and the IMF, public institutions increasingly provide programs to promote education around psychosocial development, emotional literacy, parenting techniques, anger management, self-care, and drug therapy. In contexts ranging from disaster and trauma relief efforts (Pupavac 2001; Summerfield

[4] In Lasch's words, therapeutic governance involves the "redefinition of political authority in therapeutic terms…the rise of a professional and managerial class that governs society…by defining normal behavior and by involving allegedly non-punitive, psychiatric sanctions against deviance" (1984: 49, quoted in Pupavac 2001: 360).

2004; Fassin & Rechtman 2009) to AIDS interventions (Nguyen 2010), NGO programs (Richard & Rudnyckyj 2009) to privatized factories and other corporations using emotional intelligence programs (Rudnyckyj 2011), 'therapeutic governance' is exercised by "developing regulatory technologies dispersed through supervising processes and networks appealing to self-realisation" (Pupavac 2001: 361). Oaxaca's 'culture of mental health' is characterized by a number of both state-provided and private, for-profit initiatives centered around these aims.

Whether viewed through the lens of Foucaultian governmentality or not, social and economic transformations associated with globalization—including neoliberal reforms, international development and aid projects, public health initiatives, [5] and commodity and media flows—are contributing to the spread of the 'regime of the self' and its associated techniques. These transformations can contribute to dramatic shifts in how individuals and societies regard themselves.

Psychiatric Globalization

While psychological globalization refers to discourses, ideologies, and practices around the self and emotions, psychiatric globalization refers to those specifically dealing with psychopathology through the lens of biomedical psychiatric diagnoses and treatments. In Chapter 1 (footnote 5) I provided a brief account of psychiatry's current biomedical foundations, where "psychiatric diseases are held to be discrete and heterogeneous, that is, non-overlapping and distinguishable," and in which "criteria of categories are held to be *symptoms*…rather than etiology" (Good 1992: 185). Although

[5] I discuss Mexico's neoliberal reforms over the past several decades in Chapter 1; in Chapter 5 I discuss health reforms, development goals, and public health programs specifically.

biomedical psychiatry is practiced in diverse ways depending upon the context, culture, and local medical norms, some aspects are more or less uniform across contexts—perhaps particularly the reduction of psychological illness to its barest signs and symptoms, understood to be a biomedical disease process; the diagnosis of such illness through classification systems (such as the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) and the World Health Organization's *International Classification of Diseases* (ICD)); and treatment of disorders primarily through "targeted drug treatment" thought to "restore the subject to a normal condition of cognition, affect, or volition" (Lakoff 2005: 7).

Biomedical psychiatry implies a particular orientation toward the self and emotional experience: specifically, a willingness to view mental and emotional suffering as (a) distinct and separate from bodily, spiritual, and social suffering, though these may be part of the illness constellation; and (b) as medically treatable disorder. As psychiatrist Derek Summerfield and others have pointed out, such orientations emerged historically from the European Enlightenment emphasis on science and reason as well as Cartesian mind-body dualism, which contributed to a "search for scientific accounts of the mind and its disorders" and ultimately led to the conversion of "human pain, misery, and madness into technical problems which could be understood in standardized ways and which were amenable to technical interventions by experts" (Summerfield 2004: 233).

An understanding of selves and emotions as biomedical entities that can be treated and transformed through pharmaceuticals is culturally informed, but it is by no means culturally bound. Through globalized commodities, markets, technologies, and health organizations, the biomedical model has come to saturate not only North American self-

and illness-understandings but also those of many countries, cultures, and societies to which biomedical psychiatric practice and pharmaceuticals themselves have spread. Different cultures put different spins on the biomedical model and put pharmaceuticals to different uses depending on what is considered to be normal and beneficial versus what is pathological and harmful (Ecks 2003:101).

Some, like Argentina, actively resist the biomedical model of mental illness, an effort that is itself connected to broader cultural and historical processes. Lakoff (2005) shows the ways in which Argentine psychiatry has "defended against the encroachment of biomedical standards, which they saw as part of a dehumanizing process" (15). In this process a person's illness becomes a "liquid" asset, part of a universally identifiable entity, marketable, able to be treated uniformly and covered financially through insurance companies. Argentina has resisted this model and held on to a psychoanalytic approach even as practitioners use pharmaceuticals as tools in therapy. Whyte et al. (2002), too, show that in encounters between biological, biomedical approaches to mental illness and various socio-cultural-economic contexts there is resistance and reconfiguration—from female Thais taking *ya kae ak seep* for inflamed womb caused by overwork (60) to Dutch and British women both taking and quitting medications in order to gain control over their own lives (57-60). Other countries and cultures integrate the biomedical model and psychopharmacological treatments into local conceptions and treatments—from the Netherlands to India, Manila to Japan, Africa to the Americas, health is or is becoming

commodified and patients are more and more becoming pharmaceutical consumers and 'pharmaceutical selves' (Jenkins 2010).[6]

Skultans (2007) examines the history of psychiatric thought in Latvia, showing how in the 1990s Latvians resisted psychiatric knowledge and medicalization by interpreting their distress as a natural (if undesirable) consequence of historical, political, and social circumstances in Soviet Latvia rather than as biological or psychological illnesses. However, ten years later, Skultans finds that her informants' views have shifted. No longer are they focused on the social causes of their suffering; rather, "the perception of disorder and responsibility for psychological distress and illness has shifted from society to the individual" in the eyes of both patients and psychiatrists (ibid: 166). Skultans clearly has a negative view of these changes, which she argues shift the onus of responsibility onto the sufferer, whose possibilities for agency are in turn further constricted (ibid: 172). In her view, "[t]he freedom [Western psychiatry] offers may be illusory. In this process individuals have been transformed from active commentators and critics of their life circumstances to passive recipients of diagnoses" (ibid: 9).

Scheper-Hughes' study of *nervoso* in Brazil (Scheper-Hughes 1992) has a similar, if even more critical view of the ways by which the body and self become scapegoats for socioeconomic ills. Her informants are the people of Bom Jesus, who experience severe hunger and deprivation daily but who see their bodies as problems needing medical and pharmaceutical care rather than the social structure as a problem needing reform. Like

[6] There has been a recent efflorescence of scholarly research on the globalization and experience of ingesting psychopharmaceuticals; in addition to Jenkins' 2010 volume, see Biehl 2004, 2010; Biehl et al. 2007; Ecks 2003, 2005, 2010; DelVecchio Good et al. 2008; DelVecchio Good 2010; Good 2010; Lakoff 2005; Petryna et al. 2006; Skultans 2007; Whyte et al 2002).I will discuss psychopharmaceuticals and 'pharmaceutical selves' (Jenkins 2010) in more depth in Chapter 7.

Foucault's disciplinary society in which people allow medico-judicial judgments to determine what is normal and acceptable (and ultimately reproduce those judgments in everyday practice), the non-disciplinary society of Bom Jesus allows medicine to appropriate *nervoso* and transform it

> into something other: a biomedical disease that alienates mind from body and that conceals the social relations of sickness. The madness…is transformed into a personal and 'psychological' problem, one that requires medication. In this way hunger is isolated and denied, and an individualized discourse on sickness comes to replace a more radical and socialized discourse on hunger (Scheper-Hughes 1992: 169).

Skultans, Scheper-Hughes, and others show how medicine and the 'psy' disciplines play a fundamental role in exercising power over people and their bodies, and also how the bodies upon which power is exercised also play a fundamental role in acquiescing and consenting to—and reproducing—these power relations.[7] It may be that, as Skultans (2007) suggests "[t]he economic superiority of the West, the idea of Europe as synonymous with civilization and knowledge and, not least, the new influx of psychopharmacological drugs all combine to make the new language of Western psychiatry difficult to challenge" (Skultans 2007: 9). After all, Euroamerican mental health practice is a powerful system of knowledge created far from the cultural realties of the many contexts to which it is increasingly exported through commodities, markets, international health organizations, and global media. In settings characterized by multiple

[7] Others have pointed out how the medicalization of life has emerged from the "secularization of life in Western society, a waning of the power of tradition and religion" which formerly provided spiritual interpretations of and means of relief for suffering (Summerfield 2004: 233). As Summerfield puts it, "a major feature of twentieth-century Western culture—gathering pace in the past two decades—has been how medicalized ways of seeing have displaced religion as the source of everyday explanations for the vicissitudes of life, and of the vocabulary of distress" (Summerfield 2004: 233). On the contrary, Asad (2003) argues modernity is not necessarily characterized by such diminishment of the religious in favor of the secular, but that the two are mutually constitutive (c.f. Zigon 2011: 225).

ethnic groups with their own rich systems of indigenous medicine, the implementation of Euroamerican biomedical and psychological care can have deep impacts on not only illness conceptions and treatments, but also on broader concepts and experiences of self and society.

Although these processes can yield increasingly homogenous ideas of mental health and pathology, psychiatric anthropology has shown how the application of diagnoses is mediated by cultural orientations, professional preferences and personalities, and patient understandings. Thus, although psychiatric diagnoses represent "the extension of potentially universalizing forms of knowledge and technique" (Lakoff 2005: 4), the dynamic interactions between the 'global' and the 'local' can also contribute to the creation of new imaginaries—new ways of apprehending self and others; new possibilities for living, speaking, and behaving; and new forms of hope and desire (DelVecchio Good 2007; Jenkins 2010).

It is important to note that my analysis of globalizing mental health in the framework of therapeutic governmentality and biopolitics is not meant to suggest any sinister intentions on the part of mental health practitioners, most of whom have altruistic goals centered on the relief of suffering. Nor is it meant to undermine what have been remarkable advances in the detection and treatment of mental disorder over the past three decades. The recent turn toward mental health as a global concern—to which states, international organizations, and communities are increasingly attuned—is a welcome turn from the relative inattention to and stigmatization of such issues historically. As I will show in Chapter 7, such advances can undoubtedly relieve symptoms and experiences of immense suffering. The interesting questions which emerge with the spread of

Euroamerican mental health practices and their attendant orientations toward self and emotion revolve around their consequences: What types of selves are being proposed, promoted, cultivated, and treated? How is what it means to be a human being reconfigured? What disjunctures, tensions, and contradictions emerge? And how is the local sociocultural context altered?

Before delving into these questions in more depth in the following chapters, I will outline what the globalizing content of psychological and psychiatric globalization is using several ethnographic examples. In the following sections, I describe two events which illustrate prevalent aspects of both sets of ideologies and discourses and the imaginaries they create.

PSYCHOLOGICAL GLOBALIZATION: STRESS & THE MANAGEMENT OF EMOTIONS

Posters have been hung throughout Oaxaca City advertising the event: "Stress and the Management of Emotions" with Dr. Alfonso Ruiz Soto, an inspirational speaker from the Semiology Institute (*Instituto de Semiología*) in Mexico City. The advertisements—taped on storefront facades, telephone poles, and bus stop shelters—depict Dr. Ruiz in a suit and tie, looking meaningfully into the camera, his brow furrowed and his chin resting on his hand (Figure 4.1). He has slicked-back grey hair, a severe yet pleasant face, and looks accustomed to posing for photos. His event is to take place at the Hotel Fortín Plaza, where a massive canvas—again with Dr. Ruiz's face and STRESS AND THE MANAGEMENT OF EMOTIONS in bold red letters—has been strung so passersby on one of the city's main thoroughfares, Niños Heroes, are sure to see it.



Figure 4.1: Stress and the Management of Emotions Poster

The event has been well-publicized, yet I am still surprised to find so many people there when I arrive. Entrance costs 300 pesos (about 20 USD)—five times the daily minimum wage in Oaxaca and enough to pay for several hours with a private psychotherapist. Dr. Ruiz Soto has a following, however, and did not have trouble filling the event space. Young, well-dressed women wearing a great deal of makeup as well as matching close-fitting business suits greet attendees, handing us flyers for the company sponsoring and organizing the event, Calderón & Bergés, Conseillers. I am given a notebook with the logo of a pharmaceutical laboratory printed on it, as well as several leaflets for various ‘alternative’ and spiritualist healers in the area.

The room is typical of a hotel conference space, with rows of closely spaced chairs and a stage with two large screens set up on either side. Above the stage are about a dozen

signs from advertisers, including local newspapers and pharmacies. On the stage is nothing but a white modular leather armchair.

As we wait for the speaker to emerge, the screen lights up—bizarrely—with a video of Michael Jackson live in concert, fans fainting with excitement. Audience members hush a bit to watch, and more people stream into the room. A few minutes later, Dr. Ruiz and his crew emerge, looking as though they have stepped off a movie set. Dr. Ruiz Soto is wearing a grey pinstripe suit and a pink tie, his grey hair impeccably gelled. A sharply dressed male-female pair take turns reading an introduction of our speaker in dramatic style, listing his qualifications and accolades: a PhD in English from Oxford, a PhD in Semiology from University of Nottingham, and author of the 1993 book *La Mirada Interior* [The Inward Gaze].

When the introduction ends, Dr. Ruiz—hooked up to a wireless microphone attached to his lapel—walks through the audience making eye contact as he begins his lecture. "What meanings do our lives hold?" he asks us. He explains that tonight's talk is just one in a series of workshops entitled "The Semiology of Everyday Life." "What concerns us tonight is a theme that concerns everyone," he says. "It's a subject of extraordinary importance. Stress." He wants to talk not only about stress itself, but about its *semiology*. According to Dr. Ruiz, the semiology of stress, like the semiology of everyday life, seeks to understand stress as a sign connected to all other signs in our personal and social lives. "Who here is hearing of semiology for the first time?" he asks. Most attendees raise their hands. "Welcome."

After this rather heavy introduction, Dr. Ruiz begins his performance in earnest. Accompanied by slides showing various 'stressed' individuals (one aggravatingly stuck

in traffic, another intently focused upon performing surgery on a patient) his talk quickly segues from abstract references to semiology to definitions of stress, what causes it, and how we might best manage it. His presentation is fluid and punctuated with jokes—usually referring to sex and marriage—that the audience members love. What begins as a pseudo-philosophical meditation becomes a knee-slapping performance, unintimidating and accessible. Dr. Ruiz's serious, lined face; his strikingly straight, white teeth; his suit and leather loafers; his entourage of well-heeled helpers; his spotlighted white leather chair—all of this contrasts with his jovial, charismatic performance. He has his audience hooked, and I begin to understand how he manages to fill auditoriums throughout Mexico and abroad. If anyone doubted at the outset that he or she had experienced stress, or reacted to a loved one in a stressful manner, Dr. Ruiz has used jokes, caricatured impressions of male-female and husband-wife interactions, and relatable anecdotes about the frustrations of everyday life to entertainingly demonstrate how stress impacts every aspect of our lives and being.

But what, really, is the semiology of stress? Dr. Ruiz Soto tells us we have to take the series of courses on the "Semiology of Everyday Life®" to truly find out. Ruiz's semiologia.net website provides a definition of semiology and how it corresponds to everyday life:

> Dr. Ruiz Soto® has stated that: Semiology concerns processes of meaning, which is to say, the processes that connect everything that exists. According to Ferdinand de Saussure's classic definition, 'Semiotics is the science of studying the life of signs within the folds of social life.' In effect, we inhabit a universe of meaning where everything is related to everything else, and where these relations—and consequently their meanings—are in perpetual transformation. Our very existence is a stream of experiences whose meanings are changing incessantly, configuring the quality of our lives depending on what it means to each of us.

> Nevertheless, life's meaning is not given; you have to create it, accept it, and practice it every day in each of the actions of your everyday life. Everyone is responsible—in full exercise of their free will—to configure the meaning of existence which will confer the greatest personal fulfillment and the greatest sense of human realization. People desiring to regain confidence in life and to inhabit a more harmonious, lucid existence have to face the fundamental challenge of creating themselves, their own happiness, and their own ability to love.

We can guess, based on this heady description, that the semiology of stress might refer to what stress means in everyday life and how such meaning is in constant transformation and related to all other meanings. We believe we are stuck in our (stressful) lives, but in reality we are 'free' to create them: our lives and our experiences—and the degree to which we allow stress to define us—are, like signs, arbitrary, and thus up to us to re-define.

As conveyed in Dr. Ruiz's talk, however, the semiology of stress consists basically of defining it, telling us how it can affect us, and providing some tools for individually 'taking control' of it and preventing it. Stress, Ruiz warns us, is a global public health problem: 75 percent of the world experiences 'critical stress' levels at least once a week. As for stress's "technical profile," it is related to hormones, the hypothalamus, the pituitary gland, and the adrenal gland. It affects "all social classes, even kids," Dr. Ruiz warns. Stress causes us to want to flee stressful situations in the short term; in the long term, chronic stress weakens our entire immune system and creates "multi-systemic" harm. Its effects can lead to anorexia, depression, anxiety, tobacco addiction, suicide attempts, ulcers, and infertility. It has physical, psychological, and behavioral impacts.

Dr. Ruiz switches the slide from a list of stress's pathogenic effects to one with a short-haired brunette wearing red lipstick throwing her head back, laughing. "Stress resolution: First step," the slide says. "How do we resolve these problems?" Dr. Ruiz asks. "Paradoxically," he says, "the fundamental answer is within yourself." The slide clarifies his point somewhat: "A new attitude toward life. Regain your sense of realization." The objective: "Systematic reduction of tension until a maximum of harmony, well-being, and inner peace is reached." Happiness, we are told, is found not in money, fame, power, or success; rather, it is within us. Dr. Ruiz emphasizes the importance of "internal peace," but says it is so hard to accomplish because "we are ignorant of ourselves." To become less ignorant—and therefore less stressed—we must seek and create life's meaning.

The steps Dr. Ruiz recommends we take to achieve meaning, inner peace, and lower stress levels are based loosely on Buddhist mindfulness meditation and the "Yo Observante," or "Self-Observer." For the purposes of this talk, Ruiz uses the "Yo Observante" to mean the part of the self that can 'take a step back,' 'be present,' and observe situations before reacting (as opposed to the more traditional Buddhist sense of the concept, which refers to observing your own mind and distancing yourself from your ego). If we are able to accomplish this, we will be better able to react to life situations without stress. "Observe, describe, and discover," Ruiz directs us. "Break the inner haste, which is part of modern life. Haste is the enemy of peace, knowledge, and sensuality." We are directed to 'take time for ourselves' by going to therapy, exercising, getting massages, practicing yoga, getting beauty treatments, picking up hobbies, laughing, spending time with friends, and developing a spiritual practice.

To conclude the talk, which lasted over two hours, Dr. Ruiz finally stops walking around the room excitedly and, for the first time, makes use of his white leather armchair. Settling in, he leads us through an exercise: a "meditation on the infinite simplicity of being." We are told to close our eyes, breathe deeply, and not want anything.

Managed Selves

Before moving on to an illustration of psychiatric globalization, I would like to highlight several aspects of Dr. Ruiz's presentation on "Stress and the Management of Emotions." He summarizes its philosophy on the "Semiología de la Vida Cotidiana®" website, accompanied by a photo of a young, white, blond woman hunched over and looking devastated on one side of the bench and a man in the same position facing away from her on the other. The website reads:

> A very common but little understood term: <stress>. Almost nobody understands its origins, its symptoms, or much less its disastrous consequences: heart disease, obesity, osteoporosis, anxiety, insomnia, ulcers, infertility, smoking, depression, or anorexia nervosa, among others. A multi-systemic damage that can destroy our lives in no time. Stress is, today, a silent epidemic that is affecting millions of people, couples, families, and businesses in an unrelenting manner.
>
> The main objective of this conference is to explore the source, origin, and consequences of stress, to address with greater clarity and awareness the most efficient forms of preventing it, countering it, and transcending it in our everyday lives.
>
> Clearly, the vast majority of people are immersed in this problem in different ways and to varying degrees, but they don't even realize its scope. It is an issue which deteriorates our quality of life not only emotionally and sexually, but also economically and socially.
>
> The answer, surely, is in the hands of each individual. It's a question of understanding the roots of the problem and immediately, with clarity and perseverance, finding the solution.

> In effect, it is essential to realize that internal peace is not only possible—even in the whirlwind of life—but indispensable. We can have success, power, and money, but if we have lost inner peace, we cannot enjoy that success, power, or money. What's true is that inner peace is the fundamental emotion from which to build our life project.
>
> We hope to see you here. It will be a useful and rewarding experience that will allow you to raise your quality of life and better your health, your family and work environment, and your social life. These conferences are open to the public in general—adolescents and adults—and can assist anyone who wants to become familiar with the Semiology of Everyday Life.®
>
> See you soon,
> Alfonso

As articulated on the website and in the event I attended, "Stress and the Management of Emotions" is based upon an understanding of life itself as a mental health problem: it is pathogenic and capable of generating harmful levels of stress which have repercussions for all aspects of being, whether we know we are affected or not. The following day, one of Oaxaca's main newspapers, *El Imparcial,* featured a photo of Dr. Ruiz on the front page with the headline "Stress: A Public Health Problem" [*El Estrés, Problema de Salud Pública*]. The article emphasizes that stress, a "silent epidemic," causes "millions of deaths" each year and can be exacerbate by not knowing how to "process emotions." The conference and its attendant publicity are designed to warn the population that is in peril, full of people 'stressed' by the 'whirlwind' of everyday 'modern' life: pulled in many different directions with work, family, and social obligations; stuck in traffic; under pressure—performing surgery, even—all in a tireless search for 'success.' Ruiz reminds us that seeking success is not always fun, nor is it healthy, for not only does it create stress—which itself causes 'multi-systemic' harm to our systems and which may 'destroy our lives in no time'—but also causes us to ignore

ourselves, our personal desires, and our ability to look within. There within ourselves, if we would only take a moment to slow down and breathe or get a massage, is everything we have ever wanted: wisdom, meaning, "harmony, well-being, and inner peace," the latter of which is the fundamental building block for our "life project."

The workshop thus exemplifies various aspects of the modern regime of the self described earlier in the chapter. Dr. Ruiz emphasizes human vulnerability to distress, imbalance, and psychological damage; his program is certainly preoccupied with "the language of emotional deficit" (Summerfield 2004: 234, c.f. Pupavac 2001) and "invites people to see a widening range of experiences in life as inherently risk and liable to make them ill" (Summerfield 2004: 234). At the same time, Ruiz focuses on "emotion as the touchstone of personal authenticity, a reflection of the 'real' person" (ibid) which must be expressed and managed for full exercise of freedom. The workshop presupposes (1) its attendees experience an everyday, quotidian life filled with stressful demands which compromise their individual integrity and natural state of tranquility; and (2) the desire, ability, and obligation to improve upon this situation as individual projects of self-care and self-transformation. The goal of "managing emotions" and alleviating the pathogenic effects of stress is 'inner peace' and freedom. After all, "Everyone is responsible—in full exercise of their free will—to configure the meaning of existence which will confer the greatest personal fulfillment and the greatest sense of human realization" (semiologia.net). The type of stress that Ruiz invokes is decidedly not the stress of poverty and deprivation, but the stress of the modern, upwardly mobile, and cosmopolitan—the stress of those who can afford to find ways to manage it, like paying 300 pesos to hear Dr. Ruiz offer solutions. However, his approach emphasizes that while

we might—and indeed should—find the tools to manage stress (through yoga, massage, laughter with others, spirituality, and so forth), the solution is 'in the hands of each individual.'

In sum, Dr. Ruiz draws upon an eclectic blend of globalizing pop psychological concepts—most of which can be found in any women's magazine—centering on the notion of stressed individuals seeking meaning and inner peace in the midst of inherently stressed worlds. We are implored to keep sight of what's really important: our individual integrity and enlightenment, which have been compromised by our relentlessly rushed lives. The solution to the problem of stress and the crisis of meaning in modern life is to be found 'within.' Dr. Ruiz's vision of the self is thus one that is inherently vulnerable and open to assaults from the outside world, and that, to be balanced and healthy, must be 'managed.' At the same time, his vision of the self is based around notions of autonomy and the inherent ability of each individual to transform him or herself in an agentive manner. As Ruiz's semiologia.net homesite puts it, "As long as an individual fails to transform himself, he won't manage to transform anything. To resolve our lives, change the world, and elevate the quality of our existence and that of others, we should know ourselves, become aware of our human potential, and implement it. In a word: wake up. – Alfonso Ruiz Soto®."

PSYCHIATRIC GLOBALIZATION: THE MEXICAN PSYCHIATRIC ASSOCIATION SOUTHERN REGIONAL CONFERENCE

Nearly a year later I find myself back at the Hotel Fortín Plaza again for a very different type of mental health event: the Southern Regional meeting of the Mexican

Psychiatric Association, a three-day conference bringing psychiatrists to Oaxaca from throughout Mexico. The theme of the conference is "Psychiatry of Bicentennial Mexico: Achievements and Expectations." Although I am prepared for some fanfare after having attended the 'Stress and the Management of Emotions' event as well as other mental health conferences and talks, the psychiatric conference takes advertising, sponsorship, and the promotion of mental health services to an entirely new level. Unlike 'Stress and the Management of Emotions,' the psychiatric meetings are not geared toward a general audience; like any disciplinary meeting, this one exists for members of the association holding the conference: Mexican mental health practitioners. Competing for the attention of these practitioners are dozens of laboratories and psychopharmaceutical representatives who have filled huge swaths of the hotel with psychopharmaceutical paraphernalia.

I go to the conference with a psychiatrist friend of mine, and he seems to be entirely unfazed by the barrage of pharmaceutical advertising to which we are subjected at every corner. Entering the building we are welcomed by a large canvas with the name of the association, the theme of the meetings, and the logo of one of the meeting's sponsors, 'psicofarma®' and its catch phrase, '*al servicio de la salud mental'* ['at the service of mental health'] (Figure 4.2). The conference schedule is printed on a larger-than-life Valdoxa (antidepressant) poster (Figure 4.3), next to a Paxil CR poster with photos of people apparently in the throes of depression juxtaposed with a (circled) photo of a smiling woman (Figure 4.4). This is just the entryway.



Figure 4.2: Mexican Psychiatric Association Meetings Entryway ["Welcome to the Southern Regional Conference: Psychiatry of Bicentennial Mexico, Achievements and Expectations."]

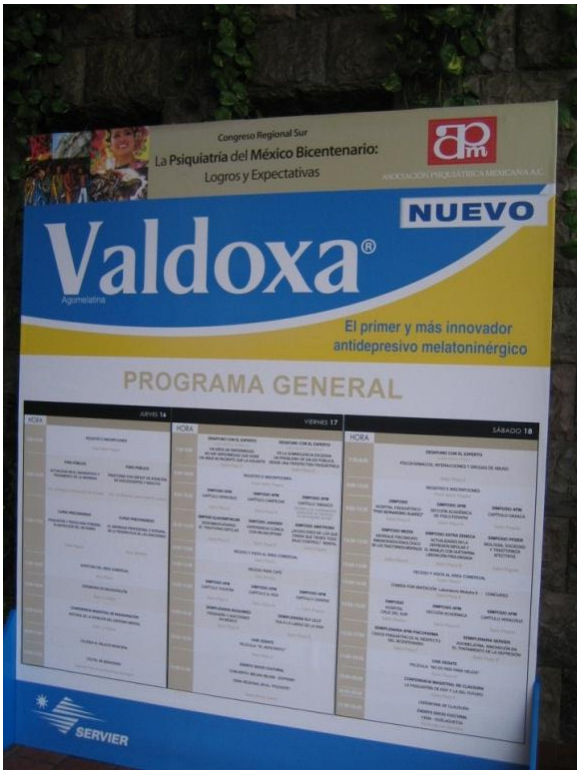


Figure 4.3: Valdoxa and General Conference Program Poster in Conference Entryway ["Valdoxa® The first and most innovative melatonergic antidepressant."]



Figure 4.4: Paxil CR Ad Poster in Conference Entryway
["Paxil CR Paroxetina, Controlled Geomatrix Release. The confidence of a friendly face."]

After attending several panel presentations—most of which discussed epidemiological findings in Mexico, psychopharmaceutical treatment efficacy, and the need for increased access to services and psychological education—I make my way upstairs to the large commercial area. Dozens of laboratories have set up colorful, high-tech stands from which representatives distribute free medication samples, t-shirts, water bottles, backpacks, and promotional pharmaceutical literature. Hundreds of people—all of whom wear nametags around their necks on laces printed with the names of pharmaceuticals—slowly make their way from one stand to the next, filling their bags. Initially hesitant, I quickly submit to the flow and the generous handouts—bottles of pills, highlighters, books, and a collapsible Frisbee. Particularly exciting is the stand

which takes my photo and prints it on a Pristiq antidepressant mug. Next to my photo it says, "In matters of mental health, I trust my psychiatrist." At another stand I have a choice of several free frozen coffee beverages to sip on while leafing through flyers on the benefits of Zoloft, sleeping medications, and drugs to help with smoking cessation. Everywhere are illuminated signs saying things like "Life as it's meant to be lived" next to photos of smiling people playing in parks, hiking in mountains, and lounging on sailboats. I now have an impressive selection of products from Lexapro, Valdoxa, Paxil, Zoloft, Seroquel, and others.

The commercial area is so absorbing I almost fail to notice that people have begun streaming out for an invited luncheon-slash-quiz show competition. The winners will win all-expenses-paid trips to attend the Mexican National Psychiatric Association conference, and from there will be eligible to win a trip to Prague for the World Psychiatric Association's International Conference in 2012. The room is decorated in an American 'Wild West' aesthetic consistent with the competition's name, "The Most Wanted" (Los Más Buscados), and the lights have been dimmed so we can see the movie being played on a large screen: Anger Management, a 2003 film in which Jack Nicholson plays Adam Sandler's psychopathic psychiatrist. The film is dubbed, but not with direct translations; rather, Sandler and Nicholson are speaking in Spanish about "complete remission of symptoms with Rivotril," the trade name of Clonozepam/Klonopin outside of the United States. Adam Sandler complains to his girlfriend about the medication side effects, but she tells him he has to stay on it for his own good.

Soon waiters begin handing out our boxed lunches and an actor in full a Western get-up—cowboy hat with a sheriff's badge on it, a red bandana around his neck, a red

collared cowboy shirt, and black jeans—starts his on-stage performance. His job is to engage the audience and get us excited about the competition; to that end, he makes jokes, dances, incites the audience to dance, and walks around poking fun at people, accompanied all the while by bright stage lights, sound effects, sensational music, the flashes of many professional cameramen roaming the room, and other helpers also dressed in cowboy garb. Via remote control, psychiatrists key in their answers to quiz questions like "How long do patients have to present with anxious symptoms before they qualify for Generalized Anxiety Disorder?" The cowboy runs up and down the aisles calling on people and the correct answers are displayed on the large screen, complete with more music and fanfare.

'With Unlimited Potential for Growth'

The company sponsoring the cowboy quiz show event, moksha8, is an American pharmaceutical marketing firm attempting to expand "aggressively" within Latin America, as their website puts it. To commercialize and promote products such as Rivotril, moksha8 targets Latin American healthcare practitioners, like those gathered in the quiz show room. The company's website promotes its image as distinctively global: replete with photos of Latin American iconography—Iztaccíhuatl volcano and *Lucha Libre* masks from Mexico, Rio's Museum of Contemporary Art and famous Christo statue—and lofty philosophical references from a number of traditions.

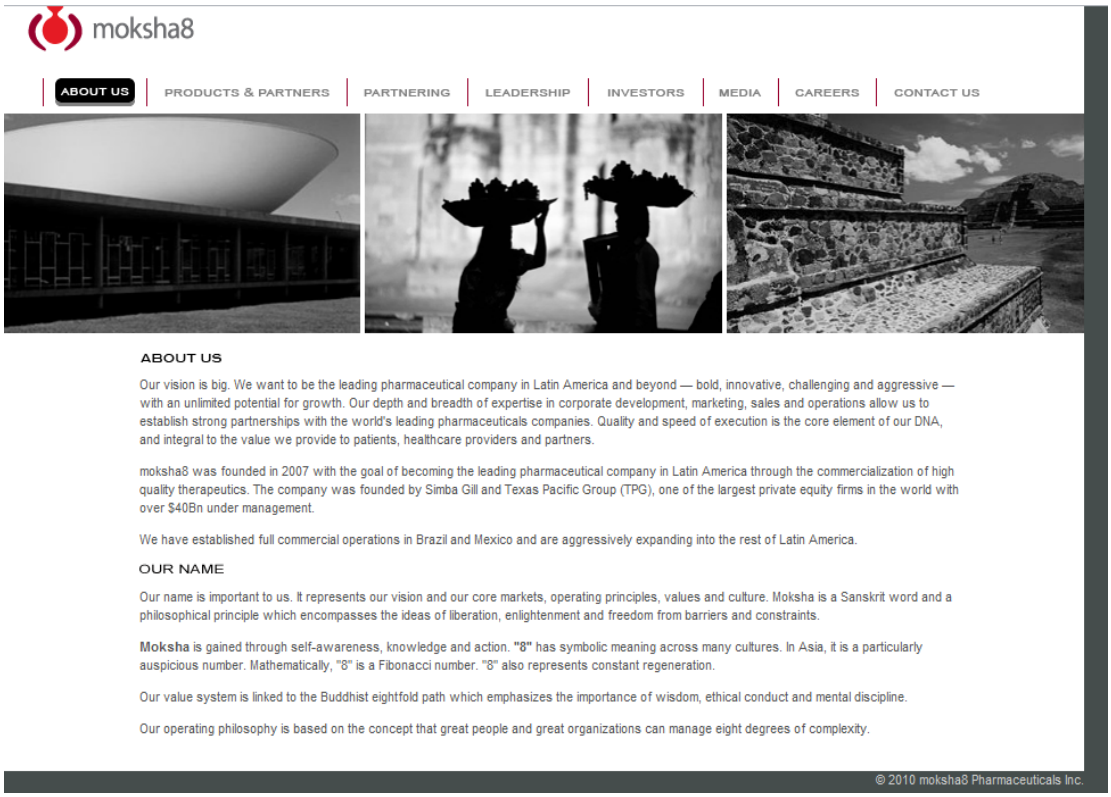


Figure 4.5: moksha8's website

At one point (the website undergoes changes regularly, it seems) moksha8's 'About Us' page began with an epigraph from Ralph Waldo Emerson: "Do not follow where the path may lead. Go instead where there is no path and leave a trail." The company's name, which represents their "vision and…core markets, operating principles, values and culture," is "a Sanskrit word and a philosophical principle which encompasses the ideas of liberation, enlightenment and freedom from barriers and constraints" (moksha8.com). The website explains that "Moksha is gained through doing right actions irrespective of fear or greed and driven by a desire to the right thing," and that "'8' has symbolic meaning across many cultures. In Asia, it is a particularly auspicious number. Mathematically, '8' is a Fibonacci number. '8' also represents infinite and constant regeneration...Our value system is linked to the Buddhist eightfold path which

emphasizes the importance of wisdom, ethical conduct and mental discipline." The company is "doing well by doing good"; they "want to be the leading pharmaceutical company in Latin America and beyond—bold, innovative, challenging and aggressive—with an unlimited potential for growth" in Brazil, Mexico, and "other high growth Emerged Markets" (moksha8.com).

Like Dr. Ruiz Soto's performance and program, moksha8 emphasizes liberation—not through managing stress, however, but through the marketing and consumption of pharmaceuticals. The basic assumption is that access to such pharmaceuticals is needed, so if there is no 'path' or precedent for such drugs in a given locale, the company will create it. In so doing, it intends to "stimulate the pharmaceutical imaginary of the physician-consumer" (Jenkins 2010: 21).

The cowboy performance, regaetón music, and colored theater lights felt a long way from the eightfold path, but the company knows its audience: the psychiatrists in attendance seemed to love it. The event encapsulated what Mary Jo DelVecchio Good has termed the 'biotechnical embrace' produced by the "flow of knowledge, scientific and medical cultural power, market wealth, products and ideas," which take place "not only between local cultures and institutions that create medical knowledge and organize practice, ethics, and the medical market but also between the culture and market of international and cosmopolitan biomedicine and its local variants" (2007: 363). The moksha8 organizers simultaneously market specific products and create a colorful, high-tech, theatrical environment which sparks enthusiasm for such products—as well as for a more encompassing global culture of biomedicine and biomedical markets.

GLOBALIZING DISCOURSES & IDEOLOGIES

In these two events, globalizing discourses and ideologies are spreading through commercialized, for-profit means; the 'experts of the soul' (Rose 1996) here are either trademarked themselves (like Dr. Ruiz) or are, like the psychiatrists, targets of psychopharmaceutical companies seeking to gain clients in their 'bold, innovative, challenging and aggressive' quest to contribute to and benefit from the fruits of emerging economies. In the "Stress and the Management of Emotions" event, Dr. Ruiz actively promotes and encourages us to cultivate a trademarked 'regime of the self' consistent with that which Rose outlines: autonomous and bound, inward-looking, and animated by the desire for freedom and the "realization of the potentials of the psychological self in and through activities in the mundane world of everyday life" (Rose 1996: 17). As a bearer of such a regime and its associated techniques, Dr. Ruiz effectively becomes a kind of cult leader whose followers pay good money to explore, cultivate, and manage themselves under his supervision. At the Southern Mexican Psychiatric Association meeting, we see not only the circulation and reproduction of biomedical psychiatric ways of knowing (e.g. sharpening diagnostic strategies and psychopharmaceutical prescription practices) and ways of 'treating' the self (as vulnerable to pharmaceutically treated disorder), but also the explicit connection between those ways of knowing and market-based strategies on the part of multinational firms.

In both cases, we see the ways in which experts actively connect with global markets, practices, and discourses. Dr. Ruiz, who travels globally offering the same seminar (though we can imagine he might revise his jokes to be 'culturally appropriate' depending on the context), draws upon a number of global influences: after the Michael

Jackson video, we learn that Dr. Ruiz has been educated in England and places himself in the intellectual tradition of Ferdinand de Saussure; he appropriates European linguistic philosophy in his trademarked approach to studying and solving the problems of 'everyday' life.' His large flashy watches, tailored suits, and impeccable image suggest a well-traveled, educated, affluent expert who is introducing the New World to Old World approaches to self-care and self-management. Even the company marketing and managing the event has a French name, Calderón & Bergés, 'Conseillers.' Dr. Ruiz then moves eastward in his use of vaguely Buddhist philosophies and practices: 'Yo Observante,' meditation, and the like.

For their part, the Southern Mexican Psychiatric Association meetings are reminiscent of Good et al.'s description of the Indonesian Psychiatric Association congress, which "facilitate an experience of the scientific, a sense of belonging to the cosmopolitan world of medical psychiatry, even for a moment, and an opportunity to imagine a future. Such events are elementary sites of the production of modern biopractices of psychiatry" (Good et al. 2007: 258). These 'modern biopractices' involve, of course, 'deterritorialized' diagnoses of disorders which are thought to be universally applicable to universally biological disorders. The job of these physicians is to detect such disorders, make them known and visible, and treat them with the 'global pharmaceuticals' (Petryna et al. 2006) actively marketed to them. The marketing in the case of the cowboy quiz show explicitly draws upon American media and iconography, from the *Anger Management* film to the red-kerchiefed, denim-wearing cowboy quizzing the psychiatrists on their knowledge of diagnoses and medications. The company responsible for such fanfare, moksha8, is funded by "Top Tier Investors with Global

Networks," "some of the highest quality private equity and venture capital investors in the world" (moksha8.com).

Psychological Imaginaries

These two events represent rather extreme examples of psychological and psychiatric globalization—the transnational flow of ideologies and practices around self and emotional and psychological well-being is not always as marked by involvement in global markets and the pursuit of profit. However, the events are rather representative of the two sets of ideologies and practices which are so notably 'flowing.'

Psychological globalization, which I will discuss first, revolves around the circulation of a 'regime of the self'—again, as Rose puts it, "the technologies and techniques that hold personhood—identity, selfhood, autonomy, and individuality—in place" (Rose 1996: 2). Specifically, the 'regime of the self' circulating in Oaxaca centers on (a) self-knowledge, including self-examination and self-understanding; (b) self-expression, including communication, disclosure, and 'emotional assertiveness'; (c) self-responsibility, including self-management, self-control, and problem-solving; (d) self-empowerment through various forms of self-care and self-esteem building.[8] A central goal of these practices is to make the self knowable, available for examination,

[8] These clusters of self-care are not dissimilar from those promoted at the Russian Orthodox church-run drug rehabilitation program anthropologist Jarrett Zigon (2011) studied in St. Petersburg: self-cognition/self-evaluation, self-reflection/self-observation, and self-reporting/self-accounting, which are supposed to lead to self-transformation and self-control (Zigon 2011: 105-108, c.f. Kharkhordin 1999). This is not surprising given that much of the Church's program draws on therapeutic traditions from Western Europe and North America such as Alcoholics Anonymous and Narcotics Anonymous, but Zigon shows how these ideologies and techniques of the self are also aligned with those Oleg Kharkhordin identified as prevalent during the late Soviet period in Russia. The similarities between and blending of the two traditions (along with Orthodox traditions and philosophy), Zigon argues, facilitates their acceptance among treatment recipients.

discussion, and improvement; to be fully functional, 'free,' and to live a good life, the self must be cultivated and worked upon at any opportunity. The implication is that 'selves' are vulnerable and prone to pathology—particularly in the context of stressful situations of modernity—but are also capable of agentive transformation. 'Selves' are not naturally cultivated or available for inspection and expression; rather, these orientations and practices must be learned. To that end, a number of services, programs, initiatives, and sites of self-help have emerged.

Emotional Intelligence

Some of them, like the "Stress and the Management of Emotions" conference, are for-profit, trademarked courses targeted toward the middle- and upper-middle classes in the city. "Emotional Intelligence Workshops" put on by the Center for Emotional Education – Live Free (Centro de Educación Emocional Vivir Libre) are another example; for about 2000 pesos (nearly $200 USD), one can take a four-day workshop on Emotional Intelligence which gives a money-back guarantee that participants will "release destructive and harmful concepts about ourselves, others, and life in general and increase our only and true coefficient of success: the emotional coefficient [el coeficiente emocional]. This in turn leads people to be less reactive, more proactive, and greatly augments their emotional assertiveness, self-esteem, and clarity about the reality around them" (email invitation to workshop, 12/23/10). The workshop is offered several times a year in Oaxaca at a number of levels (introductory, advanced, etc.), and is based around the goal of "elevating quality of life" through four "coefficients"—bodily, mental, spiritual, and emotional life—which themselves are based on four "fundamental" values

of empowerment: “Acceptance, Union (Integrity, Consistency), Responsibility and Unconditional Love” (vivirlibre.org).

Like “Stress and the Management of Emotions,” the “Emotional Intelligence” workshops emphasize the four clusters of self-care I outlined above—self-knowledge, self-expression, self-responsibility, and self-empowerment. Based on the assumption of pre-existing problems or pathologies—we all have them, after all—one must first cultivate self-knowledge (‘autoconocimiento personal,’ or ‘personal self-knowledge,’ as the “Emotional Intelligence facilitators call it) by ‘looking within,’ or by directly answering checklists to self-diagnose and establish what the most important obstacles to freedom and functioning are. The “Emotional Intelligence” website furnishes a long list of questions for people who might be “codependent,” including the following:

- Do you think you are responsible for other people, for their feelings, thoughts, actions, decisions, desires, needs, well-being or lack of well-being, including things that occur to you in the future?
- Do you feel instinctively driven to help other people resolve their problems, even when they haven’t asked for your help?
- Do feelings of guilt determine your priorities (for example, do you do what you want to do and think it’s good for you, or do you do what you think you should do to minimize guilt and create self-esteem)?
- Do you think someone else is responsible for taking care of you and making you happy?



Figure 4.6: Emotional Codependence (vivirlibre.org)

There are over 30 more questions to be answered in this vein; each one is scored with one point for ‘yes’ and zero points for ‘no’; at the end, if you have a score of over five points, “you suffer from codependency and you need to learn to love again,” presumably by taking their workshops. In the workshops, participants learn more techniques for self-exploration and for building up a sense of self-worth and self-respect—necessary for proper self-esteem—along with skills to facilitate self-expression and emotional assertiveness. Communication and talking about emotions through various modalities of psychotherapy and group therapy are viewed as central to self-care.

Along with self-exploration and communication, self-sufficiency is paramount to healthy function, as the ‘codependency’ questions suggest. Only after having taken responsibility for one’s own self, emotions, functioning, and happiness are humans viewed as stable, free, and empowered enough to help others and to thrive in relationships. The type of self or subject being promoted and cultivated is one who thinks about and takes care of him or herself before considering the needs and feelings of others. Put together, self-help workshops like “Emotional Intelligence and “Stress and the Management of Emotions” simultaneously propose subjects and selves prone to emotional problems and subjects imbued with a nearly unlimited agency through which they may ‘create their own realities.’ Self-work here becomes a matter of proactively solving life’s problems—troublesome relationships, issues at work, misbehaving children—through individual initiative in a larger project of ‘elevating quality of life.’ Perceiving insurmountable limitations, challenges, or problems—particularly if others are expected to solve these problems—is a symptom of undeserved victimhood, of not

'taking control.' The implication is that the only constraints upon freedom are self-imposed.

These imperatives connect with what Rose calls an 'ethic of active citizenship' required in 'advanced liberal democracies,' an ethic in which the "maximization of lifestyle, potential, health, and quality of life has become almost obligatory, and where negative judgments are directed toward those who will not, for whatever reason, adopt an active, informed, positive, and prudent relation to the future" (Rose 2007: 25). As we will see in the following chapter, practitioners tend to blame 'culture' for the violation of this ethic.

'The World Within': Neuróticos Anónimos

One need not pay to cultivate emotional intelligence in Oaxaca: these globalizing 'regimes of the self' are promoted, explicitly and implicitly, through a number of programs, initiatives, and campaigns offered by the state and non-profit organizations. Neurotics Anonymous (NA), for example, has 37 centers in Oaxaca and is predicated upon the idea that, as one of their members and spokespeople put it, "99 percent of the inhabitants of the planet" have neurosis, or some "emotional imbalance." According to this vision, the natural state of humanity seems to be pathological; all selves are in great need of intervention. Completely member-run, free, and predicated on the Alcoholics Anonymous philosophy, NA actively recruits members to their program by holding extremely visible public events throughout the state. One particularly large event in Oaxaca City was advertised through hundreds of flyers plastered throughout the city; at the event, NA members transported attendees from surrounding towns in what they called

"Neurotaxis." The organization outlines the "origins, manifestations, and symptoms of neurosis" in a flyer which they circulate as widely as possible. According to the flyer, neurosis is:

1. An illness that causes us a solitary existence.
2. A spiritual illness.
3. Always the same in all people; only the superficial details vary.
4. Characterized by painful SYMPTOMS.
5. Progressive if not attended to.
6. Immediately curable.
7. Caused by innate egoism which impedes the ability to love.
8. Cured by the elimination of egotism and the acquisition of the ability to love, but these change requires a FORCE greater than the individual, HOWEVER EACH PERSON CONCEIVES OF IT. This is because the intellect alone can't provide the desired change.

Like the "Emotional Intelligence" and "Stress and the Management of Emotions" seminars, NA proposes that what we as humans lack is the ability to love; controlled by our egos, we are unaware of the freedom possible if we search within, admit to our pathology, learn to express it, and thus become empowered. To that end, NA provides symptom checklists not unlike those provided by the "Emotional Intelligence" workshops. NA's checklist consists of questions such as, Are you supersensitive? Do you like to commiserate? Do you always try to justify or defend yourself? Do you lose opportunities? Are you excessively organized? Are you disorganized? Are you superstitious? At the end of the questionnaire, the flyer says, "Now you have a more general panorama of the world around you and the world within."

Becoming a member of NA involves producing self-knowledge by exploring that 'world within'—which is inherently pathological and disordered—by openly talking about it at meetings. Thus, self-expression is also central to NA's 'regime of the self,'

albeit without the help of professionals (NA firmly rejects the presence of mental health professionals; the explicit absence of authorities is what is thought to create the openness and understanding central to meetings). Members learn a particular language of self-description and confession through testimony, and such confession is thought to be a form of 'taking responsibility' for neurosis so as to produce self-change, empowerment, and freedom (from ego, from the inability to love).

The principles of Neurotics Anonymous—like those put forth in "Stress and the Management of Emotions" and "Emotional Intelligence"—are thought to be universally applicable, as are the pathologies they are designed to treat; as the description of neurosis puts it, the illness is "always the same in all people; only the superficial details vary." Indeed, when I asked one of its spokespeople why he thought NA was so spectacularly popular in Oaxaca, he declined to engage the question beyond suggesting that Oaxacans were perhaps particularly open to admitting to their neuroses. Because neurosis is universal, the question of its local manifestation was irrelevant. "Stress and the Management of Emotions," "Emotional Intelligence," and psychotherapeutic practice in general posit a notion of universally vulnerable selves which must be prodded into visibility, worked upon, given voice, and liberated. No matter where we are, we should willingly submit ourselves to the techniques that will help us become the types of people these practices seek to create.

Sites of Diffusion for the Psychological Imaginary

Neurotics Anonymous and seminars such as "Stress and the Management of Emotions" and "Emotional Intelligence" are but a few 'sites of diffusion' for the regime

of the self its attendant practices. In Oaxaca City, it seems there is a different seminar or set of seminars every week for the middle and upper-middle classes, from '*Hijos Tiranos, o Débiles Dependientes'* [Tyrannical Children, or Weak Dependents], put on by "Autora del BEST SELLER 'TU HIJO, TU ESPEJO' [Your Child, Your Mirror], to '*Como Dominar el Enojo'* [How to Control Anger] to '*Límites en Casa'* [Limits in the Home], to spiritual seminars like '*Adventuras del Alma'* [Adventures of the Soul]. Some, like *Adventuras del Alma,* are offered by foreign gurus; it was offered at 890 pesos and promised to help you become "more conscious of how to create your life, how to create your body, and listen to the concrete messages that life gives you through your physical symptoms. You will wake up your intuition by becoming closer to your *Ser Interior* [Inner Self]. Like "Emotional Intelligence," which was offered through a local women's non-profit, these types of seminars were often put on in conjunction with local organizations, clinics, and psychologists.

Radio programs like "Management of Emotions," TV shows like "Women's Decisions" [Decisiones de Mujeres], and telenovelas also spread the psychological imaginary, providing explicit moral lessons on the importance of self-care, introspection, responsibility, and agency. Churches, non-profit organizations and programs like Oportunidades, Mexico's poverty alleviation cash transfer program, have pláticas and talleres (chats and workshops) hosted by psychologists; frequently, these are free and open to the public. Covering subjects such as self-esteem, depression, management of stress, violence prevention, anger management, and 'life projects' [*proyectos de vida*], such events not only offer specific instructions regarding technologies of the self—introspection, expression, deep breathing, writing and drawing exercises—but also begin

to provide participants with a vocabulary of the self, which they in turn share with others and negotiate in everyday practice. Participants in several of the events I attended expressed that they had not been previously exposed to such ideas or practices. Additionally, as I will discuss in the following chapter, Oaxacan mental health practitioners are actively attempting to promote this psychological imaginary—the regime of the self and its attendant technologies—an effort which is central to their broader project of 'creating consciousness.'

Psychiatric Imaginaries

Psychiatric globalization, like psychological globalization, is predicated upon assumptions of universality; since mental illnesses (as defined by the *DSM* and the *ICD*) are understood to be primarily biological, the various 'imbalances,' genetic predispositions, and forms of disorder they engender are thought to be present everywhere to some degree or another, though their manifestations may vary. The psychiatric subject implicit in globalizing psychiatric discourses, ideologies, and practices, is "essentially a biological subject and…illness experience is ultimately understandable only by knowledge of the neurobiological substrate" (Good et al. 2007: 257). This in turn contributes to 'biosociality,' or communities based on shared identities around biologically defined conditions and diseases (Rabinow 1996; Rabinow & Rose 2006). Biosociality is actively promoted by an "expanding regime of biotechnical truths and pharmaceutical markets" (Good et al. 2007: 259).

A main difference between psychological and psychiatric globalization, however, at least in the case of Oaxaca, is that while the 'regime of the self' is spreading through

psychological globalization and is applicable to anyone, whether or not they have their own therapist, psychiatric and psychopharmaceutical selves (Jenkins 2010) are, by and large, confined to the clinic. Unlike in the United States, where direct-to-consumer pharmaceutical marketing, combined with more general preoccupation with mental health and disorder in the media, in non-psychiatric doctors' offices, and in daily talk, interactions, and regimens of self-care, psychiatric pathologies and the types of psychiatric and pharmaceutical imaginaries they can produce are not nearly so ubiquitous in Oaxaca—at least not yet.

In other words, while I frequently encountered casual talk both in and outside of Oaxaca City around the importance of expressing emotions, building self-esteem, the pernicious effects of '*estrés*,' the need for personal 'limits,' and other similar components of psychological globalization—and while there are a number of 'sites of diffusion' for such concepts, as discussed above—I rarely heard casual discussion of psychiatric disorders or psychopharmaceuticals outside the psychiatric hospital. Depression and anxiety were exceptions to some degree; although some elderly study participants had never heard the words '*depresión*' or '*ansiedad*,' most participants in the study were aware of both and treated them as states of being to be avoided, if not disorders requiring psychiatric medications. Even among young college students the use of psychopharmaceuticals was by and large something thought to be reserved for severe mental illness. Jaime, a young male college student who knew of various psychiatric disorders through having taken psychology classes, told me the only people he had ever heard of going to mental health practitioners—including both psychologists and psychiatrists—or taking anti-depressants were American friends of his who became

depressed due to homesickness (one of them, Jaime said, missed New York, pizza, Jack in the Box, and 'orange cheese'). Neither had my Oaxacan research assistants, also college students, ever known anyone to take anti-depressants. Additionally, and as we will see in Chapter 7, most patients at the psychiatric hospital hear about diagnoses such as depressive disorder, anxiety disorder, schizophrenia, and personality disorders—as well as the medications to treat them—for the first time upon receiving psychiatric consultations.

While psychiatric discourse, ideology, practice, and self-care are not nearly as ubiquitous as those I have designated under psychological globalization, psychologists and psychiatrists are doing everything they can to spread the word, as I will discuss in the following chapter. Psychologists regularly post flyers around the city and in newspapers advertising their services, often with lists of the disorders they are qualified to treat. One psychiatrist practicing in the Isthmus has his own radio show, '*Acerca de la salud y de la enfermedad mental,'* or 'On Health and Mental Illness,' a 30-minute bi-weekly program broadcast in Juchitán. On it, he dispels misconceptions about psychiatry—particularly the idea that psychiatry is the same thing as psychology and the idea that psychiatry is only for 'crazy people':

> I clarify that there are many people who say 'I'm okay but I want to be better, I'm going to see the psychiatrist to reinforce my mood.' I tell them, 'dear and esteemed patients and radio listeners, if someone is well but wants to be better, let alone if they have mild, moderate, or severe problems, well, even more reason, they have to go and see a psychiatrist.' That's the situation, and people are opening their eyes.

The goal here is to normalize psychiatry and actively encourage the image of psychiatry as a legitimate form of self-care, and to reassure patients and would-be patients that there is nothing wrong with seeking such care or with 'reinforcing' mood through the use of pharmaceuticals.

Another psychiatrist from the public psychiatric hospital—the one with whom I attended the conference mentioned earlier in the chapter—makes television appearances to spread awareness and has recently helped launch a 'political movement,' as he put it, to try and get the attention of the government. He and others express grave concern over the lack of funding and attention the state gives mental health, particularly psychiatry. "We didn't get anything but a tank of water," he told me in an email referencing his most recent efforts. "Politicians ARE NOT INTERESTED IN MENTAL HEALTH, much less our mentally ill patients. It's a shame, but we'll keep fighting for our part and caring for people as they should be cared for."

Like Indonesian psychiatric practice as Good, Subandi, and DelVecchio Good describe it, psychiatric practice in Oaxaca is a site "of incomplete but active penetration…for the marketing of drugs, teaching of diagnostic and therapeutic practices, and development of mental health institutions (2007: 258). Psychiatrists practicing in Oaxaca are trained in medical schools according to current biological psychiatric principles, standards, and practices, and are constantly in touch with the global world of psychiatry and pharmaceutical markets at conferences like the Southern Mexican Psychiatric Association meetings. On a local level, the perceived resistance psychiatric knowledge and practice—to the psychiatric imaginary—forms the basis of their project to spread the word near and far. As we will see in the following chapter, these perceptions

regarding Oaxacans' relative ignorance of mental health concerns are central to the professional ethos of psychiatrists and psychologists, and contribute to their broader project of spreading *psicoeducación* and changing culture.

CONCLUSION

In this chapter I have discussed and illustrated the two interrelated forms of globalization occurring in Oaxaca with regard to mental health, self, and sentiment—psychological and psychiatric globalization—and have begun to sketch out their content as well as how they are mobilized on a local level. With regard to psychological globalization, I argue that universalizing notions around the 'regime of the self' and its concomitant 'technologies of the self' are spreading rather widely in the region to produce a 'psychological imaginary.' This imaginary encourages particular ways of understanding, exploring, and expressing oneself and one's emotions, and is predicated upon an understanding of self as both inherently vulnerable and subject to psychological damage and as inherently capable of transformation and agency. Various assemblages—organizations, practitioners, public health programs, courses, TV shows—serve to widely disseminate these ideas not only as a potential *option* for self-care, but as an imperative for the appropriate exercise of selfhood and subjectivity.

I argue that although the 'psy imaginary' produced by psychiatric globalization is gaining salience in Oaxaca, it is less commonplace than that produced through psychological globalization. While psychiatrists are certainly seduced by the promise of advanced psychopharmaceuticals and the corporations which market them, non-patients are only infrequently exposed to notions of pathology encoded in the *DSM* and the

technologies available to treat them. In Chapter 7 I explore the ways in which patients embrace and are embraced by biotechnology in the form of psychopharmaceuticals (DelVecchio Good 2007: 367), but on a wider level psychiatry has not yet produced widespread 'biotechnical identities' (Ecks 2003) or 'biosociality' (Rabinow 1996; Rabinow & Rose 2006). I surmise that these identities and forms of sociality are not long in coming, however, particularly based on the enthusiasm for psychopharmaceuticals I witnessed among patients and family members at the psychiatric hospital (again, see Chapter 7).

Both processes of globalization are tied to international markets and the commercialization of well-being, self-care, and psychopathology (Jenkins 2010). Healthy people without symptoms of psychopathology become consumers of technologies of the self which are actively promoted to them; psychiatrists become the enthusiastic targets of marketing by multi-national firms; and those without connection to the transnational mental health market may be exposed to the imaginaries they produce through non-profit organizations, development projects, and the media. Most of these efforts are explicitly based on the "promotion of working on oneself in a continuous fashion so as to produce an efficient and adaptable subject" (Rabinow 2008: 187). To fully understand the interpenetrating fields of psychological and psychiatric globalization—and "to study the behavioral environment in the contemporary world" more generally—we must "address the work of psychological professionals in producing new psychological concepts and interventions cross-culturally (Breslau 2000: 177). In the following chapter, I will examine how professionals view the recipients of their interventions and analyses and

how, through a widespread project of ‘emotional modernization’ and culture change, they actively attempt to create subjects amenable to working on themselves.

CHAPTER 5

CREATING CONSCIOUSNESS, CHANGING CULTURE: OAXACA'S MENTAL HEALTH PRACTITIONERS

MAGICAL THINKING: CONFRONTING THE 'LOCAL'

My first day conducting research at the outpatient unit of Oaxaca's public psychiatric hospital, Cruz del Sur, one of the psychiatrists, Dr. Silva, told me a story about a schizophrenic patient of hers. The patient was a woman from the Mixteca region and was, from Dr. Silva's perspective, severely ill. She had both delusional thoughts and hallucinations, for which she was taking anti-psychotic medications. Unlike other schizophrenic patients Dr. Silva had treated, though, this woman seemed to be accepted by her family and community, and she was able to work and function surprisingly well. "It's because of magical thinking," Dr. Silva explained, elaborating that both the patient and her family attributed her illness to witchcraft and other supernatural factors that were not considered to be the patient's fault.

Despite the apparently protective nature of this explanation, however, Dr. Silva's commentary was framed by skepticism of both 'magical thinking' and the types of treatment she believed people who think 'magically' would likely seek. Soon another psychiatrist, Dr. Ramirez, joined us, pulling out a Lamictal notepad and reading off the names of various 'new-age' alternative treatments and workshops she had noticed around Oaxaca City. "'Family Constellations,' 'Creating Your Personal Reality,' 'Biomagnetism'?" she read, somewhat incredulously, laughing along with Dr. Silva.

Would I be looking into these treatments during my study? they asked me. Possibly so, I told them, and they asked if I could pass along any relevant anthropological literature.

They seemed simultaneously dismissive and fascinated by the treatments; mostly, I think, they wanted to understand why anyone would ever utilize them. “They’re not scientifically proven, of course,” Dr. Silva said, but emphasized that she wanted to remain open-minded, “like an anthropologist.” Dr. Ramirez said it was sometimes difficult to keep an open mind, though. “How can I explain it without sounding egotistical? We are experts in mental health,” she said, and emphasized that they had undergone years of training. They expressed frustration that so many Oaxacans, particularly those from rural, indigenous areas, seemed not to understand that and still preferred what the psychiatrists called ‘non-scientific’ treatments offered by traditional and alternative healers. “Then, they come to us,” Dr. Silva added, exasperated, “and by then their illnesses are much more complicated. But they always wind up with psychiatry in the end. Why don’t they just come here in the first place?”

This line of questioning and commentary continued throughout my months at the hospital, and was repeated by mental health practitioners outside of the hospital, as well. Although at first the spirit of such comments seemed condescending toward non-psychiatric and non-psychological forms of thinking and care, I came to realize that practitioners’ stance was more complicated. They themselves feel stigmatized in Oaxaca’s culture of health, in which only very recently have psychology and psychiatry emerged as legitimate forms of care. Practitioners mentioned over and over again that their services are still viewed by many Oaxacans as reserved for ‘crazy people,’ not as a valid form of treatment for a wide range of emotional and psychological maladies.

Mental health practitioners feel that they are marginalized on every level: institutionally, mental health is not prioritized and therefore Oaxaca's Health Services fails to provide mental healthcare with sufficient funding; professionally, other doctors resist referrals to psychologists and psychiatrists, their own prejudices clouding impartial medical judgment; and socially, they described Oaxacans shunning them through the belief that such services exist primarily for the treatment of insanity, or *locura*. 'Magical thinking' was invoked constantly to explain why psychiatry and mental health services more generally were not more respected and utilized.

As we will see, it was extremely important to mental health practitioners to correct what they saw as a grave set of misperceptions, but the fact that it was so hard seemed to confirm to them the backwardness of their own state. Since there is no psychiatric specialization in Oaxacan medical schools, all the hospital psychiatrists studied in other areas of Mexico— they sometimes compared Oaxaca to those more cosmopolitan states, not without a hint of longing. But these doctors are committed to serving the underprivileged of their home state; after all, they could be making more money working with less severe cases in private practice in Oaxaca City or larger urban centers. Rather, they want to accessibly provide what they see as much-needed services by working at the public hospital.

There, they tirelessly seek to educate Oaxacans about mental health issues, to spread awareness and 'create consciousness,' as they put it. In fact, and as I will discuss in more detail below, the perception that stigma against both mental health problems and mental health care is rampant acts as an incitement to action among most psychiatrists and psychologists in the state, who engage in explicit efforts to spread what is known as

psychological education, or *'psicoeducación.'* Part of *psicoeducación* consists of dispelling so-called 'magical thinking' and disparaging traditional medical practice, which from psychiatrists' perspective is at best a waste of time and at worst exacerbates mental illness. While patients are taking herbs and getting *limpias*, they could be taking much-needed psychiatric medications. Instead, practitioners say patients wait until illnesses have become much more severe and unmanageable until finally, as a last resort, seeking care at the hospital.

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It turns out Dr. Silva and Dr. Ramirez were actually in the midst of conducting their own research for a panel they had put together to be presented the following autumn at the Southern Mexican Psychiatric Association meeting I described in the prior chapter: the one with the "Most Wanted" cowboy quiz show. I attended the panel just after the quiz show ended, and the stark contrast between the two events was striking. In the quiz show, the prestigious world of globalized biomedical psychiatry was hyper-present. American film and music, an American-style cowboy enthusiastically quizzing psychiatrists about *DSM* diagnoses and pharmaceutical prescription practice (which practitioners have brushed up on in the commercial area, where they filled their bags with pharmaceutical goodies and wares); an award with the potential to lead to the World Psychiatric Association Meetings in Prague; and the very visible sponsorship of an American pharmaceutical marketing company all combined to create a distinctively global and post-modern milieu.

At the panel organized by psychiatrists from Oaxaca's public psychiatric hospital, the feel was quite different. It took place in an out-of-the-way room just off the hotel

restaurant—not easy to find, and the panel was not particularly well-attended. Along with Dr. Silva and Dr. Ramirez, two other Cruz del Sur psychiatrists presented—also on the topic of traditional and alternative medicine. In the first presentation, Dr. Silva spoke about "Alternative Complementary Medicine and Traditional Medicine in the Field of Mental Health." Dr. Silva divided her presentation into different types of complementary and alternative medicine (CAM, or MAC in Spanish): 'body and mind,' consisting of meditation, creative solutions, and cognitive therapy; 'biological,' consisting of herbs and vitamins; 'bodily manipulation practices,' such as massage; and 'energy' practices like chi gong, Reiki, healing touch, bioelectromagnetism, acupuncture, Ayurvedic medicine, homeopathy, naturopathy, chiropracty, and traditional Chinese medicine. Dr. Silva explained that the use of these treatments was very "cultural"; people seem drawn to them because they "engage the emotional, spiritual, and social," and claim to be "natural."

The next psychiatrist, Dr. Juárez Velasco, continued in a similar vein, reviewing the evidence for the scientific bases of these practices, of which he told us there is little. "They are not based upon authoritative knowledge," he said, drawing upon research conducted in the U.S. and published in American medical journals. Wound up in the discussion was Mexican and Oaxacan 'traditional medicine,' which the psychiatrists distinguished from CAM practices only insofar as the former were considered to be 'local' while the latter were understood as imported, and thus constituted 'emergent phenomena' requiring much more research. Additionally, the doctors explained that CAM is more likely to be utilized by upper classes while traditional medicine was more the domain of poorer indigenous communities. Finally, he brought up Oaxaca's only

public clinic for traditional medicine, located in the Zapotec town of Calpulalpam de Méndez. “Why do people go there?” he wanted to know, surmising that traditional medicine, like CAM, promotes a holistic vision of health, the idea of a ‘healthy lifestyle.’ Traditional medicine is perceived to be cheaper than biomedicine, and people like it because it allows them to avoid stronger medicines. Studies have been positive, he conceded, but they are not scientifically based—not double-blind—and only indicate salubrious effects for moderate and minor illnesses, not for mental health problems.

Dr. Ramirez then presented a rather philosophical essay on spirituality and on how traditional and alternative treatments, unlike psychiatry, purport to fulfill patients’ search for spiritual answers, meaning, and well-being. These promises are particularly hard to resist in moments of crisis or illness, she explained, but many spiritual ‘cures’ can have negative effects, like depersonalization, even psychosis—and traditional and alternative practitioners are not trained to deal with serious problems of mental illness. This was the crux of the psychiatrists’ concern: on the one hand, they were confident that their psychiatric services were the appropriate form of care for mental illness and emotional problems, but on the other, they knew people were resistant to it and in search of more ‘holistic’ forms of healing, either through new-age or traditional medicine. How could they better market themselves? In closing, Dr. Ramirez mentioned *limpias* for the treatment of *mal de ojo*, *mal aire*, witchcraft, soul-loss, and *susto. Limpias*—“you know, the kind your grandmother used to give you,” Dr. Ramirez said, getting a laugh from audience members. They have all had *limpias* themselves at one point or another.

THE CONFLICTED ROLE OF CULTURE

The Cruz del Sur psychiatrists' panel—particularly as juxtaposed to the "Most Wanted" Quiz Show at the same conference—begins to illustrate the main problem I will be addressing in the present chapter: the conflicted role of 'culture' in the professional ethos of mental healthcare in Oaxaca. At the "Most Wanted" quiz show, the idea of Mexican or Oaxacan 'culture' feels far away, and it is supposed to: the psychiatrists are engaged in a global endeavor to detect, diagnose, and treat mental disorder. The conference confirmed the legitimacy of the endeavor, whereas 'local' cultural forms, practices, and ideas only distract from it. At the Cruz del Sur panel, however, we see how the project of promoting mental health becomes much more complicated on the ground. Unlike in the idealized world of global psychiatry—which seeks to be 'acultural,' based upon notions of universally present psychiatric disorders thought to be treatable with universally effective psychopharmaceutical medications—the Cruz del Sur psychiatrists *must* confront the fact of 'culture': they are faced with it every day.

Because Cruz del Sur is the only option for affordable psychiatric care in the region, patients travel there from hours away to attend outpatient appointments.[1] Given that at least 16 distinct indigenous groups can be found within a several hundred-mile radius of the hospital, it is unsurprising that issues of 'culture' and the utilization of 'traditional' and 'alternative' medicine arise quite frequently for psychiatrists there. Despite the fact that most of them are Oaxacan themselves, psychiatrists are quite socially and culturally different from most of their patients. Especially in the public, institutional setting, patients are unlikely to have received more than a primary school

[1] I describe the hospital in more detail in Chapter 7.

education, and are quite likely to characterize themselves as indigenous and poor. Psychiatrists, on the other hand, are highly educated, and tend to be non-indigenous, monolingual in Spanish (or bilingual in Spanish and English), and members of the middle- to upper-middle class. Interactions between practitioners and patients, therefore, are characterized by significant educational, linguistic, economic, social, and—perhaps most importantly from psychiatrists' view—*cultural* divides.

I argue that these divides structure the professional ethos of mental healthcare in Oaxaca. In professionals' view, Oaxacans see mental health services as unnecessary and illegitimate, and thus mental health is stigmatized and under-addressed. According to practitioners, these problems—because they *are* perceived as serious problems—are the result of 'culture.' This perception was extremely salient in my interviews with not just psychiatrists at the public psychiatric hospital, but also with mental health practitioners in Oaxaca City and the Mixteca, in both public and private practices. Rare was the professional who did not describe 'culture' as the main challenge to the promotion of mental health in Oaxaca. (Sometimes the word 'culture' was alternated with 'customs'(*costumbres*), 'beliefs'(*creencias*), and 'traditions' (*tradiciones*), but more frequently 'culture' itself was used as an all-encompassing term.)

In this chapter I examine the interplay between three interrelated domains: (1) the transmission and diffusion of new psychological and psychiatric ideologies in Oaxaca; (2) discourses around culture, tradition, and mental health; and (3) the role of mental health practitioners as 'conduits of the global' who are actively attempting to mold 'the local' and produce subjects commensurable with not only mental health, but modernity more generally. In so doing, I argue that mental health practitioners' enterprise goes well

beyond the provision of treatment: they are explicitly attempting to foment culture change in the region. By dispelling so-called 'cultural' practices and by providing *psicoeducación* in local media, schools, health institutions, development initiatives, and clinical practice, practitioners are engaged in a widespread project of 'emotional modernization,' or the cultivation of subjects consistent with the globalizing notions of self, health, and sentiment I presented in the previous chapter. Practitioners promote, teach, and disseminate 'psy imaginaries' with the explicit goal of making them a part of Oaxacans' everyday commonsense reality. To accomplish this project, they engage with and seek to reconfigure 'the local' as they see it: resistant and in need of molding and instruction.

Mental health professionals are, I argue, central to the "dynamic relationship, tensions, and exchanges between local worlds in which medicine"—and mental health—"is taught, practiced, organized, and consumed and global worlds in which knowledge, technologies, markets, and clinical standards are produced" (DelVecchio Good 2007: 262). As mediators between the global and the local, as experts in mental health, and as leaders who have both a public presence and close access to people's personal lives, mental health practitioners are uniquely poised to impact broader understandings of health, self, and society. To understand the "formation of locality," we must understand too "the formation of the cosmopolitanism that transcends localities and mediates them" (Pigg 1996: 165). As in Pigg's analysis of discourses of 'belief' in Nepal, in Oaxaca the "relation between differentiated locality and mobile cosmopolitanism" is "at the heart of cultural tensions" activated on the ground through globalization (ibid). As the beginning

of the chapter began to show, mental health practitioners both transcend localities and mediate them, but this process of mediation is not without conflict.

In his discussion of biomedical psychiatry in Argentina, Andrew Lakoff writes that

> The psy-sciences are key sites in which selves are constituted as beings of a certain kind, where individuals come to understand the sources of their actions and adopt techniques for transforming themselves. The analysis of current transformations in expert knowledge about human behavior, then, is also a way of studying what kind of humans we are becoming…an analysis of the historically situated process in which experts come to recognize humans as beings of a certain kind (Lakoff 2005: 4).

In the current chapter I take as my object of study this 'current transformation in expert knowledge about human behavior,' the ways in which Oaxacan mental health practitioners are not only trying to 'recognize humans as beings of a certain kind,' but how they are actively trying to produce them.

Before delving into the details of this professional project, I would like to situate it within both global and national efforts to promote mental health. I begin the following section with an excerpt from Mexico's 2001-2006 Federal Mental Health Action Program [*Programa de Acción en Salud Mental*], followed by a discussion of how mental health practice is central to governance within Mexico's neoliberal democracy.

DEMOCRATIZING HEALTH SERVICES IN EMERGING ECONOMIES

> Since its founding in 1946, the World Health Organization (WHO) has considered mental health an integral part of the general definition of health. In the preamble to the WHO constitution, health is defined as: 'a state of complete physical, psychological, and social well-being, not just the absence of illness.'
>
> Advances in health sciences, particularly in the neurosciences, provide deeper understanding of the relationships between various components of health, as well as the identification of various preventative interventions. However, the

psychosocial component of health has not enjoyed equal presence in the policies of health institutions.

The General Assembly of the United Nations, along with some of its agencies (WHO, UNCESCO, UNICEF, and ILO) and the Organization of American States, have attempted to encourage member states to strengthen mental health programs and to reformulate the vision of treating the disabled mentally ill exclusively in hospital settings. [These organizations] advise strengthening primary care attention to mental health as well as promoting greater presence and participation of society more generally, both on an individual level and in organizations and associations.

Better life conditions in many countries have led to noticeable changes in indicators of health and disease which also present themselves in situations like [Mexico's], where illnesses are products of accelerated processes of urbanization. *Many chronic degenerative diseases like neurological and psychiatric pathologies are associated with the epidemiological changes that have been observed in recent years in countries with emergent economies, like Mexico.*

Mental health problems have increased dramatically on a global level in recent decades, and our country is no exception. The data suggest that mental health problems are among those which contribute most to the global burden of disease and disability. Beyond the impressive figures related to these pathologies, there is a large group of people who live in extremely difficult conditions or circumstances which put them in risk of being affected by mental illness; for example, children and adolescents with alterations in their development and education, abandoned elderly adults, female workers, street children, ethnic and indigenous groups, communities who leave their homes in cases of natural disaster and war or to seek better living conditions, and of course the population living in extreme conditions of poverty. *To respond to a challenge of this magnitude, it is necessary to invest in the psychosocial component of health to enhance human capital.*

A national health policy for dealing with mental health problems involves not only health institutions, but also the educational and labor sectors, in development and social integration, as well as in *society more generally* at the federal, state, and municipal levels.

- Julio Frenk Mora, former Health Secretary of Mexico[2] (Secretaría de Salud 2001; translation and italics mine)

[2] Frenk founded and directed Mexico's National Institute of Public Health and was an executive director at the WHO's Evidence and Information for Policy unit. He is currently the Dean of Harvard's School of Public Health.

This excerpt illustrates a number of points which frame my discussion of mental health practitioners' project of culture change.[3] As the document makes clear, Mexico has for a number of years sought to meet the guidelines laid out by international organizations—most notably the World Health Organization—for the promotion of mental health. Many of these guidelines were set in 1990 at the Regional Conference for the Restructuring of Psychiatric Care in Latin America in Caracas, Venezuela, and were summarized in the Caracas Declaration, which "called for integration of mental health into primary care, shifting from hospital-based care to community-based care, and protection of the human rights of people with mental disability" (Caldas de Almeida & Horvitz-Lennon 2010: 218). In the Declaration, the subsequent Initiative for the Restructuring of Psychiatric Services begun by the Pan American Health Organization and the WHO, and the various state mental health plans which issued from them, mental health was framed in the context of democratic human rights, on the one hand, and economic development, on the other.

These initiatives and declarations aim to shift treatment of mental disorders away from institutionalized hospital care toward primary- and community-based care, a process which is intended to protect patients' human rights by better integrating them into society, reducing stigma, involving family in their treatment, and ensuring access to adequate services in their communities. More broadly, these mental health reforms and their associated legislation, programs, and initiatives construe mental health as a 'basic human necessity' which governments must help to maintain in the interest of smooth individual and societal functioning.

[3] While the Mental Health Action program applies specifically to public services, it is helpful also in framing the overall project of mental health promotion in which private practitioners are engaged, as well.

Mexico's Congress published a research analysis brief on mental health which draws upon Len Doyal and Ian Gough's 1991 *A Theory of Human Need* in its justification for attention to mental health; such attention is needed because "physical survival and personal autonomy are preconditions of any individual action in any culture and constitute the most basic of human necessities (those which must be met to some degree before actors can effectively participate in their lives and attempt to reach other goals)" (Sandoval de Escurdia & Richard Muñoz 2005: 5, translation mine, c.f. Doyal and Gough 1991). In other words, mental health is considered a basic human need because without it, one's overall health and autonomy are compromised.

'Autonomy' is, according to the authors' definition, a function of "the degree to which we *understand* ourselves, our culture, and what is expected of us; the *psychological capacity to formulate options* for oneself (one's *mental health*), and the objective opportunities to act accordingly and the *liberty* implied by that" (ibid). Mental health is therefore defined in this context as not only the absence of mental illness, but 'a state of complete physical, psychological, and social well-being' and the "exercise of the potentials for personal life and social interaction, which are inherent to human nature and condition its well-being. A balanced mental attitude permits one to deal more effectively with the stress of everyday life, perform productive work, and make positive contributions to society" (Secretaría de Salud 2001: 13). Promoting this 'balanced mental attitude' is thus central to public mental health initiatives.

Mental health programs and reforms in Mexico are in line with the more general neoliberal health reforms enacted in Latin America over the past 30 years as conditions of loans from the World Bank and the IMF. As such, they emphasize decentralization (more

fiscal and administrative responsibility is transferred to states and municipalities) and privatization, and are explicitly linked to guidelines for economic development and modernization (Haber et al. 2008). In this light, mental health is important "not only as a matter of health, but also because of its impact on national economic development" (Secretaría de Salud 2001: 13).[4] The Secretaría's Federal Mental Health Action Program thus outlines the World Bank's estimations around the amount of productivity lost to mental health problems as further justification for the need to promote mental health as a public health priority in Mexico. Mental health problems are represented as the expected outcome of modernization and urbanization in 'emergent economies'; these processes augment the 'stress of everyday life' and contribute to pathologies which mental healthcare must be available to treat—so as to mitigate the loss of 'human capital' in the form of disability among workers (see italics in excerpt at beginning of section). On the other hand, development discourse acknowledges that development can, at least in some phases, contribute to greater degrees of economic inequality; therefore, mental health services must also be available for the poor and marginalized groups outlined in the document above ('street children,' ethnic and indigenous groups, those living in abject poverty, etcetera). Mexico's Federal Mental Health Action Program is therefore specifically designed to address problems of mental health which are viewed as inevitable outcomes in contexts of development, structural readjustment, and the creation of 'emerging economies.'

[4] Some have argued that these reforms represent a more general shift in social welfare philosophy and approach in Mexico from one in which the federal government is responsible for providing welfare needs toward one emphasizing "individual and family responsibilities and the role of the market in promoting competition and efficiency" (Haber et al. 2008, c.f. Laurell 2003).

In this context, Mexico has sought to "democratize" its health services by constructing—or ostensibly committing to construct—"an inclusive, efficient, humane, and economically healthy universal health system for the population which is linked to the overall development of the country" (Secretaría de Salud 2001: 5). The *Seguro Popular* Program [People's Health Insurance] has been the most notable reform in these 'democratization' efforts. Begun in 2004, *Seguro Popular* is a "voluntary family health insurance program for the uninsured" intended to create universal access to health services, even for the poorest of the poor (Homedes 2009: 4-5). Families make contributions to the program based on a sliding-scale fee system, and the government "allocates extra funds to the most marginalized states," like Oaxaca (ibid). While the goal of providing universal access to healthcare and of subsidizing care for the poorest families is laudable, assessments of the program's efficiency, quality, and impacts upon health status have been unfavorable (Homedes 2009; Laurell 2007; Támez González & Valle Arcos 2005). Access to services has increased in some places with the building of new hospitals and public health centers, but critics argue that attempts to grow the private health sector and promote competition between the private and public sector have contributed to health iniquities.

Oaxaca's Ministry of Health has, over the past decade, implemented a number of reforms to promote mental health specifically. These include staffing more primary care facilities (*Centros de Salud*) with psychologists; training non-psychologists to detect and treat mental health problems and educate patients about mental health; "informing and educating the general public about mental health problems"; "promoting healthy lifestyles which correlate favorably with the health of the population through permanent

media campaigns and social diffusion"; training primary care physicians and others to collect valid mental health epidemiological data; and "reinforcing the system of referral and counter-referral" to ensure patients are attended to by the appropriate professionals" (Ramirez & Méndez 2007). Oaxaca's State Mental Health Program outlines these goals and, again, explicitly links them to a perception of mental health as a basic human necessity and as a necessary condition for economic development.

Therapeutic Governance

I draw attention to these programs and reforms to emphasize how mental health promotion—growing private and public mental health sectors, educational campaigns, development programs, epidemiological studies, and increased access to services—is essential to governance in the context of Mexico's neoliberal democracy. State and federal health reforms, development initiatives, and public and private services in Oaxaca promote a universalizing concept of mental health which is consistent with the goals of the World Bank, the IMF, and other international institutions; mental health is construed as a basic human need which must be met if economic development is to succeed. This view suggests that without mental health, citizens cannot exercise their democratic freedoms nor be productive members of society contributing to Mexico's reserves of so-called 'human capital.'

As I discussed in the prior chapter, Nikolas Rose argues that psychology and other 'psy' disciplines have emerged and thrived in relation to "transformations in the exercise of political power in contemporary liberal democracies" (Rose 1996: 11). The 'regime of

the self' and the psychiatric biopractices I outlined in that chapter are essential to contemporary forms of governmentality in that they exercise power not through "brute coercion, but instead [through] diffuse mechanisms such as discourses that promote the pursuit of happiness and healthiness through certain modes of personal conduct including self-surveillance and self-regulation" (Clarke et al. 2003: 265). These are 'technologies of the self,' or "forms of self-governance that people apply to themselves" and which "pervade more and more aspects of daily life and the lived experience of health and illness, creating new biomedicalized subjectivities, identities, and biosocialities—new social forms constructed around and through such new identities" (ibid, c.f. Foucault 1988; Rose 1996; Rabinow 1992). It is precisely these subjectivities, identities, and biosocialities which Oaxacan mental health practitioners wish to create in the interest of promoting well-being in their communities. Practitioners are not explicitly attempting to exercise power, to 'govern,' or to subjugate; on the contrary, they seek to liberate their patients, alleviate their suffering, and help them realize meaningful self-understanding. At the same time, their efforts and goals must be viewed in light of the larger political, economic, and global developments of which they are a part.

As indicated in earlier sections, most practitioners expressed frustration at how difficult the seemingly straightforward project of promoting mental health was in practice. While they anticipated that there would be some resistance to the concept of mental health, and while they acknowledged there had been a noticeable shift over the past decade with regard to people's openness to the idea of mental health and of utilizing mental health services, they nonetheless faced an ongoing crisis of legitimacy. Practitioners seek to join a global movement to promote mental health, de-stigmatize

mental illness, and provide universal access to services, but they are constantly thwarted on the ground by what they see as unfair allocation processes for health funding, lack of attention to mental health on the part of politicians and public health leaders, and general society-wide stigma around mental health. This resistance is, from practitioners' perspective, largely due to local 'culture' in all its manifestations, as the following sections will discuss.

REPRESENTATIONS OF CULTURE

Traditional Medicine & Multiculturalism

It is in many ways unsurprising that 'culture' was so central to discussions of mental health in Oaxaca; after all, Oaxaca composes one of the most ethnically diverse regions of Mexico with many thriving systems of indigenous medicine. The literatures on medical pluralism and on the politics of international public health projects have extensively documented how biomedical practices tend to marginalize indigenous medicine and so-called 'traditional' beliefs. This work reveals the complicated tensions between global, 'modernizing' forces and institutions, on the one hand, and 'traditional,' or 'cultural' practices and values, on the other (Lock & Nichter 2002: 8)—tensions which are also, of course, widespread in the non-health arena as nation-states grapple with how to 'develop,' 'modernize,' and 'democratize' more generally (García Canclini 1989/1995).

The tensions between 'traditional' 'modern' medicines can have a number of consequences. In parts of South and East Asia they have contributed to state-sanctioned 'revival' of particular aspects of indigenous medicine in the name of promoting culturally

'authentic' forms of modernization (Lock 1980; Leslie & Young 1992; Chatterjee 1993; Ferzacca 2001, 2002). Elsewhere they have contributed to the creation of dangerous 'others' seen as threats to public health and modernizing and development projects (Nichter 2001; Pigg 1996). As Stacy Leigh Pigg pointed out over 15 years ago in relation to healing in Nepal,

> More than just a field of therapeutic possibilities, medical pluralism is also an arena for the negotiation of social difference…illness and healing power come to be imbued with an imagery of differentiation—a symbolics of ethnicity, race, gender, and class…social differences are not simply variables influencing medical outcomes. Rather, the definition of medical problems and the interactions in medical encounters themselves contribute to the social experiences of difference (Pigg 1995: 19, c.f. Crandon-Malamud 1991; Comaroff 1981).

The first two sections of this chapter began to illustrate this 'imagery of differentiation' in Oaxaca, where mental health practitioners—particularly psychiatrists—tend to be dismissive of informal and indigenous forms of care, directly contrasting them to rational, 'scientifically proven' medicine and psychological practice. This attitude is readily apparent in Dr. Silva and Dr. Ramirez's concerns over 'magical thinking,' a 'problem' which was invoked repeatedly throughout the course of my fieldwork. Dr. Cardozo, a private psychiatrist in the city who was also the director of the psychiatric hospital for many years, shared Dr. Silva and Dr. Ramirez's frustration, perhaps especially because he felt that 'magical thinking' and 'alternative' treatments contributed to the stigmatization of psychological and psychiatric treatment. He said that many Oaxacans

> still maintain magical thinking…I have to tell you, in Oaxaca lots of people use alternative treatments—which are not professional, of course. The intervention of

> people who perform *limpias*, cures, magical treatments…So the idea of the psychologist, of the psychiatrist—these are still thought of as only for crazy people, in a pejorative sense, in the sense of rejecting that type of population. When someone goes to the psychiatrist they even make sure that nobody knows, that nobody sees them go into the office. There is still a certain type of stigma and this of course makes treating mental health difficult.

This attitude did not surprise me, per se, but based on what I had read of traditional medical practice in Oaxaca as well as findings from the literature on medical pluralism, I expected there to be more officially sanctioned blending in the realm of healthcare. Particularly since Oaxaca officially promotes 'multiculturalism,' I theorized that at least some aspects of traditional care might be integrated into the dominant medical and psychological systems—even if they were done so in the service of some form of 'culturally authentic' modernization (Ferzacca 2002).

In fact, I came across only a handful of cases in which anything like blending was occurring. Perhaps most notable among these is the *Unidad de Medicina Tradicional* (Traditional Medicine Program) within the Health Ministry, which sponsors several traditional medicine clinics, trains biomedical practitioners in 'cultural competence,' and generally seeks to legitimate indigenous medicine and validate the importance of culture in matters of health. Like Oaxaca's State Mental Health Program, the *Unidad de Medicina Tradicional* is the result of federal legislation which is itself linked to international mandates and guidelines. In the "Program for Specific Action: Traditional Medicine and Complementary Systems in Healthcare," the Health Secretary notes that the "open intention" to embrace traditional and complementary medicine in global health efforts officially began with the Declaration of Alma Atta in 1979, in Kazajistan, as part of a meeting convened by the WHO and the United Nations Children's Fund (UNICEF).

"Since then," the document states, "Mexico has spread, signed, and issued a number of agreements and proposals to assess and incorporate traditional and complementary medicine in health systems" (Secretaría de Salud 2007: 13).

In 2001, Mexico's constitution officially began to "recognize the country as a multicultural nation and guarantee the right of *pueblos* and indigenous communities to preserve and enrich their languages, knowledge, and all the elements which constitute their cultures and identities" (ibid). This constitutional amendment also "assures effective access to health services which duly embrace traditional medicine" (ibid). Such decrees are tied to wider efforts to officially promote multiculturalism and indigenous rights in Latin America and elsewhere, efforts which have been the subject of multiple anthropological critiques. Charles Hale draws attention to the ways in which multiculturalist policy offers some concessions to indigenous communities in order to more fully control the terms of political debate and legitimate citizenship, meanwhile determining which cultural demands are reasonable and still conducive to neoliberal capitalism. This process in turn undermines possibilities for collective indigenous action and dissent (Hale 2002). As he puts it, "The increasingly prominent discourse of multiculturalism among diverse groups of dominant actors and institutions in Central America has the cumulative effect…of separating acceptable demands for cultural rights from inappropriate ones, recognising the former and foreclosing the latter, and thereby creating a means to 'manage' multiculturalism while removing its radical or threatening edge" (ibid: 507).

Such amendments stand in direct contrast to the Mexican government's former stance toward indigenous medicine, which treated it as a direct threat to modernization.

The *Instituto Nacional Indigenista* (INI), or National Indigenous Institute, attempted to eradicate indigenous healers (in addition to other indigenous practices) in the interest of consolidating a 'modern' national identity: "INI pursued…active campaigns that encouraged indigenous people to discard 'traditional' medicine as superstitious belief, unscientific practice, and, in a word, a fraud that was dangerous to indigenous people's own health" (Ayora-Diaz 1998: 174). INI's policies changed dramatically in the 1970s in conjunction with the Declaration of Alma Atta and other (often economically motivated) policies promoting multiculturalism; however, the suspicious attitude toward traditional medicine on the part of biomedical and cosmopolitan health practitioners is still quite notable.

The 'Right to Believe'

Most Oaxacan mental health practitioners espouse an attitude of semi-tolerance: patients can continue 'believing' in traditional medicine—*curanderos, brujos* ('witches'), and the rituals they perform—as well as the indigenously defined illnesses they treat, such as *nervios* and *susto,* as long as such beliefs and practices do not interfere with psychological or psychiatric treatment. One of the psychologists at Cruz del Sur, Damian, explained the situation in a manner more or less representative of other practitioners' views, as well:

> Whitney: Have you seen other patients who have a different way of thinking about their emotions and their illnesses? Like, those who have gone to *curanderos,* or who think their problem is something other than 'mental health'?
>
> Damian: Yes, the grand majority of the patients who come here or who have some kind of mental illness, there's a distinct way of thinking about what's happening to them, about how they feel. Because of the nature of the disorder

they feel it's something external to them…That someone's performing witchcraft on them, that someone who wants to do them harm is casting a spell. Obviously you know that the state of Oaxaca has many mystical religious beliefs, based on Oaxacan tradition [*la tradición Oaxaqueña*]. So here it's like, 'let's go and get a *limpia*, he has *mal de ojo,'* or 'they did him 'harm' [*daño*, in cases of witchcraft], and—I don't really know, but that's the way people think. Obviously the patients then say, 'Someone's performing witchcraft on me,' 'they're 'harming' me,' but it's just part of the disorder. We have to teach them that it's also a question of mental illness, but yes, many patients believe that it's [witchcraft].

W: And do you tell them that it's not?

D: Well, that's what *psicoeducación* consists of, through the process of group intervention, you try to reformulate those ideas and beliefs for something more…in the sense of something more scientific. And give them other explanations for why they're having those symptoms, why they feel like people are watching them, why they feel like others are cursing them. And not just with patients, but also with their families. Because the family, what they do—they always have to look for lots of ways to cure their loved one—"cure" in quotations—and what do they do? Well, they take them to the *curandero*, they take them to the witch, they take them to the herbalist, they take them to a million different people. Sometimes we'll even give them treatment instructions here and they'll keep going to the *curandero*. Others take them to the priest so he can say prayers, and things like that. That's how it is, generally, and the majority of people [here] think like that and act in that way.

W: Do you all [practitioners at the hospital] think they should stop going to the *curandero*?

D: We can't get rid of that type of belief [*creencia*], so what we do is tell them that it's okay—or, it's okay if they believe in something, because when we're in this type of situation it's good to latch on to something to be able to get out of the [mental health] crisis. So if they have a really strong belief we can't negate it—what we do is tell them it's okay and that they should continue with their treatment like prayers [with the priest], or a sweep [*una barrida*, similar to a *limpia*], but don't let them stop taking the [psychiatric] medication, they have to continue the medication. So we don't strip them of the right to believe if they have other alternatives, but what we say is 'Don't be non-compliant, stick with your treatment.' This is their process, so we keep following up in outpatient services and there we continue explaining to them and teaching them through *psicoeducación* what the process is going to be and what the characteristics of their mental illness are. There are some families who understand it's a prolonged and sometimes tedious process, and some for whom it's harder to explain. [They'll say] we already took him to the *curandero*, and he gave us these teas…' But then they realize that when we give the patient medication and treat him here, his state improves. So their hypotheses and beliefs start changing. But we can't remove their beliefs in one stroke and forbid them to believe in that stuff—they have to believe. They also have to believe in some god from the religions they're immersed in, and in some ways, that's also a support for them.

In Damian's view, the majority of patients at the state psychiatric hospital come in with 'beliefs' around traditional medicine, witchcraft, and 'folk illnesses'; it is the job of practitioners to re-educate patients and their families about 'more scientific' understandings as they commence treatment. He and other professionals emphasize that it is important not to entirely dispel 'magical thinking' because it is important for patients and their families to 'believe in something'—this is considered a 'right'—but such beliefs become a threat when they contribute to non-compliance with psychiatric medications. Other professionals mentioned how sweatbaths, massage, and prayers could be helpful but that herbs could interfere with the effects of psychopharmaceuticals and so must be discontinued. Still others complained that "charlatan" *curanderos* deceived patients and charged exorbitant amounts for ineffective treatments, thus leaving the ill unable to afford psychiatric medications. (Interestingly, several practitioners mentioned that oftentimes these were non-native *curanderos* coming from abroad—"*curanderos* in coat and tie," as one psychiatrist put it—who advertised on the radio and TV and charged thousands of pesos for their cures.)

Managing Multiculturalism

As Damian indicates, traditional healthcare—in the form of *curanderismo* and its associated practices—was generally represented as an aspect of 'belief,' folklore, and culture, not as a legitimate form of care for emotional or psychological ills.[5] On the contrary, from practitioners' perspective its existence contributed to patients waiting too

[5] Pigg (1996) notes that in "development discourse, the word 'traditional' always signals a world of shared and unquestioned beliefs. This is the realm of habit, rather than reason. 'Beliefs' are always associated with group identity and taken, usually, to be a feature of ethnicity" (178).

long to seek psychiatric care, thus complicating illnesses further. Even among those who acknowledged that *curanderos* serve an important societal function—by providing a form of medical care and psychological support in communities lacking more 'authoritative' medicine—tended toward skepticism or, at the very least, expressed that if they were to be useful, *curanderos* and other practitioners (like midwives) would need guidance and training from biomedical practitioners. As Jorge Díaz, the head psychologist at Huajuapan's SSO Mental Health Services, put it,

> in the absence of professionals, *curanderos* do important work for communities. We train traditional medical practitioners so that when they're out there they can give basic psychological care…we have programs where there's someone in charge of training, say, midwives—traditional midwives, and that's where we intervene psychologically…to train them and give them information, give them understanding of the importance of how to attend to a—a person who ends up in their hands. Since they don't have this kind of training, at least we can give them the knowledge of [things like], 'I can refer you here,' or 'I can listen to you,' because sometimes that's all that can be done…But unfortunately sometimes women keep practicing [midwivery] without getting trained—they're not registered with the Health Secretary.

As in many instances of medical pluralism—like Ayurveda in India or *pengobatan tradisional* in Indonesia (Leslie and Young 1992; Ferzacca 2002)—when indigenous or traditional forms of care are integrated on an official level it is only partially, to the extent that they do not interfere with biomedical practice. Like other institutional endorsements of multiculturalism, aspects of traditional medicine inconsistent with approved notions of modernity are 'managed' and downplayed, their 'radical edge' removed (Hale 2002: 507).

In cases where traditional medical practice was sanctioned, such as the *Clínica de Medicina Tradicional* in Calpulalpam de Méndez, allopathic doctors practice next door.

In Calpulalpam the two seem to have a mutually beneficial relationship; one of the practicing *curanderas* at the clinic explained that she refers more 'serious' (*grave*) cases—like extremely high blood pressure, or high glucose levels among diabetics—to the biomedical clinic, while the biomedical clinic refers patients with more diffuse symptoms—headaches, stomachaches, emotional issues—to the traditional practitioners. The biomedical clinic at one time had psychologists on staff, but when I was there the *curanderas* had taken on the de facto role of counselors in cases deemed emotional, psychosomatic, or psychological. In this and other instances of blending, traditional services must be managed and overseen by biomedical practitioners if they are to be trusted by members of the establishment.

Surprisingly, given that most of the official attention to traditional medicine on a state level seems to consist of little more than lip service, the state has built a full-scale hospital for traditional and alternative medicine outside of Calpulalpam. I visited it with a *curandera* friend of mine, Gladys, who practices in the smaller *Clínica de Medicina Tradicional* and who works in Oaxaca City at the *Unidad de Medicina Tradicional*. Our taxi couldn't make it all the way up the dirt road leading to the future hospital, so Gladys, her husband, and I walked a bit before coming upon the newly constructed hospital, surrounded by a padlocked fence. It is a lovely building, tucked in the forest with magnificent views the smell of pine all around. We crawled under the fence and explored the clinic's light-filled rooms, its pleasant archways, brick detailing, and its large traditional sweatbath structure (*temascal*). The space for women recovering after labor looks out onto the mountains, and there are plenty of consultation rooms for the *curanderos/as*, midwives, herbalists, homeopaths, and acupuncturists the building is

slated to host—as well as a 'conventional' doctor, of course, in cases of emergency. The problem is that, like many well-meaning projects in the state, the government failed to fully fund the clinic; at least at the beginning of 2011, there wasn't quite enough political volition to finish the job. So the building stands there, uninhabited and halfway finished, an apt metaphor for the state's half-hearted efforts to integrate traditional medicine into official practice.

Culture and Mental Health

Again, the institutional marginalization of traditional medicine in Oaxaca is not necessarily surprising given that (a) indigenous medical practice—among many other indigenous practices—has been marginalized historically in Mexico and elsewhere, and (b) biomedicine and traditional medicine stand in tension on a nearly global scale, as literature on medical pluralism has shown. *Curanderos*, shamans, and other indigenous healers are frequently portrayed in opposition to the modern, from Nepal (Pigg 1996) to Bolivia (Crandon-Malamud 1991). Pigg notes about the Nepalese case that "[s]hamans belong to a world of local and personal relations, while doctors clearly belong to the institutions of a cosmopolitan modernity" (Pigg 1996: 162). The ruptures between tradition and modernity are well-documented in medical anthropology literature and have historically been reproduced *by* medical anthropology, as Good (1994) points out in his discussion of the Health Belief Model utilized in modernist anthropology by Rivers, Pritchard, and Levi-Strauss. 'Inferior' and 'irrational' 'beliefs' were thought to be illness-producing, while rational, 'knowledge'-based western approaches and understandings were thought to prevent illness.

Having been exposed to such work, I was prepared for the marginalization of traditional medicine when I began my research. In my first weeks conducting interviews, I was under the impression that mental health practitioners were mainly concerned with low levels of 'compliance' due to utilization of traditional medicine and a general lack of knowledge about mental health among the population, as Damian discussed in the interview excerpt above. However, the more interviews with mental health practitioners I conducted, the more I saw that understandings of 'tradition' and *curanderismo* as barriers to mental health expanded outward to encompass a broad swath of qualities, behaviors, and characteristics which roughly fell under the category of 'culture.' In practitioners' view, 'culture' and 'mental health' are fundamentally incommensurable, and their discourse sets up a binary opposition between the two (see Table 5.1).

Table 5.1: Culture/Mental Health Discursive Opposition

'CULTURE'	**'MENTAL HEALTH'**
Tradition (based on subjective beliefs)	Science (based on tests and objectivity)
Magical, intuitive	Rational, authoritative
Pre-modern	Modern
Closed, backward	Open, progressing
Localized, specific	Globalized, universal
Taught through folklore, customs	Taught through *psicoeducación*

As Table 5.1 indicates, each putative aspect or quality of 'culture' finds its opposite in professional discourses around 'mental health.' So where 'culture' is perceived and represented as *traditional* and based upon subjective, intuitive beliefs (*creencias*), 'mental health' is perceived and represented as *scientific*, based on objective instruments which are universally valid, such as the *DSM* and *ICD*. Where 'culture' is represented as local, specific to particular ethnicities or regions, 'mental health' is based

upon global principles and is universally attainable—providing one distances oneself from 'cultural beliefs.' Culture is represented as a relatively closed system, insulated and backwards, whereas mental health is associated with notions of openness and progress (inherent to notions of modernity). And while culture is represented as being transmitted and reproduced through folklore, customs, and rituals, mental health is taught through intentional educational practices, known as *psicoeducación.*

In these discourses, the more 'culture' a person or community 'has,' the less capacity for mental health; Oaxacan 'culture' is also represented as the main reason for Oaxacans' *resistance* to mental health practice and to a more general 'culture of mental health' or 'culture of psychology.'[6] This view is similar to what Pigg describes as the "bland, bureaucratic language of international AIDS intervention efforts," in which "all local values and meanings are 'cultural'" (Pigg 2002: 59). However, unlike that language, which claims all interventions should thus be 'culturally appropriate,' in Oaxaca there is a curious lack of anything akin to a cultural competency movement in matters of mental health. I never even heard of a professional linguistic interpreter in mental health efforts,

[6] It is important to note that 'culture' was not always isomorphic with 'indigeneity' in these representations. In other words, it was not only indigenous groups who were perceived to hold onto 'cultural' beliefs and who were thus resistant to mental health; rather, these attitudes were attributed to Oaxacan 'culture' more generally. At the same time, professionals seemed to generally consider indigenous Oaxacans more 'cultural,' and thus were more difficult subjects of education and intervention. This finding thus recalls but in important senses differs from Beltrán's 1967/1979 account of relations between Indians (indigenous) and Ladinos (mestizos) in Mexico. He writes that an "ideology that justifies the subjugation and exploitation of the Indian compels the Ladino to form a false image of himself…It is composed of prejudices and ethnic preconceptions which do not stand up under rational analysis. In this undesirable situation the Latino resorts to an indirect solution: he builds his self-image through comparison with a contrasting one, that of the Indian, to which he attributes stigma, blemishes, and dirt…Thus, on the basis of contrasts, of conceptual opposites…the Ladino constructs his image, idealizes the model, and makes it operate as a mechanism for furnishing identity" (1967/1979: 138-139.). This identity in turns acts as a rationalization for continued domination. In the present case we can see how such contrasts and 'conceptual opposites' have essentially transcended the mestizo-indigenous divide to form a societal tension around notions of 'culture' more generally.

and while practitioners sometimes spoke of having to respect people's 'beliefs,' I heard nothing of efforts to recast mental healthcare in 'culturally appropriate' form.

Perhaps this was because particular cultural characteristics and practices were viewed as mutually exclusive with the Euroamerican mental health ideologies practitioners were attempting to promote—and thus, from the practitioner perspective, needed to be changed rather than catered to. As I discussed in Chapter 4, these mental health ideologies are based around (a) the 'regime of the self,' composed specifically of ideas around self-knowledge, self-expression, self-responsibility, and self-empowerment, which themselves must be cultivated through various 'technologies of the self'; and (b) the view of humans as biological subjects promoted by the "expanding regime of biotechnical truths and pharmaceutical markets" (Good et al. 2007: 259). Table 5.2 shows the discursive opposition set up between practices connected with 'culture' and those connected with 'mental health.'

Table 5.2: 'Cultural' vs. 'Mental Health' Practices

'CULTURAL' PRACTICES	**'MENTAL HEALTH' PRACTICES**
Use of indigenous medical care	Use of psychological & psychiatric services
Endorsement of indigenously defined illnesses (e.g. *susto, mal de ojo*)	Endorsement of DSM/ICD diagnoses (e.g. depression, schizophrenia)
Resistance to and non-compliance with psychological and psychiatric treatment	Acceptance of and compliance with treatment
Use of herbs	Use of psychopharmaceuticals
Machismo, chauvinism, inequality	Gender equality & human rights[7]
Violence, aggression	Self-control
Repression of personal feelings, emotions (or expression of the wrong types of feelings)	Expression and management of personal feelings, emotions
Ignorance of self	Self-knowledge
Low self-esteem	High self-esteem
Fatalism	Empowerment
Forbearance, stoicism	Expression & rejection of suffering
Group responsibility	Individual responsibility
Cultivation of/dependence upon social & village bonds, self-sacrifice	Self-cultivation

Questions of Culture

As I discussed at the opening of the chapter, psychiatrists tended to express strong opinions about culture and 'magical thinking' as barriers to mental health, to understanding the biological nature of mental illness, and to compliance with psychopharmaceutical regimens. Ironically, for psychiatrists, the appeal of new-age healing was also portrayed as an aspect of 'culture,' albeit part of the culture of more well-off and educated Oaxacans. Although treatments like biomagnetism, acupuncture, Bach Flowers, yoga, and Reiki are by no means 'local' but rather a very concrete consequence of globalization, Oaxacans' desire for such 'unscientific' cures in favor of psychiatry seemed only to confirm their frustrations with the local context in which they

[7] I will discuss the *machismo*/chauvinism/inequality vs. gender equality and human rights opposition in the following chapter.

had to practice.[8] Unlike psychologists, who were primarily concerned with Oaxacans' 'cultural' dispreference for expressing emotions, psychiatrists were primarily concerned with the de-stigmatization of mental illness and with treatment adherence. Culture and magical thinking, whether encouraged by traditional or new-age medicines, were viewed as barriers to these goals. As Dr. Álvaro González of the psychiatric hospital put it, "We still have magical thinking here, you know? Culturally, because we are heavily influenced by overvalued ideas of…mental illness being not mental illness, but rather witchcraft, a spell, or something like that."

Like most psychiatrists I interviewed, Dr. Alegría Canino—who has a private practice in Oaxaca City—discussed how, because of 'culture,' psychiatry is viewed as an option of last resort which Oaxacans hide from others due to stigma. Speaking about patients attempting to hide their visits to her office and make it inside without being seen, she said such behavior is "more than anything very cultural." She went on to discuss patients who come from "communities" [*comunidades,* e.g. rural indigenous communities] who have "already sought care from all the *curanderos,* with all the alternative medicine, before coming to a medical consultation. Logically they've then let a lot of time pass, and their illnesses are, in many cases, much more complicated as a result." Dr. Canino had had one patient, however, who was referred to her by a *curandero* in the Zapotec town of Tlacolula:

[8] At the same time, several psychiatrists acknowledged that these barriers were due in part to the local importance of spirituality and to Oaxacans' understanding of health, nature, sociality, and spirituality as intimately linked. The Cruz del Sur panel I described earlier in the chapter attempted to address some of these concerns, as well as their perception that Oaxacans perceived psychopharmaceuticals as destructive to these links and as possibly addictive. Seen is this light, 'culture,' 'magical thinking,' and cultural practices were more understandable, and a handful of hospital psychiatrists had made efforts to investigate these matters further. However, such inquiries among practitioners, were, to my knowledge, relatively rare.

> The *curandero* realized that the little girl didn't have anything he could cure, and that they'd have to take her to a psychiatrist. [And I was like] wow, that's great and I wish they were all like that, because the girl was truly psychotic. So she needed medical treatment…And this was the first time that a person, um, who dedicates himself to *limpias* and whatnot, had that type of mission. To say 'it's not for me to cure, let's let the psychiatrist cure it.' That is our mission.

Dr. Canino's concerns—and her approving stance toward the *curandero* who validated psychiatric practice by referring his patient—speak to the more general crisis of legitimacy practitioners experience in Oaxaca, where they feel their services are ill-understood and under-solicited. They express that while they *could* be helping to solve complicated problems of mental illness, patients obdurately continue to fear them, stigmatize their practice and the illnesses they treat, and seek care from local healers. Dr. Canino and others felt that psychology was not quite so stigmatized or rejected. "That's much easier [for people]," she said. The attitude is "if I go to a psychologist, I'm healthy, but if I go to a psychiatrist I'm sick. This is the vision most people have."

Although psychologists do say that there has recently been more openness to their services, they too felt there were cultural barriers and expectations—a "culture of resistance," as one psychologist put it—which prevent Oaxacans from seeking services and from cultivating their own mental and emotional health. Dr. Tenorio, for example, claims that a *machista* culture, stronger in Oaxaca than in Mexico City, where she used to practice, prevents men from seeking psychological treatment:

> Dr. Tenorio: [Women are] more determined to confront problems that are presented to us and to look for solutions. Men, they negate the problem and refuse to recognize it, as though it's a weakness in their virility.
>
> Whitney: Was it the same in D.F.?

> T: No, in D.F. it's more…men are going to group therapy more. And of my friends who were also studying [psychology] there, we were 50/50 men and women.
>
> W: Why is it different here?
>
> T: I think it's because of culture. In Mexico City there's more openness. People are more open.

While Mexico City is characterized as an 'open' culture (with fewer gender taboos), Oaxaca is characterized as closed and in need of opening. Similarly, psychologist Arnoldo Guzmán said there was more demand among women for mental health services because of *machismo:*

> Here there's a macho culture, you know? It's always like that, and I don't know if it's universal, but with little boys, it's like 'don't cry, you're a man.' Here, men are only allowed to cry if they've been drinking. If they're drunk, they cry, but—it's that, right? Accepting help is easier if you're a woman…I think it's a question of culture.

Interestingly, Dr. González from the psychiatric hospital says *men* are more likely to come seek treatment, both because they have a tendency to experience more severe psychoses and because of "cultural questions": "more care is given to men here [in Oaxaca]…it's like men deserve more attention." Contrary to psychologists, who insist it is women who generally utilize their services, Dr. González opines that men are more likely to receive treatment because they are viewed as more deserving than women.

Like Dr. Tenorio, psychologist Jose Luis Armiento described Oaxacans as 'closed' [*cerrados*] in his discussion of how indigenous women are more emotionally repressed than *mestizos*:

> [Indigenous women] are more closed…It's harder for them to talk—or, there's much more embarrassment and much more…or, I—overall I feel that the thing is

> that there's still a lot of repression, mostly with women, who can't live their lives freely…In general, those with whom I've worked…don't last very long. I think therapy is not really part of their culture yet.

Lara Hernández, a psychologist who works with young women from indigenous communities who have received grants to come to Oaxaca City to study, discussed how she, too, found indigenous women more 'repressed,' particularly in their ability to express happiness and joy:

> Lara: For me it's very important in therapy, even if they don't ask for it, is to kind of, kind of recuperate the emotional toolkit [*equipo emocional*] we were born with, you know? The ability to express sadness, anger, happiness, fear; the ability to healthily manage emotions. For me, that's really important, and it's a goal of mine that helps them reach their goals, as well.
>
> W: And how do you reach this goal?
>
> L: Well, eh, we go over how the family was managed, how much they were permitted to cry or not, or whether there are beliefs [*creencias*] which don't permit them to be more spontaneous. Now thinking about what you asked me, something really interesting I've come across is—I normally have a schematic, you know? Of anger, love, sadness, joy—as polarities. And normally we repress anger, sadness—women repress anger more and men repress sadness more. Both repress fear. But something I discovered as I finished a workshop with the grantees—all of whom are indigenous—is that they also repress happiness. [W: Yeah?] Yes, it's like, it's really frowned upon when people laugh and joke around forcefully. They seem crazy, and when what are the neighbors going to say, you know? This was something really novel for me, that a feeling [*sentimiento*] that could be positive is also repressed.
>
> W: So they can't express happiness in public.
>
> L: It's bad, it's bad to laugh like that.
>
> W: And how did you arrive at…or, how did you realize this?
>
> L: I explain the schematic, and how when we're little we can fluidly and flexibly move from one side to another. Then as we become more educated, we realize, but—they say 'how ugly you look [when you're] angry,' and 'your mother doesn't talk that way,' so then it's like I don't feel accepted acting that way and I swallow [my anger]. But later, when I want to be affectionate, this little piece of anger I kept inside doesn't let me be affectionate. It's the same with sadness. When people say, it already passed, it's not a big deal, forget about it, it's not

> worth it, we don't let ourselves cry. So when I want to be happy, well, there's an unexpressed sadness that doesn't let me get there. So once we see the schematic, I ask them how it's been in their families. Because each family is different. And some told me, 'well, in my family it's fine to express anger but sadness, no,' or 'my mother lets me do this but my father doesn't,' and that's how this came out. They told me that happiness was forbidden, that you can't be very euphoric because it's frowned upon.

In this view, humans are born with a universal set of emotions [*un equipo emocional*] that must, for healthy functioning, be able to be expressed. These consist of sadness, anger, happiness/joy, and fear, and they must be expressed when needed. However, cultural norms and familial expectations cause people to repress particular emotions, which accumulate and prevent them from being able to experience and express still other emotions: they 'swallow' them instead. Lara's view is that in indigenous communities, there is a cultural tendency to repress joy, happiness, and laughter—a tendency that is contrary to healthy emotional function and to mental health more generally. Thus, Lara teaches the girls—in an "Emotional Expression" course often required of grantees—to get in touch with their emotions. She emphasizes that they have to be careful, though:

> you don't want them to go back to their communities dying of laughter [*muriendo de risa*] because they're going to be rejected. But it's nothing more than learning that it's okay, and it's valuable, it's part of expanding your *equipo emocional*. But you have to see where you feel safe being spontaneous and where you have to be a little more careful…I tell them that people who never get mad, who never cry, who never fall in love, well, they seem very calm and stable, but that's not as healthy, right?

The range of healthy behaviors and emotions conducive to 'mental health' is thus pre-determined; while 'culture' might cause people to frown upon and repress particular expressions of emotions, the presumption is that such repression must be transcended. In other words, while sanctioned emotional expression varies across communities, the ideal

equipo emocional is universal and universally attainable, provided one has the benefit of a therapist and can see beyond one's 'culture.'

Culture is thus associated with repression of healthy emotions, as Lara argues, but it is also associated with pathological expressions—inappropriate and harmful jokes as well as verbal and physical violence. With regard to verbal aggression and inappropriate joking, psychologist Adriana García says,

> I think it's culture, which sometimes generates verbal violence. Here in Oaxaca it's thought to be something funny, something that's not important but that really generates psychological distress in people, right? At any stage [of development], what happens is that culturally you get insulted, and it's supposed to be a joke, just a joke, but really it remains as an emotional scar [*cicatriz emocional*] that comes out after a while and generates depression and low self-esteem.

In Adriana's opinion, even if people do not realize that culturally sanctioned joking is harmful, it can cause longstanding emotional problems which must be worked out in therapy. Adriana and others connect culturally sanctioned verbal aggression to physical aggression, as well, which is "culturally permitted" or seen as "normal": "From the point at which they say 'you're fat, why don't you go to the gym,' well this is psychological violence, and then the stronger insults start, until they in turn generate physical violence."

Gender and *machismo* are central to discourses on culture; as the quotations from Dr. Tenorio and Arnoldo Guzmán suggest above, *machismo* and patriarchal social structures are presumed to be some of most notable aspects of 'culture' in Oaxaca. They prevent men from appropriately expressing emotion and seeking psychological treatment, and they contribute to violence and aggression—a subject to which I return in Chapter 6. Practitioners thus see it as their role and duty to help people rise above their harmful cultures in pursuit of mental health, liberty, and stability.

Dr. Villareal, who formerly worked as the director of a state-sponsored anti-domestic violence program and clinic, described culture as something one can decide to step out of or abandon if it's oppressive or contrary to your human rights, as many cultures are construed to be. She felt it was her obligation to fall on the side of human rights (as opposed to 'culture' and 'customs') and show women that they have alternatives:

> Dr. Villareal: At what point can you, in defense of human rights, ignore culture, you know? This is a really thorny issue. Human rights give you the right to be free, to live, to have food. On the other hand, each region has its own culture, and I can't go and say you're worthless because you're from that culture, your culture isn't valuable—I can't say that. So the option we've come up with and that we've used to avoid these culture clashes [*choques culturales*] is to let women know their options.
>
> Whitney: Their options?
>
> V: Yeah, the options we have that inform our decisions. What kind of life do you want to live? And if you change your entire life scheme, what will you have in exchange? Or—because if you renounce—because there are cultures where if you renounce your customs, they basically, basically kick you out of the community. So that's going to be painful for you. It's a loss, but in exchange for what you lose, what do you win? So you decide what's more important for you. What we want is to avoid making irresponsible decisions, and they're the ones who…We've given credence to the woman. What she tells us is true.

Later in the interview Dr. Villareal summed up her views on culture:

> V: It's complicated, and then from the standpoint of definitions, you say culture is everything involving music, dance, food, tradition, customs, forms, tools—all of this is culture, and all culture is valid. Then when you say, 'I'm going to break with this,' it's very complicated. I say, 'You want to get out of it? Yes? *Órale,* then out you go.

Cultural Burdens and the Right to Feel

My discussion with Natalia, a psychologist working at the same domestic violence crisis center, provides a rather representative example of professional

orientations toward culture. Talking about women who have suffered abuse, she said that the reluctance to cry or show weakness is "very cultural, so the idea is to change this, tell them 'you can suffer, you can cry, this doesn't mean you don't have worth. On the contrary, we're going to empower all the qualities you do have, including the right to feel, to get stressed." "In Mexico," she lamented, "there are many cultural burdens." She went on, describing what her duty as a mental health practitioner is in light of this challenging situation. "It very much involves getting rid of cultural ideals," she said. "Social ideals, educational ideals, family ideals, and to generate our own concepts of what it means to be a woman, a mother, a partner, a friend. But here [in Oaxaca], our culture toward women—the struggle doesn't allow for much."

I responded by asking her if it was difficult to 'change a culture.' "You start to feel very alone," she responded. "It's a process, you know? In the development process, or the mental health process, you start to experience solitude, because if you don't stick to the ideals, the roles, you begin to feel rejected." Nevertheless, Natalia travels around the country offering 'human development' seminars emphasizing "love, liberty, and self-esteem"; she works at schools, clinics, and with domestic violence campaigns, attempting to replace so-called 'cultural' ideas and practices with (putatively 'acultural') ideas and practices conducive to the attainment of mental health.

Like other practitioners, Natalia's endeavor is much grander than simply providing effective services. Rather, to transcend the 'cultural problems' this section has outlined, Natalia and other practitioners are actively attempting to enact cultural change by promoting a sort of 'emotional modernization.' Psychological education, or *psicoeducación*, is central to this project.

PSICOEDUCACIÓN

Psicoeducación technically refers to what the Mexican government defines as "the process of acquiring abilities and conduct that permit the patient, his or her family, and the society to confront the obstacles that mental illness generates, making use of information which permit them a better understanding of the mental illness and its consequences" (Gobierno Federal 2010: 1). The General Health Law, or *Ley General de Salud*, says that the federal government must promote and support the development of "socio-educational activities and the dissemination of the guidelines for the promotion of mental health"; thus, such dissemination is an explicit part of Oaxaca's Health Ministry's (SSO) activities. Although *psicoeducación* is, by its strict definition, geared toward the mentally ill and their families, in practice it encompasses a much broader swath of activities, discourses, and ideologies, as we will see.

To promote 'mental health' practices and attempt to dispel 'cultural' notions, mental health practitioners provide *psicoeducación* in local media, health institutions, development initiatives, schools, churches, and clinical practice. One of the basic goals of these efforts is to de-stigmatize and normalize mental health care, to portray it as just as important as any other type of care, and to encourage Oaxacans to seek services. As Jorge Díaz from SSO Huajuapan explains it,

> We have to figure out which way to best educate people. It's been very difficult to introduce people to all these services, and there are still paradigms around, 'if I go to the psychologist it's because I'm crazy'…Going to the psychologist is something else. It's checking emotional and mental health like going to the dentist, like a physical examination for the stomach or some other part of the body. But we neglect our emotional sides. I think there are still taboos where

> people have, um, well, it's true, they have a certain [attitude toward] going to the psychologist.

Because of this 'attitude'—which, again, is discursively linked to the 'culture of resistance' described above—practitioners and programs must explicitly re-educate community members. At the psychiatric hospital, *psicoeducación* takes place with patients and with their family members when they come to visit. As I discuss in Chapter 7, the psychiatric hospital regularly displays educational posters about particular mental illnesses and medications, and both psychiatrists and psychologists there dedicate as much time as possible to such educational efforts.

Psicoeduación projects were also pervasive outside of the clinical context, in both private and public sectors. Public health workers paint educational murals on walls about the functions of a psychologist, just as they paint murals about the flu, hand-washing, and vaccines (see Figure 5.1).



Figure 5.1: Services a Psychologist Can Provide, mural in Teotitlán del Valle [*"Give talks to parents as well as any group of people who ask for help; Support adolescents in choosing future studies; Support teachers of various types, [provide] information about problems that come up commonly in the student community; Work with adolescents in workshops so they have spaces to socialize with peers in a healthy environment; Principal objective: provide help to the whole community in matters of health, collective collaboration for the benefit of the community."*]

Oportunidades, Mexico's cash-transfer poverty alleviation program, requires health 'chats' (*pláticas*), which are sometimes about the function of mental health services, the definitions of various mental illnesses, and the proper expression of emotions. Psychologists give well-advertised talks at schools, community centers, and churches on these topics.



Figure 5.2: Encuentro Familiar, La Merced

Figure 5.2 depicts a poster for a free family get-together, or *encuentro,* at a well-known church in Oaxaca City, La Merced. At the top, the poster says "Health isn't pleasure or pain, but physical, mental, and emotional well-being." The adult event was themed "Quality of Life" and conducted by a practitioner of Chinese medicine and Acupuncture, while the adolescent and children's event was "Living my Personal Liberty," conducted by a psychologist from Puebla (the La Merced *encuentros* also frequently featured local psychologists). (The members of the pictured family are all wearing clown noses.) As I discussed in the previous chapter, some psychiatrists even go on local TV and radio to discuss mental health and provide *psicoeducación.* They write columns in newspapers and advertise through leaflets and posters displayed on street corners and on their office walls.

One need not suffer mental health problems to receive *psicoeducación;* rather, these lessons are thought to be applicable to everyone. Similarly, mental health services

are not only for cases of emotional distress or mental illness, but are to be utilized for general self-maintenance, like dentistry. Implicit to these efforts is the view that Oaxacans do not naturally know how to recognize emotions, express them, take care of their mental health, or seek appropriate services when they have mental health problems. Thus there is a great need for so-called "awareness-building" or "creating consciousness" [*concientizar, crear conciencia*] and for dissemination of mental health information. By taking on the role of teachers, practitioners hope their efforts will 'diffuse' [*difundir*] and become internalized on a subjective level.

Managing Emotions

As part of SSO's program for adolescent leaders, *Grupos de Adolescentes Promotores de la Salud* (Adolescent Health Promotion Groups, or GAPS), public health workers train young people to detect and prevent mental health problems, as well as to "manage emotions and feelings," as one of the program's educational flyers put it (see Figure 5.3).



Figure 5.3: GAPS Flyer on Emotional Health

The flyer explains to adolescents that "emotional health is the balance in which we feel good with ourselves and with others. It complements a healthy and active life. It consists of learning and recognizing our emotions and developing behavior which helps us express them. The management of emotions and feelings is a fundamental part of emotional health." The flyer urges adolescents to ask themselves how they are feeling:

> Have you had days in which your emotions are like a rollercoaster? Do you suddenly feel very happy, then something makes you sad, then you quickly feel happy again? Our state of mind can be very affected by hormones, pressure from our parents and at school; if we suffer these changes frequently and for prolonged periods of time, we can even develop physical illnesses.

Although the flyer says there is no "magic recipe" for emotional health and for preventing stress, anxiety, depression, and anger, it does recommend specific steps: "Express feelings and desires; the consequences aren't usually as serious as we suppose"; "Talk to your parents or friends when you don't feel well emotionally"; "In the face of a crisis or a problem, don't be guided by your emotions." In sum, the flyer concludes,

> You're in charge. Sometimes we're taught that crying isn't good, or that laughter is shameful…but repressing the expression of our emotions only creates confusion and inability to manage situations which arise for us. Find a way to unburden your feelings. Don't keep them inside; it's not healthy. You have control over your emotions, your life, and your decisions.

As the GAPS flyer shows, *psicoeducación* efforts do not stop at promoting mental health services as a legitimate form of care. Rather, they explicitly promote the practices and ideologies around 'mental health' shown in Table 5.2, which themselves are consistent with the globalizing notions of health, self, and sentiment I presented in the previous chapter. Centered on teaching teenagers self-exploration, self-expression, and self-control, the GAPS program promotes a view of selves as both agentive and able to attain empowerment and freedom, on the one hand, but vulnerable to emotional imbalance, on the other.

The excerpt from my interview with Lara Hernández above (page 196) also reveals the ways in which practitioners promote these ideas and practices in the clinical setting. In her work with indigenous girls in the city for their educational grants as well as in her private practice with Oaxaca City-based patients, Lara teaches patients to identify emotions, to value them as legitimate and worthy of expression, and to express them using a particular language of affect. Her practices are based on a blend of Gestalt

psychotherapy, 'Holding Therapy' (known in Spanish as *Terapia de Contención*) as developed by Czechoslovakian psychologist Jirina Prekop, and more general psychotherapy. She describes her approach as one which is

> very much about feelings—not so much about how to understand things with the head, but the ways the body speaks to you. Like if there's a sensation here, or a sensation there, what messages is it sending you? To the extent that you allow feelings to flow, things begin to fall into place. So it's important to understand things, but above all it's important to let yourself *feel* more and be more aware. Like, 'how do I feel here?' or 'how do I feel with him?' 'What happens when I do this?' 'What scares me?' 'How do I manage it?' It's a long process in which [patients] begin to become more [emotionally] flexible.

Psicoeducación in Lara's case consists of explicitly cultivating these globalizing ideas of emotional and mental health in her patients. They are taught to explore and inspect their inner selves and emotions, to express what they find there. In the process, they are shedding harmful 'cultural' beliefs and habits, building self-esteem, and ostensibly becoming 'empowered.'

Sacando Sentimientos

Interestingly, several *curanderos* I interviewed reported that they too explicitly promoted emotional expression and management. Miguel Carrasco, a *curandero* working with a community health organization which blends various approaches to health (this was, along with the *Centro de Medicina Tradicional* in Calpulalpam, a rare instance of blending between traditional medicine and biomedicine), said that their organization provided

> a series of *pláticas* about what depression is, sadness, grief, crying. Why violence? Why insults? Why all this aggression? And once [the community members] had all this information they got involved, because they were saying

> things like 'In my community, what I've seen is that there's a lot of aggression,' 'what I see is that there's sadness, there's pain.' We did many reflective exercises, and once you do those they start to feel—not just talk, but rather to feel and get emotions out.

In these group sessions, which the organization provided in 25 different communities throughout the state, they focused on the management of emotions,

> because we saw that people were very reserved, very serious, very inhibited…we saw that there was so much feeling, so much pain from questions of migration, questions of illness, questions of poverty, questions of neglect, and in some cases, rape and violence…Part of the work was to teach people to be able to get their feelings out [*hacerle sacar a ellos a sus sentimientos*]. They would sometimes tell stories, very sad stories, which would then awaken these emotions and which would then make them cry. Sometimes we would do socio-dramas which represented difficult things, tough life problems. Or on the other hand, sometimes there would be a good deal of laughter…These exercises were complicated and really difficult to handle, but they led to really nice results. Because we got everyone to become sincere, get their emotions out, and cry. They didn't just talk—they yelled, they expressed themselves, they cried.

The most important aspect of these sessions, according to Miguel, was how people learned to 'not just talk' about emotions, but to truly 'feel' them and get them out in the open. Unlike other practitioners, though, Miguel did not juxtapose these practices with cultural practices or attribute lack of emotional expression to 'culture'; rather, he invokes social problems like migration, poverty, and violence to explain why people are in pain and to justify the need for them to express their pain. Nor are mental health practices opposed to 'cultural' or 'traditional' practices in Miguel's account. Their program uses sweatbaths, *limpias,* and massages as "techniques" or "tools," as Miguel put it, for accessing self and emotions. After the sessions, members Miguel says you feel "completely liberated—you feel like a new person."

Acceso al Mundo de la Persona

Psicoeducación efforts are, from practitioners' perspective, having an effect. Psychologists and psychiatrists generally express that there has been more 'opening' [*apertura*] because of *psicoeduación* and other aspects of modernization more generally, like media exposure, more universities and high schools offering courses in psychology, and new roads:

> Adriana García: You could say there's been a lot of 'marketing' [uses English term, as is often done in the case of 'marketing'] around psychology, and now it's normal that people choose it as a career...it can give you a future. But before, people didn't see it this way; [they thought] psychologists don't do anything but listen…psychologists don't help with anything, you know? They just sit and do nothing. But now with all the publicity people have realized that a psychologist is something else—it's not what people thought…Universities [have advertised] that they have programs and give certificates and everything, but it's also media, right? Television has helped us with that social opening [*apertura social*]. There's now all these programs which have psychologists in them, they put a segment in about psychology, and people start to say, 'Oh, there's a field of mental health.' We focus so much on physical health, that our glucose is fine, that our blood pressure is fine, but the mind is very powerful and it's necessary to have it in a good state.
>
> José Luiz Armiento: Before, Oaxaca was very closed to the exterior. I don't know if you know, but before, it was really difficult to get to Oaxaca. Until about 15 years ago, the highway was really bad, and the culture remained very closed. I think little by little it has opened. There's more…it's homogenizing with the rest of Mexican and American culture.

Some practitioners also mentioned the importance of the local clinics offering courses for professionals, like the Centro Humanista described in Chapter 2. Such programs train dozens of people every year who may not work as individual counselors, but who integrate psychological concepts and practices into whatever work they do (like organizing group therapy sessions in offices or emotional expression workshops in

development projects), thus disseminating psychological knowledge and technologies of the self—and contributing to the general '*apertura social'* around emotional and mental health.

Thus, despite ongoing resistance, overall practitioners seem to believe that Oaxacans have become more expressive and more willing to access services whether or not they see themselves as ill. As *psicoeducación* begins to permeate and become part of commonsense reality, traditional notions of constraint, inhibition, and privacy begin to relax and provide more 'access to the world of the person,' as Dr. Marian Pérez puts it:

> There's been a global increase in psychological support—psychiatric support is different—in a population like the Oaxacan one, where we are so influenced by our traditions and customs, it used to be that you had to keep everything that happened within the family…This has started to open up…both psychology and psychiatry have created greater access to the world of the person [*mayor acceso al mundo de la persona*].

EMOTIONAL MODERNIZATION AND THE CREATION OF SUBJECTIVITIES

Liberation and its Limits

In his discussion of the 'genealogy of subjectification,' Nikolas Rose argues that the regime of the self has not emerged as a *consequence* of modernity or late modernity or as an outcome of historical events. Rather, particular "[d]evices of 'meaning production'…*produce* experience; they are not themselves *produced* by experience" (1996: 25). The 'regime of the self,' in other words, itself helps produce particular experiences of modernity and subjects who are commensurable with 'modern' moralities. Mental health practice in Oaxaca is, I contend, a 'device of meaning production' which not only provides means of self-understanding and technologies for self-cultivation in the

context *of* modernity, but which actively seeks to produce the psychological conditions *for* modernity itself.

As I have argued, practitioners seek to make these meanings part of Oaxacans' commonsense realities: their embodied, phenomenological ways of being, acting, and speaking. This project of emotional modernization attempts to cultivate subjects who disavow harmful 'cultural' practices and ideologies and—through a range of possible therapeutic interventions and technologies—replace them with putatively salubrious practices and ideologies around mental health. Put another way, mental health practitioners seek to create the types of people who will not think in 'magical,' 'cultural' terms but in psychological and psychiatric terms; who express and manage their emotions instead of repressing them; who take their medications, seek out therapy, and agentively engage in the creation of their own liberation and empowerment. Oaxacan mental health practitioners aggressively promote *psicoeducación* and emotional modernization not because they seek to exercise power or subjugate the population in any intentional or malicious sense, but because such ideologies and practices are viewed as vital to well-being and the alleviation of suffering. The orientations toward and technologies of the self practitioners teach and encourage are thought to be emancipatory, not constraining.[9]

However, if we understand government in the Foucaultian sense of the "more or less rationalized programs, strategies and tactics for the 'conduct of conduct,' for acting

[9] As in Good's 2010 account of Indonesian psychiatrists, Oaxacan practitioners are "drawn into the pharmaceutical world"—and the world of biosociality more generally—"in terms of advancing modernity" (Good 2010: 130, c.f. Ferzacca 2001; Williams 1973, 1977); however, the nostalgia for a "mystical world of the past" past is largely lacking in their discourse. Interestingly and as I will discuss in Chapter 8, nostalgia does seem to characterize their perceptions of moral decline due to migration processes. However, very few mental health practitioners expressed any desire to work with *curanderos* or to revitalize any aspect of traditional Oaxacan healing.

upon the actions of others in order to achieve certain ends…all those multitudinous programs, proposals, and policies that have attempted to shape the conduct of individuals" (Rose 1996: 12), the ways in which mental health practice composes an aspect of governmentality and subjectification become clearer. Even though—and perhaps because—the subjects it seeks to create are those poised to pursue liberty and self-realization, psy disciplines inherently exercise power over those to whom they are exposed. They help to create and reproduce the kinds of subjects who see themselves as vulnerable to emotional and chemical balances but who at the same time 'take responsibility,' unburden and manage their emotions, and who are engaged in ongoing projects of self-transformation with the ultimate goal of freedom, autonomy, and empowerment. These goals, in turn, are meant to help produce and reproduce the conditions for economic development and democratic governance, as the beginning of this chapter discussed. Empowerment, in a sense, becomes a form of discipline. As Rose puts it, the regulatory role of psy is "not just to control, subdue, discipline, normalize, or reform [individuals], but also to make them more intelligent, wise, happy, virtuous, healthy, productive, docile, enterprising, fulfilled, self-esteeming, empowered, or whatever" (ibid).

In their analysis of 'economies of affect' in two separate 'development' settings (Mexico and Indonesia), Richard and Rudnyckyj (2009) demonstrate how particular affective discourses and practice help produce neoliberal subjects—laborers who are "commensurable with neoliberal norms" and who both positively experience and help to elicit political and economic transformations. The authors show how participants "meet the challenges of globalization"—becoming "responsible, productive and competitive"

employees, in the Indonesian case and becoming effective transnational NGO partners in the Mexican case—through affective practices and discourses (Richard & Rudnyckyj 2009: 60) associated with Rose's concept of advanced liberalism such as individuality, responsibility, and freedom. In their analysis, "people not only experience but also construct global dynamics" in neoliberal contexts (ibid).

Although I am describing a somewhat broader phenomenon in that practitioners attempt to effect the project of emotional modernization not only among 'laboring subjects' but throughout society, Richard and Rudnyckyj's discussion is helpful for understanding the "relationship between structures and sentiments" in Oaxaca (Richard & Rudnyckyj 2009: 57; c.f. Williams 1973, 1977). In the "Democratizing Health Services" section earlier in the chapter, I showed how *psicoeducación* is tied up with national and global imperatives to broaden access to mental healthcare, destigmatize mental illness, and promote multiculturalism—projects which are frequently linked to loans from international organizations like the World Bank and the IMF. In development discourse—and in turn the discourse of much state-provided care—mental health is considered a 'basic human right,' essential to citizens' practice of autonomy and liberty and to their ability to produce 'human capital' in the context of emerging economies. A particular 'economy of affect' emerges not only as a *result* of such modernizing projects, but also as a *means* of making them possible.[10] Globalizing discourses, ideologies, and

[10] Zigon (2011) makes a similar point in his analysis of neoliberal governmentality and morality in a Russian Orthodox church-sponsored drug rehabilitation program in Russia. Zigon views neoliberalism as a "paradoxical form of governance in which government actively creates the conditions within which appropriate kinds of behavior and activity are more easily enacted, and at the same time encourages a radical decentralization of responsibility requiring the institutional and personal cultivation of autonomy and discipline" (Zigon 2011: 12). Although in Zigon's study the Russian Orthodox Church is ostensibly opposed to neoliberal ideologies of morality, its programs unintentionally cultivate the types of subjects who are prepared to live within and even reproduce such ideologies through processes of self-work and

practices around mental health—which promote regimes of self, biosociality, and medicalization—dialectically produce the types of subjects who make 'development' and 'economic freedom' possible in the first place.

However, though many 'psy' patients and patrons in Oaxaca do compose an emerging middle class—which has arguably been made possible by Mexico's gradual 'opening' through neoliberal reforms over the past 30 years—many are poor, disenfranchised, and generally 'left out' of development. Notably, though, while they may have been left out of development, they have not been left out of the expanding 'regime of the self,' which is perceived to apply regardless of socioeconomic status (and certainly regardless of 'culture,' as we have seen). Whether *psicoeducación* comes in the form of *Oportunidades* talks, educational sessions at the psychiatric hospital, or TV programs, many poor Oaxacans are exposed to it. Far from cultivating subjects who might labor successfully and productively in new industries, professions, and modes of capitalist production, emotional modernization in Oaxaca frequently involves attempts to mitigate the ravages of ongoing poverty and unemployment. As several of the practitioners quoted in this chapter suggest, many of the emotions people learn to 'get out' [*sacar*] and express when they unburden themselves [*desahogarse*] revolve around the pain of poverty, migration, violence, and powerlessness.[11]

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responsibilization. Subjects in this context, like in the context I am describing, are encouraged to become empowered and free, on the one hand, but to view themselves according to a particular neoliberal logic and morality, on the other. Thus Zigon underlines the ways in which "the cultivation of responsibility, self-discipline, and self-control, in other words, the cultivation of limits on one's way of being in the world, has become the dominant ethical strategy in much of the world today for living sanely within these possibilities" (ibid: 232).

[11] I will return to these issues as well as the issue of what types of subjects and selves are being produced in subsequent chapters, particularly 6, 7, 8, 10, and the conclusion.

What are the implications of attempting to cultivate liberated, empowered selves through mental health practice in contexts where agency is severely constrained by poverty and a range of destructive forces largely out of people's control? Returning to a quotation from the "Stress and the Management of Emotions" website discussed in the previous chapter, Dr. Ruiz writes that "As long as an individual fails to transform himself, he won't manage to transform anything. To resolve our lives, change the world, and elevate the quality of our existence and that of others, we should know ourselves, become aware of our human potential, and implement it. In a word, wake up." Phrased as a matter of individual volition, 'waking up' and becoming aware of one's own potential—even 'changing the world'—would seem to be simple matters of choice and responsibility. Such a view, widely circulated as part of *psicoeducación,* seems to grossly overestimate the possibility for agency, for "personal power" (*poder personal*, as one workshop in Oaxaca City put it), in communities characterized by various forms of structural violence.

On the other hand, from the psy perspective, mental health discourse, ideology, and practice are meant to alleviate suffering and help create psychological conditions under which people *are capable of* thriving and "living sanely" (Zigon 2011). The thought is that without self-esteem and the language of emotional expression (among the healthy), without the appropriate medication regimen (among the mentally ill), community members would lack the tools to flourish even if they found themselves in circumstances where flourishing were a possibility. Practitioners are daily exposed to expressions of distress, to the grim details of patients' illness narratives confirming the seemingly intractable nature of suffering in the region. Both because of and in spite of

such suffering, practitioners want to provide Oaxacans with the material to imagine 'possible selves' (Parish 2008) through encouraging positive modes of being-in-the-world, emancipatory means of expression, and new forms of meaning-making.[12]

Immodest Claims of Causality

The conflicted role of 'culture' in the clinical ethos complicates what would seem to be a straightforward project of mental health promotion, however, and raises questions about what Paul Farmer calls "immodest claims of causality" in explanations for health disparities among the poor. 'Immodest claims of causality' refer to the tendency to conflate "structural violence and cultural difference"—to interpret health inequalities as the results of cultural difference and cultural beliefs rather than poverty and inequality—which can obscure the social determinants of illness and wind up shifting blame to those who are victimized by such structures to begin with (Farmer 1999: 23; Hirsch 2003; Holmes 2006, 2007; Hunt and de Voogd 2005; Martínez 2005; Castañeda 2010; Nichter 2008).[13] Indeed, this tendency has composed one of the most widespread and trenchant critiques of biomedical healthcare and international health efforts in medical anthropology. As Mark Nichter puts it in his *Global Health* textbook targeted toward practitioners and health-care activists,

[12] I return to these issues in the dissertation's conclusion.

[13] In her doctoral dissertation, Konane Martínez (2005) discusses the "clinic-community" divide among in a transnational Mixteco community and shows how both migrants and Oaxaca-based Mixtecos are construed as "irrational social actors" in clinical contexts (xiv). As she writes, "[g]overnments and health care systems in both Mexico and the United States tend to emphasize 'culture' and 'folklore' 'tradition' or 'non-western beliefs' as major 'barriers' to full and effective utilization of opportunities or services provided…the use of the term 'cultural barriers to health care,' as often used by health care professionals, perpetuates structural violence that inhibits a truly community based and informed health care delivery system. It tends to de-emphasize other more determinant barriers such as cost, undocumented status, lack of insurance, and transportation. It allows the organization to blame the patient in the not understanding [*sic*] biomedical treatments, terminology or etiology" (Martínez 2005: 221).

> "We must…be wary of the simplistic and misleading use of health representations in 'cultural barrier'-type explanations for why public health projects have failed or should not be initiated. Such explanations often blame the victim and use culture as a scapegoat for other, more compelling reasons for failure, including poor program planning and implementation, cultural insensitivity on the part of practitioners, an inconsistent supply of resources, poor access to information, and forms of structural (institutional, systemic) violence…Cultural-barrier explanations are commonly based on (mis-)representations of culture as monolithic and the 'local' as both stagnant and somehow juxtaposed to the modern" (Nichter 2008: 7).

Oaxacan mental health practitioners are, as I have mentioned, keenly aware of the monumental social and economic issues their patients face; understandably, they feel quite helpless when it comes to those problems, and emphasize how mental health awareness and services can provide tools to better deal with such adversity. In interviews, psychologists and psychiatrists invariably pointed out that social strife contributed to high rates of mental disorder and demoralization in Oaxaca. However, they also nearly invariably attributed low levels of service utilization, lack of awareness about mental health, and non-compliance with treatment to 'culture' and its concomitant ideologies and practices. It was local 'culture,' therefore, which needed to be changed in order to foster a more global culture of mental health. Why is culture understood as changeable or correctable while poverty and adversity are seen as immutable givens?

Managing Difference

These contradictions reveal the ways in which mental health practice becomes a "key site for managing difference" in contexts of globalization (Ticktin 2011: 150). In Oaxaca, as in many places, 'culture' becomes a proxy for the societal tensions and

polarities which globalization and modernization often seem to intensify. This intensification is perhaps as much a consequence of social changes as it is the discourse of modernity itself, which "produces the very differences that it seems to be about" (Pigg 1996: 163). This is not to deny that culture is, indeed, important in matters of mental health; it undoubtedly is. However, we must critically examine cultural discourses and representations, which themselves produce forms of knowledge, advance and ossify ideological positions (Nichter 2008; de Vries & Nuitjen 2003). Anthropologist Michael Jackson writes that by "reducing the world to simplistic, generalised category oppositions such as Us versus Them," discourses on identity and cultural fundamentalism tend to "become self-perpetuating, and [admit] neither synthesis nor resolution. Always defensive and idealistic—as is all magical thought—it resists empirical test, fearing that the complexity of lived experience will confound its premises" (Jackson 2002: 115). This is a fitting description for the case of professional mental health discourse in Oaxaca, in which category oppositions—which do not necessarily describe any observable differences in reality—are pervasive.

Although in reference to a very different set of processes, Friedman's (2000) discussion of academic approaches to globalization is helpful for understanding such polarization. Critiquing Appadurai's and Hannerz' accounts of transnationalism, Friedman writes that

> The core of transnationalism appears to be a will and desire to transcend boundaries and everything that they represent in the form of closure, locality, confinement, terms that are associated with backwardness, provincialism and curiously a lack of culture, supposedly in the sense of cultivation. This model is one that polarizes the cosmopolitan with respect to the local and defines the former as progressive, as the future of the world, as the civilized while relegating the latter to the barbaric, the red-necked, the reactionary and racist. This polarity

> is not a recent invention, but is very much part of the cosmological structure of the global system. Its historical appearance might be said to be salient in periods when real polarization occurs, when global elites exit in theory and practice from the local and national fields in which they were previously embedded (Friedman 2000: 648).

This analysis can be productively applied to Oaxacan mental health practitioners, as well, who see themselves as distinct from the 'local' and what it stands for. They have not exited from the 'local and national fields in which they were previously embedded'; rather, they are quite embedded by nature of the fact that they are living, working, and offering services in their home state. But, as I have sought to illustrate in this and the prior chapter, they are intimately tied to the global endeavor of promoting mental health through progressive and cosmopolitan means—an endeavor thwarted, in their opinion, by local values and mores. As 'conduits of the global' who are nonetheless practicing locally, practitioners seek not to 'transcend' the local but to change 'culture,' which they associate with 'closure, locality, confinement…backwardness, [and] provincialism.'

'Culture' is thus objectified and 'othered' in the politics of representation emerging from practitioners' struggle with the local (Said 1978). It becomes a scapegoat for behaviors and practices seen as mutually exclusive with the globalizing Euroamerican vision of mental health and with psy imaginaries; as such, 'culture' is viewed as contrary to a powerful 'regime of truth' (Foucault 1980) which determines what composes proper behavior and sentiment, and which is itself tied to broader forms of governmentality. By 'creating consciousness,' promoting *psicoeducación* and 'emotional modernization,' and dedicating themselves to the care of the Oaxacan population, mental health practitioners seek to create the types of subjects who willingly submit themselves to therapeutic authority in the interests of their own liberation.

CHAPTER 6

GENDERED TRAUMA & ITS EFFECTS: DOMESTIC VIOLENCE AND PTSD

INTRODUCTION

This chapter examines the ways in which local and global efforts to detect and deter domestic violence, promote gender equality, and encourage women's empowerment dovetail with Oaxaca's burgeoning mental health sector. During approximately the same period in which mental health services have begun proliferating in Oaxaca, the state has also seen a dramatic growth in women's rights initiatives broadly circulating information around the unacceptability of domestic violence and the necessity of treating both its physical and psychological effects—and more and more people seem to be accessing psychological services to address such 'emotional scars.' If promoting awareness of domestic abuse as unacceptable is a relatively new phenomenon in Oaxaca, connecting it to psychological and emotional aftereffects is even more recent, and represents an important shift of thought.

In this context, 'trauma' and post-traumatic stress disorder (PTSD) are emerging as salient means of interpreting social and political disturbances, albeit unevenly and in ways structured by local orientations toward particular types of violence. Curiously, while migration and political conflict are framed as both violent and extraordinary enough to occasion PTSD, domestic abuse is represented as a ubiquitous "cultural problem" too ingrained and ordinary to generate the disorder—despite the widespread anti-gender violence campaigns. Among mental health professionals, trauma resulting

from domestic violence is thought to contribute to a spectrum of disorders, most commonly depression, anxiety, and personality disorders—but not PTSD.

The disparity between clinical practice and broader discourse on domestic and gender violence is surprising in light of the fact that diagnostic criteria for the types of trauma which may contribute to PTSD has broadened significantly in recent years.[1] As McNally (2003, 2009) and others have pointed out, this diagnostic "bracket creep" has created a clinical ethos in which virtually any stressor is considered capable of generating the disorder.[2] No longer is PTSD particular to victims and witnesses of extreme violence (e.g. war veterans, sufferers of torture, and victims of rape); now, the diagnosis is applied to 'traumas' resulting from events such as fender-benders, overhearing sexual jokes in the workplace, and seeing violent events depicted on television (McNally 2003, 2009). Domestic violence-related trauma has long been thought to contribute to PTSD; in fact, as Fassin & Rechtman (2009) and others have pointed out, the diagnosis came about through the convergence of social movements advocating for veterans and female victims of violence.[3] Given that domestic violence has been central to the development of PTSD as a diagnosis, that campaigns to eradicate domestic violence and emphasize the

[1] PTSD is defined by the *DSM-IV-TR* as an anxiety disorder thought to be caused by exposure to traumatic events which evoke 'intense fear, helplessness, or horror' (*DSM-IV-TR,* APA 2000). The diagnosis requires the presence of symptoms from three symptom clusters: re-experiencing (through recollections, nightmares, flashbacks, etc.); avoidance (including avoiding thoughts related to the stressor, 'detachment from others,' loss of memory around the event, 'restricted range of affect,' and others); and hyperarousal (problems with sleep, irritability, hypervigilance, etc.) (APA 2000).

[2] Metzl (2010) also uses the concept of 'diagnostic bracket creep' as conceptualized by feminist theorist Jacquelyn Zita (1998; c.f. Kramer 1993) to discuss the gendered process wherein "demand, supply, and desire for [psychiatric] drugs conspire to expand diagnostic boundaries relentlessly outward, creating an ever-growing set of indications for an ever-widening set of psychiatric illnesses" (Metzl 2010: 145).

[3] Additionally, there is ongoing debate about whether the traumatic effects of domestic violence and other forms of repeated and chronic abuse may even lead to a distinct form of the disorder, known as "complex PTSD" or DESNOS (Disorders of Extreme Stress, not Otherwise Specified), "an expanded set of symptoms hypothesized to better capture the phenomenology of the trauma response in highly traumatized populations" (Hinton & Lewis-Fernández 2010, c.f. Herman 1992b).

emotionally traumatic effects of abuse are widespread in Oaxaca, and that diagnoses for other disorders have been increasing rapidly in the state, the fact that PTSD is rarely applied in cases of domestic violence in this setting is especially striking.

Focusing on professional and lay understandings of trauma, this chapter examines several separate but interrelated processes. The first section shows how domestic and gender violence have come to the fore in Oaxaca through global and local campaigns and how they have become an important aspect of clinical psychological and psychiatric practice. I argue that particular notions of 'culture' are mobilized in this process, contributing to representations of violence as culturally sanctioned and experientially mundane. The subsequent section examines how such representations contrast with representations of other types of violence and play into the local clinical ethos of PTSD. Rather than "bracket creep," a "bracket narrowing" has taken place—one which highlights the roles of culture, gender, and structural violence in the experience and treatment of trauma-related disorder. The final section of the chapter presents case studies from the Oaxacan psychiatric hospital which illustrate the forgoing processes and highlight the role of trauma and the work of diagnoses in women's narratives. Put together, these processes show how, in the local incorporation of globalized discourses and psychiatric categories, cultural conceptions of violence and gender circumscribe professional and popular interpretations of distress.

GENDER & DOMESTIC VIOLENCE IN OAXACA

'It Marks You'

Although urban assaults, political violence, and drug-related violence are important sources of insecurity in Oaxaca, a large part of the state's perceived violence problem stems from its extremely high indices of domestic abuse and gender violence, a problem which has garnered a good deal of attention in recent years. Carmen, a 56 year-old Oaxacan housekeeper and mother of three living in Oaxaca City, remembers when she began hearing talk of about domestic violence in Oaxaca for the first time. Fifteen years ago, she assumed it was a normal aspect of life, that it was "a man's right…to hit me, to tell me I'm worthless, to be neglectful." She elaborated:

> I never noticed I was living violence, you know? Because many times, for example, my father would say, 'You have everything you need, don't you? You don't lack anything, you have food and a roof and—your husband, who cares? He doesn't show up? He'll show up sometime.' When he disappeared or when my father knew that he was with some other woman—no, there's no problem. 'You're his wife, you're in your house.' These things traumatize you even if you think—you say everything is fine. You think things are fine, but throughout your life it marks you, and when you finally manage to understand the emotional damage it's caused, lives are completely destroyed. So it's important what's happening now, that there are organizations and groups that can help.

Carmen's perception of gender inequality was formed long before she was married: her mother became pregnant with Carmen after being raped while her husband was in jail on false murder charges, and since Carmen was technically illegitimate, her mother did not insist that she have the same rights as her older half-siblings. She worked from a young age and did not begin school until she was ten, then made it through the sixth grade before her parents could no longer afford her education. At 16, they insisted she marry a friend of hers with whom they thought she was carrying on. By 18 she had her first daughter, and while her husband continued going out drinking and pursuing other women, Carmen assumed full responsibility for the home and family. "I started to

see that I had a responsibility to take care of both my husband and my daughter…I never thought I could leave and fight in my life for *me*, because I was told that this is what you have to do: live like this, raise a family."

Carmen did just that, until about ten years ago her husband fell ill and was diagnosed with HIV. "They told me I had to take a test, too," Carmen said, "but I didn't know anything about the virus then. I said, 'No, not me! I'm religious—all I do is spend time with my children at home. I couldn't have it.'" Now Carmen spends a great deal of her time and energy on her own treatment, which often requires full-day trips out to the state-run HIV clinic. Despite her upbeat and energetic personality, she expresses feeling trapped in her marriage and stigmatized by many people in her church and community. Recently, Carmen has begun to think of these experiences as types of 'violence' which have, through the years, 'traumatized' her and contributed to feelings of isolation, anger, helplessness, vulnerability, and low self-esteem.

Carmen explained that there was very little attention paid to the problem of gender violence before, but as we drove by a billboard painted with the slogan "A Life Without Violence Against Women" advertising a 1-800 violence help line, she marveled at the changes she had seen in Oaxaca's recent history. Her understandings of violence have shifted dramatically over the years in conjunction with statewide and global efforts to detect and deter violence, promote gender equality and 'empowerment,' and to bolster development—efforts which have contributed to a profusion of initiatives and organizations focused on these objectives in Oaxaca (and Mexico more generally) during

the last decade or so.[4] There, as in many other places, governmental public health efforts, NGOs, human rights and feminist organizations, churches, and mental health clinics explicitly attempt to define violence, educate the population about it, and encourage victims to seek services for support.

In this context, women's experience of both physical and psychological violence is increasingly talked about, dealt with in psychological therapy, and connected with traumatic emotional aftereffects. For Carmen, the explicit links between her own experience, violence, and trauma have emerged in the course of group and individual therapy at the HIV clinic. There, the psychologist focuses on identifying the traumas each woman has suffered and on 'getting them out'—verbalizing, processing, and expressing them physically:

> [The psychologist] tells us that we need to work on these traumas; for example, there are exercises, there are therapies to get them out, get all of them out, talk about them…She did one exercise where we hit something, to get it out, get out everything…We have to first identify the problem…to be able to work on it, because a lot of the time we unconsciously carry this problem and therefore we don't overcome it, you know? And then you just keep living the same way…The doctor starts to say now that it's happened, there's no other solution, I can't stay in the same place, so the thing is working it to overcome it—to erase it so that we can be healthy, have a better quality of life, and to consider ourselves important, to build some self-esteem. To get it out, to clean the mind. But it's not easy, it's not easy to do it. Rather, it's a long process…

The psychologist teaches women that 'traumas' may be present whether or not they are identified or experienced as such; if gone unrecognized, they may cause emotional and psychological problems over the years. As Carmen put it, "living violence" can "mark

[4] The UN's Millennium Development Goals, for example, explicitly target gender equality and women's empowerment as means to economic development. For discussions and critiques of female-focused development models, see Kabeer (1999) and Worthen (2011).

you." Understood to be pathogenic in this way, the traumatic effects of violence must be brought to consciousness, expressed, and 'overcome' in psychological therapy.

This understanding of violence and trauma is quite new for Oaxaca, where the general perception among both professionals and laypeople is that violence has historically been an assumed condition of women's existence which ought to be accepted with forbearance. The remainder of this section will discuss how gender violence and trauma have emerged as matters of both public and clinical concern, and how particular 'cultural tropes' around *machismo* and women's experience have been employed in this process.

Local Gender Violence Initiatives

Although these changes have taken place gradually, in the past several years the issue of domestic and gender violence has become markedly more visible in the media, legislation, and political decision-making. This is likely due to the growing national and international attention to the issue combined with improved detection and local increase in mental health services and psychological interventions, as discussed below. According to various national and statewide surveys and institutional staff members interviewed for the present study, anywhere between 40 to 80 percent of Oaxacan women have experienced some type of 'gender violence,' including psychological/emotional, physical violence, sexual violence, property violence, and economic violence.[5]

[5] These types of violence are defined differently depending on the institution. One of the more concise definitions comes from the federal Special Prosecutor for Crimes of Violence against Women and Human Trafficking (*Fiscalia Especial para los Delitos de Violencia contra las Mujeres y Trata de Personas*, known as 'fevimtra.' According to them, psychological violence exists "when someone says or does things that can make you sad, isolate you, affect your self-esteem, make you feel fear or wish to die, with insults,

Oaxaca's general institutional definition of 'gender violence' as "any gender-based action or conduct that causes death, injury, or physical, sexual, or psychological suffering in the public or private sphere" originated at the 1994 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women "Belém do Pará" in Brazil, organized by the Organization of American States. Although in 1998 Mexico ratified the Convention covenant and began enacting domestic violence-related reforms soon thereafter, Mexico did not pass the "General Law on Women's Access to a Life Free of Violence" drawn up at the Convention until 2007, and Oaxaca did not pass it until February, 2009, the penultimate Mexican state to do so. The passage seems to be contributing to increased attention to gender violence, equality, and human rights on an institutional level in the state.[6]

The Oaxacan Women's Institute (*Instituto de la Mujer Oaxaqueña*, heretofore referred to as the IMO) is one of the most visible of these establishments. Founded in 1998 as part of Mexico's National Women's Institute, the IMO seeks to eradicate discrimination against women, promote a gender perspective in all entities of public

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threats, or by ignoring you." Physical violence is present "when someone uses physical force, a weapon, or any object to injure you, not only with by hitting, but by pushing you, pulling you, or pinching you, among other [aggressions]." Sexual violence occurs when "you are degraded or when your body or sexuality is harmed; for example, being touched without your consent, forced to have sexual relations, or being subjected to offensive sexual words or signals." 'Violencia patrimonial,' or 'property violence,' occurs when your belongings or those of your family are damaged or stolen. And economic violence occurs when your income is controlled or denied or when you are paid less than a man for the same type of work.

[6] Wagner (2003) provides a summary of many of the domestic violence-related initiatives, organizations, and legal reforms that have emerged over the course of the past 40 years in Mexico, beginning Mexico City-based women's NGOs and feminist groups in the 1970s and 1980s. Programs like the Intra-Family Violence Assistance Center (CAVI) and the Grupo-Plural Pro-Victimas in Mexico City were established in 1990, and legal reforms have been enacted sporadically in all of Mexico's states since the 1994 "Belem do Pará" convention. Desjarlais et al. (1995) also note growing institutional attention to the issue of sexual and domestic violence in Mexico City; in the years since their volume was published, those initiatives spread to southern states like Oaxaca, particularly Oaxaca City but more and more in its rural regions, as well.

administration, and thus promote equality among men and women.[7] As part of the General Law on Women's Access to a Life Free of Violence, the IMO founded its Center for Attention to Female Victims of Gender Violence in Oaxaca City in 2008. The Center provides psychological, medical, and legal help for women who have suffered any type of gender violence, including a shelter for severely battered women. It has several doctors, psychologists, health promoters, social workers, and lawyers on staff, as well as a 24-hour hotline.

As discussed in Chapter 2, Oaxaca's Ministry of Health (SSO) also has a number of departments and programs throughout the state aimed at prevention and treatment of violence. They recently created a Prevention and Attention to Domestic Violence and Gender Department and a Specialized Center for Prevention and Attention to Domestic and Gender violence, which also offer educational sessions and staff hospitals and health clinics with people trained to deal with victims of violence. *Oportunidades*, Mexico's notorious cash-transfer development program providing stipends to women who attend health sessions and checkups, also organizes talks on violence at public community health centers.

The Cultural Trope of Violence

One of the main goals of these programs is to stimulate cultural change in Oaxaca. As Dr. Villareal, former director of the IMO's Center for Attention to Female Victims of Gender Violence, told me, the IMO is explicitly trying to alter the "cultural structure" of Oaxaca by bringing violence to public consciousness in all its forms "after

[7] http://www.imo.gob.mx/mision.html

so many years of cultural practices rendering it invisible, something normal, something commonplace, something acceptable." The theory that domestic violence is cultural is typical in both everyday talk and in the more pointed discourse of Oaxaca's anti-violence campaigns. This theory, or 'cultural trope of violence' as I will refer to it, maintains that abuse of women is a ubiquitous, natural, 'invisibilized' (*invisibilizado*) aspect of the traditional ethos that must be 'unlearned.' As such, Oaxacan—and often Mexican or Latino—culture is characterized as male-dominant and chauvinist, or *machista.*

One of the IMO's flyers explains how domestic violence is seen as part of a sociocultural system that says men are naturally superior to women:

> Historically, beliefs, myths, customs, traditions, and values that society and culture have created around women and men, around the feminine and masculine worlds (duties, responsibilities, activities, roles, functions, behavior, dress, ways of being, living, and acting) have determined that men are 'naturally' superior and have given them power over women…who [are] considered naturally inferior.

This flyer is typical of the educational materials disseminated throughout the state. Another, distributed by the federal Special Prosecutor for Crimes of Violence against Women and Human Trafficking ('femitra'), tells women that

> It's likely that you, like many women, are living in violence and you haven't noticed because you have learned that:
>
> - A man is jealous because 'he cares about his woman'
> - He has a right to control us because 'he takes care of us'
> - It's 'normal' that a man insult, threaten, or hit his partner when he's angry
> - Women do things to deserve being hit or mistreated by their partners

These educational materials warn women that violence is not natural but a crime ("violence is a crime" or "*violencia es un delito*" is one of the most publicized slogans, printed on huge billboards, bus stops, and buildings), inform women they have a right to a life free of violence, and incite them to seek help immediately. Often such flyers include self-diagnostic quizzes asking questions whose answers indicate whether a woman is experiencing violence. "Do you feel that your partner is constantly controlling you 'out of love'?" "Does he criticize and humiliate you in public or in private, offer negative opinions about your appearance, the way you are, or the style of your clothing?" "Has he ever hit you with his hands, tugged you, or thrown things at you when angry or when you were discussing something?" A high score on the quiz tells you that you are "living violence" or that your relationship shows "signs of power abuse" (SSO educational materials 2011). Such quizzes are distributed at public clinics and, if a given clinic has staff members trained to detect and treat domestic violence, are often administered as part of female patients' standard appointment schedule.

Fleshed out, the cultural trope of violence maintains that *machismo* both sets the stage for domestic violence by tacitly approving of it or even encouraging it as a man's right, and also causes it to be perceived as a natural, taken-for-granted (thus 'invisibilized') aspect of female-male relations. Because violence is taken for granted, the trope posits that women do not know their rights, and so do not recognize that they are being violated; therefore, they do not 'speak out' or have the tools to escape the abusive situations in which they find themselves. This model also suggests that violence is inherited and endemic, in the sense that mothers teach their daughters that violence (including infidelity) is something that cannot be helped and must be endured: "you are

inculcated with the idea that the man rules the house, and if you choose to marry him you have to put up with him," as one psychologist put it. "It is a question of culture." [8]

'A Way of Life'

Although some professionals discuss domestic violence and mistreatment of women as a problem that affects rich and poor, mestizo and indigenous, and that spans education levels, many consider the problem to be worse in rural, indigenous regions, where 'customs' and 'beliefs' are thought to be stronger.[9] Dr. Cardozo, a psychiatrist who has practiced in Oaxaca since 1995, referred to domestic violence and mistreatment of women as "aspects of culture" which are "very, very common in our communities, in the interior regions of the state…and which I see as inadequate but people from [rural regions] are so accustomed to that they see as a part of their lives, as a way of life."[10] This type of observation is characteristic of health practitioners who have treated patients in situations of violence:

[8] In her piece on domestic violence, gender, and sickness in Mexico, Finkler (1997) finds that domestic violence is disturbingly common, but writes that "In Mexico, wife beating is *not* considered "natural," as a husband's, or mate's privilege, despite the fact that by its prevalence a woman may have been exposed to it in her natal family, seeing her father beat her mother: wife beating is uniformly condemned and considered evil. For this reason, this practice in Mexico carries a moral load, resulting in anger and sickness" (Finkler 1997: 1149).

[9] The perception that rural indigenous cultures—particularly the Triqui and the inhabitants of the coastal Mixteca region—are inherently violent is quite widespread in Oaxaca. This view implies that indigenous communities commit a type of 'cultural violence' in which the culture itself "preaches, teaches, admonishes, eggs on, and dulls [people] into seeing exploitation and/or repression"—of women, in this case—"as normal and natural, or not seeing them (particularly not exploitation) at all" (Galtung 1990: 295). By targeting "culture" as culpable for these inequalities, the discourse on gender violence may reproduce historically held stereotypes of indigenous communities as backward, uncivilized, and violent—and ignore the ways in which indigenous communities themselves have been subject to structural violence.

[10] This impression stands in interesting contrast to Oscar Lewis's 1959 observation that *machismo* and its associated practices "is much weaker in rural areas than in the cities and weaker among the lower classes than in the middle and upper classes" (Lewis 1959: 17).

> *Dr. Sánchez, psychiatrist:* We are talking about customs. Oaxaca still conforms to a basic family system in which the man is in charge. I have always said that in the *pueblos* they are crueler than in the city…
>
> *Dr. Esquivel, psychiatrist:* ...in the Mixteca there is still the custom of hitting women—there is mistreatment but now they live it as a custom, it's normal to them, you know? They are behind in this sense. They don't defend their rights—they don't know what that means.
>
> *Natalia, psychologist at IMO:* I always tell them, 'you see, if you have [emotional problems] it's normal, because when you suffer violence you will have those types of symptoms. It's not that you are crazy, it's that you suffered from violence.' We throw out irrational ideas from the first session, try to pull them away from that. Because culturally, if you come from a village in the Sierra [a rural indigenous area], you don't even know what a psychologist is…What's important is that [women] learn the concept of violence and that [they] see that violence is not normal. Because they think it is. Because they've lived it generation after generation, so it's hard for them to understand. I see the blockage, their resistance in the first ten minutes of the first session, but then from there they relax.

Because domestic violence is seen as an essential and invisible aspect of 'culture,' one of the main jobs of anti-domestic violence campaigns is to define violence and make it visible such that women know they are suffering it. As indicated above and in the prior chapter, this involves nothing less than an attempt to effect broad cultural change by creating consciousness and changing everyday practices. Such a project is extraordinarily complex in a place like Oaxaca, with its numerous indigenous groups, dizzying linguistic diversity, and daunting geography.

'Living Violence' & Healing Trauma

To reach Oaxaca's more remote regions, the IMO has a mobile clinic and boasts a visible media presence through billboards, flyers distributed throughout the state, and 30 educational programs and commercials on women's rights aired on radio and television stations in Spanish, Zapotec, Mixtec, and Chinantec. One of their recent campaigns airs a

series of television and radio commercials depicting men not only physically attacking women, but also committing more subtle forms of violence like demeaning their partners, limiting their independence, or withholding money from them. Each of the commercials proclaims the campaign's catchphrase: "This too is violence." Dr. Villareal of the IMO maintained that their success in reaching women was mainly due to these media efforts:

> Many women just recently, through the media—through TV programs and other local diffusion that we are doing as well—they start to realize that what they are living is violence, what they thought was quotidian and normal. That your husband yells at you because the soup isn't hot enough, this is natural. That if the kids aren't bathed and they are crying because you didn't feed them and he hits you, when you're not getting any economic support so that you can feed them in the first place—they see this as something natural. But then violence becomes more visible [through the media] and many women open their eyes and say, 'Ohhhhh, *I'm* living violence!' and they look for somewhere to seek help. They end up here…and I can't resolve their economic problems, but I can support them by offering psychological attention. Empower them so they are self-sufficient and self-determining. From there they start to work and make their own decisions to sustain themselves. They know then that they deserve a life free of violence.

It is here that the convergence between anti-violence gender equality campaigns and Oaxaca's burgeoning field of mental health services is most conspicuous. In addition to de-normalizing, defining, preventing, and removing violence as a taken-for-granted assumption of daily existence, Oaxaca's anti-violence initiatives encourage victims to seek support—medical, legal, and, perhaps most prominently, psychological. As part of their more general work on violence, many of these initiatives explicitly attempt to promulgate understanding of emotional and psychological health: to spread '*psicoeducación.*' Talks and workshops, therefore, often teach the definitions of various psychiatric disorders and discuss topics such as expressing emotions, self-esteem and

empowerment, and the function of psychologists and psychiatrists (I discuss *psicoeducación* in more detail in Chapter 5).

Anti-gender violence campaigns teach about and promote psychological treatment, and for their part, mental health practitioners themselves often either volunteer to work in such campaigns or wind up confronting violence in their private practices. Most psychologists, psychiatrists, counselors, and others working in the context of mental health mention that whether or not patients initially come to their offices because of domestic violence or rape, it is often a part of patients' backgrounds, especially females'. Nearly every mental health practitioner in the current study mentioned domestic violence as one of Oaxaca's main social and mental health problems and said they had routinely encountered the problem among patients in their clinical practices. As I discussed in the prior chapter, although seeking psychological and psychiatric treatment still carries some stigma in Oaxaca, *psicoeducación* efforts—along with exposure to psychological practice and concepts in the media and an increase in practitioners in rural areas—are changing such perceptions. More and more, psychology is thought to be a necessary and helpful form of self-care.

In this vein, 'psychological violence' is reportedly the most common type of violence in Oaxaca, and thousands of women have sought mental healthcare to deal with its effects. The local newspapers *El Imparcial* and *Diario Despertar* reported that in 2008 alone, 2,500 women sought help for psychological violence at the IMO—and this number does not account for the many more who presumably sought help at community clinics, with private practitioners, and with alternative and traditional healers. The IMO's definition of psychological violence is slightly more encompassing than others',

including "any action or omission that harms the emotional stability of women, which can consist of negligence, abandonment, repeated neglect, jealousy, insults, humiliations, devaluations, marginalization, indifference, destructive comparisons, rejection, blackmail, restriction of self-determination, and threats, which lead the victim to depression, isolation, devaluation, annulment of self-esteem, or even to suicide." As such, the meaning of violence itself expands to encompass not only physical abuse, rape, and assault, but also violence that produces psychological and emotional sequelae, or trauma.[11]

Many psychologists and therapists explain that, due to the culture of *machismo*, women are not likely to connect emotional distress with violence, or even to realize that they are emotionally distressed to begin with (thus presenting with psychosomatic ailments). Therefore, therapy often focuses on making this connection explicit and on exploring what impacts the violence has had. This is part of "*sensibilización*" (sensitizing) and "*concientización*" (awareness building). Lidia, a psychologist from Spain who has also worked in El Salvador, said violence against women in Oaxaca is so normalized "it's often difficult to work…to make visible [to patients] that this is a situation of violence they are living, that it is affecting them…that it's not normal."

[11] The concept of a distressing event causing health-related aftereffects itself is not new in Oaxaca: *curanderos* have been treating *espanto* (fright sickness, also known as *susto*) for centuries. The symptoms of *espanto* often resemble those of depression (sadness, desperation, exhaustion or insomnia), and the events leading to *espanto*—at least among the patients and *curanderos* with whom I spoke—tend to include things like fires, natural disasters, falling (especially near a river), being surprised by wild animals (particularly snakes), or witnessing violence. Finkler (1997) presents a case study of a Oaxacan woman in Mexico City who is abused by her husband and returns to Oaxaca for treatment of *espanto*. In my research, however, domestic abuse was never mentioned as a precipitating factor, even when I specifically asked if it could cause the illness. One explanation for this is that treating *espanto* often requires returning to the place the frightening event occurred in order to perform a ritual. To do this in the case of domestic violence could entail identifying the perpetrator, which could invite stigma and gossip—especially in the context of a small village.

Similarly, Roxana, a psychologist at a holistic mental health clinic who focuses on violence, has made concerted efforts to educate institutions (like the SSO) and patients about detection, prevention, and treatment of violence, focusing especially on the emotional base of many physical problems and on the traumatic emotional impacts violence can have. Her perception is that state health services refuse to focus on domestic violence and continue to medicalize women's distress rather than acknowledge that their physical conditions "have to do with masked emotional suffering, at the bottom of which is domestic violence." Both Lidia and Roxana offer group therapy, individual therapy, and educational sessions in rural and urban settings.

Such discourse and practice is, as noted, quite new for Oaxaca, and goes hand-in-hand with more general changes in healing practices and orientations toward emotional experience. As one local psychologist put it, "Fifteen years ago…we didn't associate the experience of domestic violence with the experience of trauma, you know? They were—they were worlds apart." In a very real sense, practitioners are both teaching and treating trauma and recovery in Oaxaca, and their project goes along with a broader mission to effect changes in Oaxacan culture more generally.

PTSD AND THE MEANINGS OF VIOLENCE

'The hand I've been dealt'

Given the extraordinary attention to gender violence and emotional trauma as well as growing rates of diagnosed mental disorder in Oaxaca, one might expect awareness and diagnosis of post-traumatic stress disorder to have shot up considerably in recent years. PTSD's cachet has grown in Oaxacan clinical practice, but not in relation to

domestic or gender violence, and not in popular awareness. Rather, PTSD has come into its own as a diagnosis in Oaxaca's clinical practice almost exclusively due to the perceived traumas of political violence and migration, despite the fact that there are far fewer initiatives, organizations, and programs devoted to these types of violence.

This only occurred to me after having interviewed over a dozen female outpatients at the public psychiatric hospital, Cruz del Sur. Though various psychiatrists at the hospital had told me they increasingly diagnose PTSD in other contexts—suggesting that the diagnosis and its attendant symptoms were, indeed, salient there—during my first months at the outpatient unit I was struck by the fact that none of these women carried the diagnosis despite the violent experiences they had sustained. Rather, the majority were diagnosed with and treated for affective disorders, personality disorders, and mental delays [*retrasos mentales*]. When I inquired as to whether PTSD was ever diagnosed in relation to domestic violence, psychiatrists and psychologists both in and outside of the hospital answered that because it is so chronic in Oaxaca, because it is a part of 'culture,' women do not experience it as a traumatic event that occasions PTSD symptoms as defined by the DSM or the ICD. As one psychiatrist put it, "they don't live it as a posttraumatic stress, because it seems to me that they incorporate it as part of their life structure. They see it like, 'This is the hand I've been dealt.'"

Another psychiatrist explained that traumas generative of PTSD are always extremely violent and unexpected, not quotidian events like domestic violence. She said, "trauma has another meaning. For us, it's an unexpected event in which the person is affected in a sudden, violent way…Violent not in the sense of physical violence precisely, but rather something intense that obviously one can't control…Domestic

violence isn't considered a traumatic event as such, and even less when it's chronic." Unsurprisingly that psychiatrist, like many others, emphasized the necessity of patients presenting the specific characteristics of PTSD symptomatology in order for the diagnosis to be relevant. She explained that in the majority of domestic abuse, childhood rape, and sexual assault cases not treated immediately, the traumatic impacts develop into depression and anxiety.

Several factors are at play here. There are ongoing debates within the broader psychiatric community around what traumatic stressors are capable of causing PTSD, and thus what types of traumas and resultant symptoms make patients eligible for PTSD diagnoses according to the *DSM*, which is currently undergoing revision.[12] As the anthropological literature on PTSD has shown, in practice and according to the particular cultural setting, PTSD privileges some types of violence and traumatic experience while it excludes others (Breslau 2000; James 2004; Salis Gross 2004). This can be understood as a function of the interaction between professional preferences and perceptions, patient symptom reports and ease of expression, and more structural factors regarding what types of trauma merit resources, treatment, and professional attention. What is perceived as ordinary and bearable versus extraordinary and unbearable in a particular cultural setting affects both how individuals experience violence and express its emotional impacts as well as how professionals in that culture conceive of mental health and incorporate ideas about pathological conditions and treatments.

In many documented cases, the perception of a traumatized group of people leads to a huge growth in diagnoses of the disorder (James 2004; Stubbs 2005; Friedman-Peleg

[12] See Hinton & Lewis-Fernández 2010 and McNally 2009 for review and discussion of proposed changes to the PTSD diagnosis in the *DSM-V*.

& Goodman 2010). Not so in Oaxaca. Rather than "bracket creep," wherein the types of traumatic experience considered capable of causing PTSD expand to encompass any number of stressors (McNally 2003, 2009), PTSD in Oaxaca has undergone a type of "bracket narrowing" in relation to domestic violence. Has this happened because—as the ubiquitous 'cultural trope of violence' suggests—women have actually normalized the experience of violence, stress, and shock, such that these cannot be defined "outside the range of normal human experience"—as the *DSM* initially defined traumatic events—and thus would be unlikely to lead to PTSD symptomatology? Have women dissociated to protect themselves against symptoms? Have their traumatic experiences, often left undetected, transformed into other types of illness? Or are the symptoms of PTSD just not salient for Oaxacan women who have experienced situations of violence? These are possibilities, but I theorize that the discrepancy has as much, if not more, to do with local representations of culture and violence and their resultant clinical ethos.

Framing Violence

In everyday discourse, quotidian talk, and the clinical context, political violence, migration, and gender violence are quite differently framed. As discussed above, domestic abuse is represented as a pervasive cultural problem so ingrained it could not possibly occasion PTSD. In contrast, the traumas and stresses of migration and Oaxaca's 2006 political conflicts (described in Chapter 1) are represented as extraordinary, remarkable departures from the normal, moral order of things which frequently result in post-traumatic stress. Numerous mental health practitioners said that not only had

diagnoses of PTSD in relation to these social crises grown in recent years, but that the disorder is underdiagnosed and is likely much more prevalent than most people know.

This is perhaps an unsurprising characterization of the emotional impacts of the 2006 conflicts, which were quite historic and represented the most flagrant violence Oaxaca has seen in recent history. Migration, however, is quite commonplace: at least a quarter of Oaxacan families have one or more migrant family member, and in many towns the majority of males have left for the United States. This is not to downplay the emotional impact of migration, which can be quite severe for both migrants and their non-migrating family members (see Chapters 7, 8, and 9), but to point out that migration is—like domestic violence—quite a pervasive social phenomenon in Oaxaca, and one that has considerable history.

Interestingly, as in talk about gender violence, concepts of 'culture' pervade talk around migration, but in quite a different sense. Mental health practitioners discuss migration as traumatic precisely because it represents an experience of extreme "culture shock":

> *Dr. Sánchez, psychiatrist:* Migrants confront a culture that has nothing to do with what they know, and this is a trauma. It's a disorder that causes them stress and trauma and that confuses them, such that they arrive at a post-traumatic state. And this is in the sense of culture shock—we're not talking about rape, accidents, nothing like that; we're talking about a social phenomenon.

> *Dr. Solís, psychiatrist:* …emigrants are a group that frequently get sick in the United States and they come back to Mexico ill… these are people who go to the US and experience an extreme clash of cultures—imagine, you come from a tiny village and you've never even gone to Oaxaca City or another big city of the type…Suddenly you get to the US and this occasions huge culture shock…And of course in addition, you live in constant stress which adds to the problem of post-traumatic stress disorder.

Whereas gender violence is not considered a trauma capable of generating PTSD because it is experienced as a normal part of culture, then, migration is considered a trauma capable of generating PTSD because it is experienced as a cultural shock. (Psychiatrists also mention 'transcultural psychosis' as a common diagnosis among former migrants.) Whether or not a migrant has a traumatic experience while away, that cultural shock in itself is, in the view of many mental health practitioners, enough to create the conditions necessary for PTSD.

Although people did not regularly discuss the cultural aspects of trauma in relation to the 2006 conflict—except to describe corruption and impunity as intrinsic aspects of Oaxaca's political culture—it is represented as an extraordinary and disturbing departure from the usual.

"Panic," "stress," "fear," "instability," and "trauma" were frequently mentioned in reference to 2006, in addition to the various psychiatric disorders thought to have been generated or exacerbated by the conflicts, particularly PTSD:

> *Paulina, psychologist:* …These are things that aren't spoken about, they're not said, but it impacted us emotionally a great deal, those of us who live in Oaxaca. The situation was so stressful that at six in the evening no one was on the streets because they were afraid of going home, afraid of the barricades.[13] There were moments in which…helicopters passed and when they did, people hid in their houses. Out of fear. It was a situation of panic, of fear, and no institution has dealt with it. So the emotional impacts have remained. That's where we are.
>
> *Jorge, psychologist and activist:* …there is a lot of social violence in Oaxaca, and we have a repressive governor. It generates a totally unstable situation, a feeling of vulnerability...It generates a situation of stress. Many people were tortured, disappeared, many people were assassinated, and this means that there are lots of women in processes of pain, of depression, of anxiety, of post-traumatic stress…

[13] Barricades or '*barricadas'* refer to the roadblocks that different neighborhoods in Oaxaca City erected during the conflict to prevent armed forces from entering. Military forces regularly policed the streets and allegedly broke into people's homes to extract those who were suspected of inciting rebellion.

> *Dr. Gutiérrez, psychiatrist:* 2006 was something terrible and in some ways people have wanted to minimize it, but it was something that impacted the entire population…It was terrible in various senses and was a watershed in the life of Oaxaca. More than anything it modified mental health. People see barricades and they get frightened, alarmed, they enter into panic, and, well, it's us [the mental health practitioners] who have treated it all.

Mental health practitioners say that circumstances recalling the 2006 conflicts regularly inspire panic, anxiety, and desperation in patients—mostly teachers—who were traumatized during those events. Oaxaca has a strong history and current tradition of social protest; sit-in demonstrations, called *plantones,* are frequent in the city center, and roadblocks set up by various protestors are a constant. Teachers' protests and *plantones* are required by the teachers' unions, and psychiatrists mentioned patients with PTSD diagnoses who experience flashbacks and panic attacks when they are called upon to attend.

Dr. Cardozo, who has worked in both private and public psychiatric settings in Oaxaca for nearly two decades, mentioned PTSD caused by the 2006 conflicts as one of the most notable changes in Oaxacan mental health he has witnessed. "We have a psychiatric association and when we got together we saw that all of us had people with post-traumatic stress disorders and panic from the critical [2006] situation," he recalled. The violent events of 2006 account for almost all cases of PTSD Dr. Cardozo has treated, and he notes that since that year the disorder has become "much more notable, much more frequent." Dr. González, an outpatient psychiatrist at Cruz del Sur, echoed Dr. Cardozo's observations:

> I have seen it in consultations, sequelae of this movement in that many people present post-traumatic stress, you see that, or that they reach psychosis…There were people in civilian brigades who were kidnapped, who were killed, police who detained you just out of suspicion. So yes, this has an impact, because the

> fact that someone can grab you out of suspicion, well this implies that you could just disappear, that you could be thrown in jail or that they could accuse you of any type of crime. This impacts the people here, and it's an impact in the sense that many are still in this situation. Therefore they should be in treatment, right? Now there are people who are frightened at the sight of a policeman. This is a sequelae of what happened since the movement—so yes, the movement altered mental health here.

Representations of both migration and 2006 often emphasize shock: the shock of a new culture in the case of migration, and the shock of unexpected, politically motivated brutality and conflict in the case of 2006. The victims of domestic violence, however, are considered to be beyond shock because such violence is expected and culturally sanctioned. Here, from practitioners' viewpoints, women's experience of violence is outside the "impress of extremity" (Jenkins 1996, c.f. Forche 1993).

Structural Violence in the Clinical Ethos

Overall, then, while migration and the 2006 conflicts are frequently portrayed as visible sources of shock, trauma, panic, 'transcultural psychosis,' and PTSD, domestic violence is portrayed as a type of invisibilized and regularized violence which contributes to a range of diffuse symptoms. In a sense, practitioners are calling attention to women's experience of 'structural violence': the historical, economic, political, social, and cultural means by which inequality is reproduced and by which particular groups become systematically marginalized, subjugated, and vulnerable to assaults upon dignity, body, and psyche (see Farmer 1999, 2004, 2005; Galtung 1969, 1990). Indeed, it could be argued that many Oaxacans' lives are constrained by structural violence; as I have discussed elsewhere in the dissertation, Oaxaca is a place characterized by widespread poverty which maps onto ethnicity and indigeneity, where the political process is

frequently corrupt and exclusionary, and where women are particularly marginalized and at disproportionate risk for particular types of assault like rape and domestic abuse. Denouncing structural iniquities against women, some of which are culturally perpetuated, may indicate progressive movement away from such marginalization.

However, these representations have paradoxical consequences. It is precisely the theory that domestic violence is a normalized part of culture, so prevalent as to be invisible, that contributes to an understanding of the distress it causes as too ingrained to be traumatic or to generate PTSD. This view in turn informs the local clinical ethos, in which the traumatic effects of domestic violence are almost uniformly diagnosed as affective and personality disorders. The paradox lies partially in the fact that unlike most diagnoses, PTSD is well known for its political resonance and ability to mobilize resources and draw attention to justice and inequality. Despite its flaws, the diagnosis could plausibly aid rather than impede local efforts to 'visibilize,' detect, prevent, and treat the emotional aftereffects of domestic violence. Instead, the cultural trope of violence contributes to a view of women as so traumatized that they are almost inured to the most pernicious emotional impacts of the trauma they have sustained. As Judith Herman pointed out nearly two decades ago, 'outside the range of usual human experience' is scarcely an accurate description of domestic violence, given its frightening prevalence. But "traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life" (Herman 1992a: 33).

The only broad epidemiological study of PTSD in Oaxaca I have come across, conducted four Mexican states and including over 2500 adults, found that the risk of

PTSD was twice as high in Oaxaca as in the other states studied, and that 20 percent of Oaxacan women met the criteria for the disorder (Norris et al. 2003; Baker et al. 2005). Further, those who had experienced recurrent, sexual, childhood, intimate partner, and family violence were *more* likely to meet the criteria than women reporting other types of violence. The authors note that the "routine stressors of poverty, discrimination, and oppression"—structural violence, essentially—"reduce women's capacities to cope with traumatic stressors" (Baker et al. 2005: 526).

These findings are in line with other studies indicating that powerlessness, marginalization, and insecurity contribute to women's elevated risk of developing psychiatric symptoms and illnesses (Brown & Harris 1978; Desjarlais et al. 1995; Patel & Kleinman 2003; Kohrt & Worthman 2009). Overall, current research suggests that far from inuring women to the traumatic emotional and psychological sequelae of violence, chronic partner and family violence can put them at higher risk of PTSD—particularly when those women live in contexts of poverty, inequality, and discrimination, as so many Oaxacans do.

GENDERED TRAUMA AT THE PSYCHIATRIC HOSPITAL

This chapter has thus far examined several processes. First, I showed how gender violence and trauma have emerged as important areas of public and clinical concern in Oaxaca and how particular cultural tropes of violence are mobilized in that process. Second, I considered the differential use of PTSD in reference to particular types of violence, arguing that popular and professional representations of migration and political violence differ dramatically from representations of domestic violence, and in so doing

circumscribe clinical interpretations of distress. Finally, I will examine how these processes manifest in the treatment of trauma at the psychiatric hospital, and how women themselves talk about the impacts of domestic violence.

Verónica: 'I have a trauma'[14]

Verónica is a 35 year-old woman from a small rural village three hours south of the hospital. Shy and reserved, Verónica wore a threadbare polyester dress that looked as though it may have been her only one. She was accompanied by her husband, Emiliano, who asked permission to enter the room, bowing slightly and removing his large straw hat when walked through the door. The couple described themselves as *campesinos,* or peasants, making a meager living off of a small bit of land they share with other relatives. Both Verónica and Emiliano could read, but neither had studied beyond primary school.

Verónica and Emiliano had been receiving treatment at the hospital for four months at the time of our interview, and both were taking Fluoxetine (Prozac). When I asked what type of problem had caused her to seek treatment, Verónica explained that she had a "trauma" resulting from domestic violence in her household when she was growing up:

> I have a trauma that I bring from my childhood, from when I was a little girl, from fear that my father was going to hit me or that he wanted to…what's it called? He wanted to…rape me. Attempted rape, that's how it was. And I grew up with this. With my family it was pure abuse. His drunkenness and the attempts [of rape], that's how I grew up, with this trauma all my childhood, up to the moment when I came to feel so horrible that I just couldn't go on.

[14] I provide a more in-depth account of Verónica and Emiliano's story in the following chapter.

The couple explained that most of Verónica's seven siblings also suffered from 'trauma,' and that several had even migrated to the United States so as not to have to live near their abusive father. Verónica, however, continued to see her father regularly, and Emiliano explained that after these visits, Verónica's agitation and anger were at their worst. Whether or not she was in direct contact with her father, Verónica reported debilitating symptoms such as intense fear ('*puro miedo*'), sadness, excessive crying, desperation, suspicions that others were trying to harm her, and extreme "insecurity"—both in the sense of feeling unsafe and lacking confidence in herself. She also said her illness had led her to mistreat her children by screaming at them or punishing them unnecessarily because she always felt so desperate, angry, and impatient.

When Verónica told her sister-in-law about some of these experiences, the sister-in-law told her "it could that your mind is sick," and suggested that Verónica seek out a psychologist. At that point, Verónica did not yet know what 'trauma' was, nor did she understand why she felt so badly all the time:

> Verónica:…when I started getting treatment, they told me that I had a trauma. But before that, I just thought it was…it was my life…that that was my way of life, my way of being. I didn't know what I had…
>
> Whitney: So who told you that?
>
> V: The doctor.
>
> W : The doctor in Miahuatlán.
>
> V: Yes.
>
> W : The psychologist?
>
> V: Yes, [she said] 'you have a trauma.'
>
> W: So what did you think when she told you that?

> V: Well, I said—well, according to her that was a trauma, but that name for it—I didn't know about it. I didn't know the name 'trauma.'

Once she learned what it meant, 'trauma' resonated with Verónica as an explanation for her distress. The idea that abuse—rather than personal shortcomings or character defects—was to blame for her suffering provided a narrative to which Verónica could relate and around which she could fashion an understanding of herself and her social situation. She began taking Rivotril (Clonazapam, a benzodiazepine), which provided great relief. "It wasn't until then that I started to control myself," she said. "I went to a much better place. It was a life change…I started being able to walk around talking with my neighbors and didn't feel badly, like I was bothering them. I started to feel more confident and to sense a change."

Once Verónica started to feel better, though, her doctor weaned her off the Rivotril and her symptoms returned. She was told her treatment would be cheaper at the psychiatric hospital, so she went to Cruz del Sur. Meanwhile, Verónica and Emiliano both sought help from an herbalist and a *curandero,* but they said herbal and spiritual remedies were no help. The couple emphasized they needed psychiatric medicines, which go "straight to the central nerve" (see Chapter 7). At Cruz del Sur, the psychiatrist prescribed Prozac, which Verónica said was extremely effective, and diagnosed Verónica with depression and anxiety rather than trauma. Verónica said she did not have a clear understanding of what those diagnoses were, nor did she seem to identify with them (it was unclear whether she told the Cruz del Sur psychiatrist about her childhood abuse). She continued to attribute her problems to trauma caused by her father's abuse.

Flor: 'I feel I have wasted away'

Flor is a 45 year-old woman who was born in Puebla and raised in Veracruz, but has lived in Oaxaca City for 14 years. When I met her at the hospital, Flor was receiving psychiatric treatment in the outpatient unit with a diagnosis of severe depression. Her bearing was reserved, quiet, and sad, and she was quite thin. Unlike most patients, who are accompanied by a family member or partner, Flor waited for her appointment alone, standing rigidly in the waiting area in a leather jacket, clutching a black leather purse.

Though she spoke softly and seemed restrained, when Flor began to tell her story her sadness and desperation were evident. She explained that she had been depressed since she could remember and that she had attempted suicide numerous times throughout her life since the age of 18. Three months before we met, a final suicide attempt led her to seek psychiatric attention for the first time, at which point she was hospitalized for a week. Flor had never heard of depression before her hospitalization, which was prompted by the Unit for Attention to Female Victims of Gender Violence at the *Instituto de la Mujer Oaxaqueña* (IMO). She went to them to seek help for the chronic domestic violence she has suffered since she was a child, and which she sees as the main contributing factor to her mental health problems:

> The problem that has brought me to this strong depression is, my problem has been…family. Domestic violence…I suffered a lot of violence. Physical violence, emotional, I don't know what they call the violence that one suffers when you are harassed—sexual harassment. I suffered violence on the part of my stepfather when I was six, five—six years old. I spent my childhood with him, but with a lot of violence, a lot of aggression, physical, sexual, and emotional. Always—he was someone who made me afraid of many things.

When Flor was 18 she began having convulsions, which her family blamed on hormonal changes but which she now believes were 'nervous crises' (*crisis nerviosas*) caused by her intense desperation and anguish. After a childhood of abuse by her stepfather, Flor married a Oaxacan soldier who was also abusive. She filed for a divorce over eight years ago, but the husband had not granted it at the time of our interview. He was in and out of town for years due to his military obligations, and when he did find himself in Oaxaca with Flor and their two kids, Flor tried to distance herself to avoid his physical attacks and verbal abuse. He told her he would never be the one to leave and that if Flor wanted to separate, she would have to leave him. Finally, she did. At the time of our interview she was living alone, not far from her kids (who are 17 and 23 years old and living together), who Flor said were angry and disapproving of her illness and her decision to leave. Flor's isolation has been devastating.

> So, recently I left my house and now I don't live with my kids, I am living alone because of the problems with my husband. Yes, for threats and all that, I decided to leave my home. I filed a lawsuit against him, but it hasn't been heard. So, as a result of that I have a severe depression. I've tried to commit suicide several times…I've gone way downhill. I have no value to myself or to others. There's no—I'm going through the motions now and I have no reason to be here. I do things just to do them, nothing more, but I don't have a real reason to be here. This is why I come for psychological therapy and psychiatric consultations.

Flor had a negative experience as an inpatient at the hospital—she reported feeling trapped and bothered by the fact that the other women seemed so much sicker than she was; being there seemed an affirmation of the depths of illness she had reached. At the same time, she did not understand why she was discharged, since her symptoms were not controlled and once discharged, she had another 'crisis' in which she stopped eating altogether. At the time we talked she reported that her eating patterns had gotten

better, but overall she said she had not found "psychological or psychiatric control of any kind." Rather, she felt that she had "wasted away."

Much of Flor's story focused around her existential lack of purpose and her lack of self-worth. "Since I was a little girl I have not had an—any esteem for myself," she said. "No. I have really devalued myself as a woman, as a person. I don't feel as though I'm worth anything." This was a theme that Flor was working on with her psychologist at the hospital, who told her that she should value herself as a person and as a woman, and that it is lack of self-esteem and self-worth that has contributed to her depression. Both the psychologist and the psychiatrist emphasized that it would be a long road to recovery, and that Flor would have to work hard to get better by coming to her appointments and taking her medication.

Flor is not typical of outpatients in the sense that she is receiving regular therapy; because of time, distance, and lack of personnel in the hospital, most patients' treatment is confined to medication consultations with the psychiatrists. However, Flor said that the medication helps much more than the therapy—she takes Lexapro (an SSRI for depression and anxiety) and Stilnox (for sleep problems), which she said help to calm and stabilize her. However, they are exorbitantly expensive (over $300 USD a month) and have not assuaged many of her symptoms.

Flor endorsed having recently experienced every item on the Screen for Posttraumatic Stress Symptoms (SPTSS; Carlson 1993) except reliving her traumas, which she said usually only happened in nightmares.[15] She mentioned 'thinking too

[15] For logistical reasons I was only able administer the SPTSS to several patients, and even then the process had to be abbreviated. Therefore, rather than asking participants to tell me how many times they had experienced each symptom in the last week, I asked if they frequently continued to experience them. I

much'; trouble sleeping and eating; nightmares of her husband attacking and hurting her; lack of desire to do anything; inability to keep herself from thinking about bad things that have happened to her; fear, discomfort, and the feeling of being 'absent' when she is around others; anger and irritability; and excessive sweating and heart palpitations. She also mentioned being bothered by a new symptom of 'forgetting things' and becoming disoriented; sometimes, she would find herself walking on the street and not know where she was or where she was going. She asked her psychiatrist if the medications could cause this, but the psychiatrist told her no, that this was a way to allow herself to leave her reality and to keep herself from processing her current and past experience. Flor described herself as feeling "closed, very deep in a hole, dark and where I can't find the exit." She had never heard of PTSD.

Although Flor tries to distract herself by embroidering, exercising, and doing chores (she stopped working as a vendor when her depression became too severe), she said "my head just keeps thinking, thinking things…even if I'm out in the street [doing things] my head just keeps on thinking." Finally, Flor reported a profound sense of loneliness and solitude.

> I feel like I have lost many things, I lost everything…Family, kids, everything, no? I feel completely alone and this brings on my depressions. Sometimes I'm okay and sometimes I wake up with a depression that makes me want nothing to do with the outside world, nothing. I close up inside myself.

Several months after my interview with Flor, Dr. Villareal of the IMO mentioned her as a "success story"—apparently Flor's divorce had been granted, and she had

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therefore do not have scores for the scales I administered, but rather a general sense of post-traumatic stress symptomatology.

become increasingly less isolated from her children. Dr. Villareal said that Flor's diagnosis had been changed by the Cruz del Sur psychiatrist, as well:

> The doctor told her that if she had noticed the violence she was living earlier, maybe her illness would not have become so extreme. She wouldn't have somatized so much and it wouldn't have become chronic—because now she has a personality disorder and bipolar disorder. They explained this to her and she was really angry, saying 'Why? Why I am so sick? Because nobody told me before that the life I was living was going to make me sick? Now I'm going to have to take medicine for life, and now that I know I'm sick what makes me most angry is that I could have avoided this illness altogether.' …Now she's empowered, and though we're not going to be able to get rid of the illness, we can change her attitude.

DISCUSSION & CONCLUSIONS

Verónica and Flor's stories illustrate several of the processes this chapter has described. Like Carmen, whose story I presented at the outset of the chapter, Verónica and Flor's experiences have been shaped by highly visible anti-gender violence campaigns, which seek to make violence visible in all its manifestations and to reshape Oaxacans' thinking about gender relations more generally. Only recently have these women begun to explicitly define their experiences of domestic abuse as 'violence,' and the resultant emotional effects as 'traumas.' Additionally, both Verónica and Flor sought psychological and psychiatric treatment for the traumatic effects of violence in the clinical setting, underlining the convergence between anti-violence initiatives and Oaxaca's growing field of mental health services.

These narratives also reveal the multiple sources of insecurity—and the "gendered effects of insecurity" (James 2008)—in Oaxacan women's lives. In Carmen's case, she was marginalized first through her status as the 'illegitimate' child of a rape and later as an HIV-positive woman. The fact that her mother was raped and that she was infected

with HIV unknowingly by her unfaithful husband speak to the not-so-invisible ways in which violence shapes Carmen's life. Like Flor, she has been subject to verbal and physical abuse from her husband (though less so since they contracted HIV; since then, he has become religious, reduced his drinking, and ceased pursuing extramarital relationships). Like Verónica, Carmen has struggled with poverty and lack of educational opportunity. Verónica was physically and sexually abused by her father and Flor by her stepfather; in Flor's case, that earlier abuse contributed to almost total isolation once she separated from her husband and children, since she was afraid to see her stepfather and thus refused to visit her family in Puebla. Flor and Verónica both describe incapacitating sensations of fear and insecurity, and both attribute all their symptoms to the experience of violence.

Given these factors, it is clear that Carmen, Verónica, and Flor—and perhaps most other women in similar situations—have been subject to an array of violences, including 'structural violence.' However, Verónica and Flor's experiences complicate the cultural trope of violence promoted by the anti-violence campaigns and reinforced by the local clinical ethos. In line with that trope, both women were inculcated with the idea that they should endure abuse from males, and until recently neither of them had a clear means of denouncing it. The visibility of gender violence as a serious societal concern, along with the growing salience of discourse on 'trauma,' contributes to a milieu in which it has been possible for both women to make direct links between violence and its debilitating emotional aftereffects and seek treatment for help with them. But while Verónica and Flor may have considered the domestic violence they suffered as 'part of their life structure,' as Dr. Cardozo put it, they did not express its emotional

consequences as routinized or experientially mundane. Rather, both women found their symptoms—many of which were in line with the specific symptoms necessary for a diagnosis of PTSD— to be highly debilitating and disruptive. While it is important to recognize these women's agency and resilience, it can hardly be argued that they are inured to violence's psychological or emotional effects.

Like many women at the hospital, Verónica and Flor reported great relief from antidepressants and anxiolytics, and expressed profound gratitude to the psychiatrists for kind treatment and an impressive ability to treat their suffering when other professionals and healers had failed them. However, the women's stories also reveal more subtle themes of guilt, responsibility, worthlessness, and anxiety—sometimes about performing their roles as mothers and partners. Unlike the diagnosis of PTSD, which can have the effect of externalizing illness and conferring innocence on victims (Breslau 2004; French 2004), affective and personality disorder diagnoses posit illness as the internal consequence of problematic brain chemistry or unfortunate genes, potentially contributing to gendered feelings of self-blame. Experience of violence and other social factors are of course acknowledged as contributing factors to these disorders, but not in a causal sense, such that the process of diagnosis and treatment can have the effect of obscuring violence and its traumatic effects and subtly shifting responsibility for suffering to the woman. No Oaxacan mental health practitioner would condone domestic violence or disregard its detrimental effects on mental health; however, there is little room in the context of institutional psychiatry to routinely confront domestic violence as a matter of diagnosis, treatment, and prevention.

Interestingly, observations like these have contributed to a distinct sense of anti-psychiatry among many of Oaxaca's psychologists and therapists, both in institutional and private practice. These practitioners frequently critique psychiatry for pathologizing normal and adaptive emotions, for misidentifying the source of patients' problems, and for using diagnoses and medications as shortcuts when what is really needed are explicit actions to change the social situations in which Oaxacans live, like violence. The PTSD diagnosis, they say, cannot capture the essence and meaning of violence in patients' lives, or it ignores particular experiences of violence just because patients do not present with a series of specific symptoms. Although diagnoses of PTSD would not contraindicate therapy and intervention—rather, the presence of the disorder would suggest the need for such actions—psychologists consider the diagnosis a symbol of psychiatry's over-medicalization of human suffering and eschew it *a priori* of patient presentation. Ironically, however, the absence of PTSD as a salient means of interpreting domestic violence-related trauma results in an overreliance upon other diagnoses which arguably pathologize women's distress just as much, if not more, than PTSD would.

We must also consider structural constraints on modes of expression (Jenkins 1991, 1996). In Oaxaca, as in many other places, mental health practitioners are well aware of the fear many female patients experience when faced with the option of denouncing a partner and explicitly attributing suffering to violence on his behalf. Especially in a region where the majority of women have not completed primary school and where a woman's place is widely considered to be the home, the costs of denunciation and full expression of emotional trauma are often considered to be quite high. Secondly, as mentioned earlier and in prior chapters, part of *psicoeducación* in

Oaxaca is the incitement for Oaxacans—particularly women—to recognize and express their emotions, since it is widely thought that they do not know how to do so, and that traditional Oaxacan culture discourages such talk. Indeed, 'expressing feelings,' especially as inner properties of individuals that merit articulation, is a very recent addition to the culture of emotional health in this region.

In this context, the particular constellation of symptoms required for a PTSD diagnosis could be quite difficult for female sufferers of domestic violence to both identify and express. On the other hand, it is also possible that local mental health practitioners themselves have internalized—and explicitly promoted—the belief that a 'culture of violence' inures people to its traumatic effects, thus inhibiting detection of trauma-related symptoms in cases of domestic abuse. It is one thing to emphasize the extremely problematic prevalence of domestic violence in Mexico, to critique the ways in which it is symptomatic of unequal relations between the sexes, and to attempt to change those relations through state and country-wide initiatives and interventions. However, the ways in which such observations are translated to the clinical sphere can obscure the violence women are finally beginning to be able to denounce. Though it is meant to stop 'cultural practices' from silencing distress, the cultural trope of violence may ironically silence it in other ways, by creating expectations and stereotypes, a totalizing vision of women's experience that practitioners themselves use in their own diagnostic processes.

I realize that my argument could be construed as an appeal for more diagnoses of PTSD in cases of domestic violence and abandonment of cultural explanations for violent behavior—which themselves are meant to be part of a feminist critique of *machismo*. However, a spike in diagnoses of PTSD in relation to domestic violence could have

problematic consequences itself, particularly by silencing the important cultural critique that gender violence initiatives attempt to highlight. Although it may have unintended consequences, the heart of that critique is that only through broad cultural change and elimination of inequality can violence be addressed. If the PTSD diagnosis were widespread, it could indicate undue medicalization and problematic de-politicization of gendered violence. At the same time, more than other psychiatric diagnoses, PTSD can provide the opportunity for political and social action while also moving away from "the individual model of responsibility that pathologizes a human response to intensely frightening experiences" (Root 1996: 374), which is ostensibly what the anti-gender violence initiatives—and many mental health practitioners—are working toward.

These processes draw attention to the logic and disjunctures of discourse and practice in rapidly shifting cultures of mental health. Professional practice and institutions are significant because they can act as shapers of culture: whether particular violent events are 'selected' as potentially traumatic in the professional setting can impact local understanding of such phenomena and concepts of self and experience more generally. As such, the fact that PTSD is not utilized in cases of domestic violence in Oaxaca—but is growing in reference to other types of traumatic experience—acts as a weathervane for how violence, trauma, and gender are being negotiated in this setting. While expansion of Euroamerican mental health practice can signify potentially homogenizing discourses, ideologies, and forms of care, it can also be generative of novel social practices and self-understandings.

A version of this chapter is forthcoming in Culture and PTSD*, eds. Devon Hinton and Byron Good, Cornell University Press.*

CHAPTER 7

NARRATING ILLNESS AT THE PSYCHIATRIC HOSPITAL

INTRODUCTION

Based on interviews and observation at Oaxaca's state psychiatric hospital, Cruz del Sur, this chapter discusses how patients negotiate understandings of illness and emotion in the clinical setting. The first part of the chapter provides an ethnographic description of Cruz del Sur, whose outpatient services are regularly overwhelmed by demand from patients hailing from all eight regions of the state as well as other areas of southern Mexico. I move on to describe the characteristics of the outpatient participants in the current study—including their demographic data, help-seeking pathways, principal complaints, illness attributions, perceptions of treatment, and the means by which they have become aware of mental health services—and provide an account of doctor-patient interactions.

The second half of the chapter is composed of a series of six case studies which provide experience-near accounts of distress and elaborate upon explanatory models of illness, treatment-seeking pathways, and experiences of psychiatric treatment. I show that most patients see their afflictions as rooted in social and familial crises, particularly violence and loss, relationship breakdowns, poverty, and migration. As such, their narratives highlight both the ubiquity of social suffering in Oaxaca and an understanding of the self as constituted through relationships with others. As a site of diffusion for *psicoeducación* and the distribution of highly desired medications, the hospital provides patients with another, more medical understanding of their suffering as mental illness

warranting psychopharmaceutical intervention. Patients partially integrate this medical model into their illness narratives insofar as they begin to view psychopharmaceuticals as essential to the mitigation of social and familial crises and to resuming participation in social life. However, though patients engage the psychiatric 'bionarratives' (Carpenter-Song 2007) suggested in treatment and begin to craft 'pharmaceutical selves' (Jenkins 2010), these do not supplant understandings of illness as socially and morally constituted. Hospital treatment in this context does not usually make allowances for "alternative models of the self" (Fabrega 1989: 281), but the reverse is not true: patients pragmatically accept aspects of the psychiatric model which they deem most efficacious for control of symptoms and which generate hope for recovery.

For their part, hospital psychiatrists are keenly aware of the social determinants of emotional distress and psychiatric disorder, but concentrate their efforts on providing drug therapy and *psicoeducación* while dispelling 'cultural beliefs,' 'magical thinking,' and the use of traditional medicine, as Chapter 5 discussed. These practitioners "stand on the divide between desire and inadequacy" (Good 2010: 130): desire to make psychiatric care available to the mentally ill, and inadequacy due to lack of funding and perceived resistance among patients, policy makers, and politicians. The case studies of returned migrants at Cruz del Sur show how migration presents an additional barrier to providing effective care in this context, in that migrants, their family members, and their psychiatrists must rely upon fragmentary accounts to reconstruct the often harrowing circumstances under which illness occurred in the United States. Especially given the lack of infrastructure for transnational healthcare and record-keeping, coming to a

diagnosis and treatment plan for migrants who sicken in the U.S. can prove extremely difficult.

HOSPITAL PSIQUIÁTRICO CRUZ DEL SUR

Oaxaca's psychiatric hospital is located in the town of Reyes Mantecón, about 15 miles outside of Oaxaca City en route to the coast. From the city center it is a dusty, traffic-filled 45-minute bus or taxi ride through urban sprawl—a profusion of mechanics and car-parts shops, car-washes, fruit stands, roasted chicken vendors and restaurants, schools, and military bases. About a mile from the hospital the highway splits and the surroundings change dramatically from smoggy, traffic-filled commerce to expansive fields with mountains in the distance.

I made the trip many times during my fieldwork, often in collective taxis (*colectivos*) with the word 'HOSPITALES' etched on their back windows, since Cruz del Sur is only one of several hospitals located in the vicinity. In addition to the psychiatric hospital, the taxis stop at the *Hospital de Especialidades* (home to various types of specialized physicians), the Children's Hospital, and the HIV/AIDS clinic. Upon entering such a taxi, passengers must of course tell drivers at which hospital they would like to be dropped off, which can create an awkward exchange and elicit glances, as though others are attempting to divine your malady on the basis of your hospital destination.

A few weeks into my fieldwork at Cruz del Sur I stopped taking *colectivos* and began to drive myself the distance to the hospital—a relief given that my commute had been an hour and a half each way since I lived slightly outside of town. A neighbor of mine who regularly had to travel to one of the hospitals for treatment usually budgeted

her entire day for the trip and appointment. One never knows in Oaxaca when there might be road blockages (*bloqueos*) due to protests, which are a nearly daily occurrence in the hot spring months. On more than one occasion I found myself stuck, in 90 degree weather, on newly blocked-off streets, drivers honking angrily and attempting to go over medians to get out of the jam. Some days I arrived at the hospital drenched in sweat due to such ordeals; other days I had difficulty getting home and found circuitous routes which I navigated while nervously attempting to assure my car did not overheat.

If my commute was difficult, however, it was nothing compared to what most patients at the psychiatric hospital endured. As I discuss later in the chapter, they often made overnight bus trips to arrive there for half-hour morning appointments. No matter how early I left home hoping to arrive at hospital before patients, they were always waiting there in the morning outside the small-looking hospital protected by a metal gate. The gate remains closed throughout the day, presided over by an enterprising *empanada*-seller and her son, who seem to turn a good business on the hungry patients, family members, and children waiting for their appointments. A security guard sits behind the gate, the first authority to process patients as they arrive. Next to the security guard is the main waiting area: an outdoor covered patio with a row of blue plastic chairs. It is here that most patients wait for their names to be called.

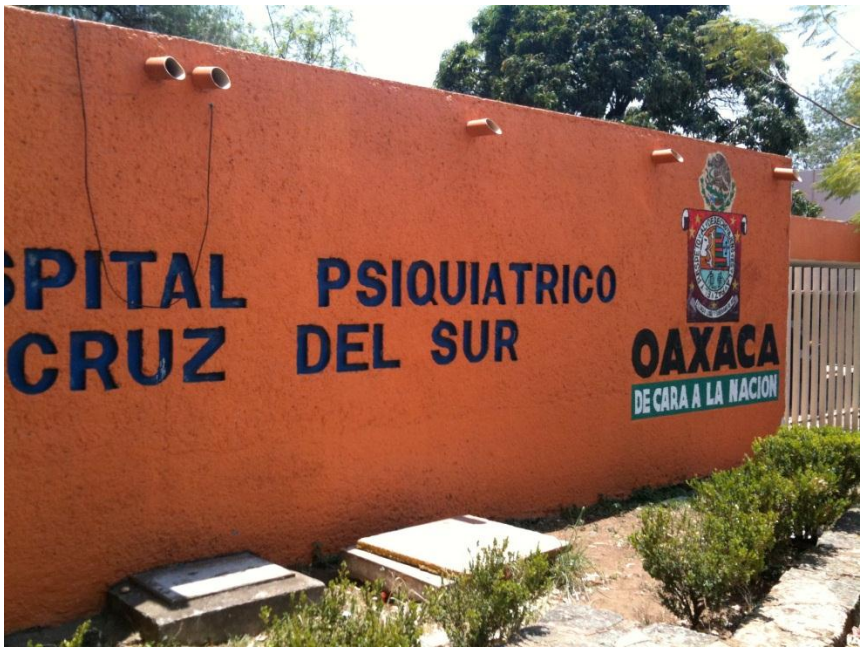


Figure 7.1: Cruz del Sur Façade

They sit or stand, usually looking glum and bored, sometimes despairing, their heads in their hands, sometimes resting, sometimes angry-seeming. Most patients arrive with at least one but often several family members. Many of the women and men wear clothing typical of Oaxaca's rural communities, men in straw hats and *huarache* sandals; women with their hair in long braids, clothes covered by colorful embroidered aprons. Other patients look like they came from the city and sport hooded sweatshirts, sneakers, and fashionable purses. Children cry, munch on crackers from the vending machines, and play hide-and-seek. Rarely does anybody read, talk on their phones, or distract themselves in any way, such that the waiting has a purposeful feel to it which suggests any minute one's name might be called and one's problems might finally find resolution. Occasionally there is laughter and levity in the waiting area—often inspired by the intake nurse who records patients' weights, heights, and basic histories, often making jokes and getting laughter out of patients and their families.

Inside the hospital, the clacking of typewriters never ceases: from behind temporary partitions made of opaque plastic and metal, the psychiatrists, in their white lab coats, keep rhythm to the day by typing outpatient histories before, after, and during consultations. There are other noises, too: the frequent passing of extraordinarily loud buses, construction—on the hospital premises and the surrounding properties—that often makes it almost impossible to carry on a conversation, and the barking of the hospital mascot, a dog named Jonas or Schizo depending on who you ask. Though by no means the most destitute of hospitals compared to many sites around the world, Cruz del Sur's outpatient facility is somewhat chaotic, an unlikely scene for therapeutic interaction.

As mentioned in Chapter 2, Cruz del Sur was founded in 1963 as a farm, or '*granja*,' hospital in which patients would have livestock and work the land to grow their own food as part of their treatment. The '*granja'* model has fallen out of favor in Mexico and has been replaced by the '*Modelo Hidalgo*,' in which treatment focuses on reintegration of the patient into society (de-institutionalization, essentially). The outpatient facility has been functioning since the hospital's inception, but very few patients utilized until 1994, when psychiatrists began to offer services (as opposed to general doctors). Now the hospital has eight psychologists on staff (two in the outpatient facility, two in the men's '*pabellón*,' or inpatient dormitory, two in the women's *pabellón*, and two offering other group and occupational therapy), 8-10 psychiatrists depending on the day (generally six in the outpatient and two in the inpatient facilities), and a number of nurses and social workers. There are 120 hospital beds, 70 for men and 50 for women, but the intake psychiatrists only hospitalize the most serious cases, such that the facilities are usually only at 60 percent capacity.

The inpatient facility has a somewhat calmer, more controlled feel than the outpatient facility. The *pabellones* are huge, high-ceilinged dormitories with rows and rows of single beds; like at many psychiatric hospitals, patients do not enjoy the benefit of much privacy. At the entrance to both the men's and women's *pabellón* is a barred cell without furniture for aggressive patients. Nurses and students dispense medications, monitor patients, and engage in ongoing banter together. Outside is a large, pleasant courtyard with trees, walkways, benches, and a good deal of open space (Figure 7.2).



Figure 7.2: Cruz del Sur Courtyard

Patients often lie down and fall asleep on the ground in this open space, and there are several fenced-off concrete recreational areas for patients who do not have the freedom to roam the grounds. There they sit on benches or stare through the chain-link fence, sometimes strangely accompanied by upbeat techno music playing from outdoor

speakers. The inpatient facility has occupational, physical, and art therapy, gardens where patients can tend to plants (Figure 7.3), and an open-air chapel (Figure 7.4).

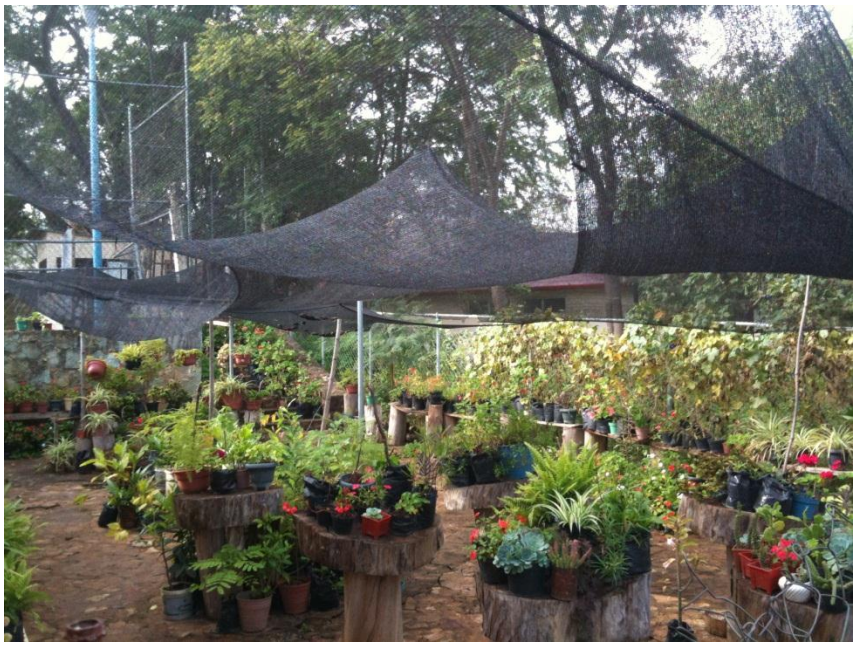


Figure 7.3: Cruz del Sur Patient Gardens



Figure 7.4: Cruz del Sur Chapel

It seems as though most inpatients receive a good deal of one-on-one attention, supervision, and therapy in addition to their psychopharmaceutical regimens. Although the dormitories leave something to be desired, the courtyard spaces and therapy rooms are quite pleasant.

Outpatients, on the other hand, are not required to receive psychological therapy. One psychologist on staff complained that due to disciplinary biases, psychiatrists were unlikely to refer outpatients to the psychologists on staff. A psychiatrist, in contrast, said that all patients "with awareness of their illness" should be receiving psychological as well as psychiatric treatment. Nevertheless, rarely did participants in the present study know that psychological services were available at the hospital, and only a few mentioned utilizing them. One reason for this might be the extraordinary distances many patients must travel to receive their treatment, resulting in lack of time to utilize other services. Practitioners say these formidable distances are one of the biggest challenges to providing healthcare in the state: due to its several large mountain ranges, it is quite difficult to navigate, and many towns are almost completely isolated from major cities and highways.

SELF, ILLNESS, AND SOCIAL SUFFERING

Another oft-mention challenge in providing effective care is the state's extraordinarily diverse cultural and linguistic profile and patients' tendency to come to the hospital with their own explanations for their ailments—explanations which can

diverge considerably from those held by the psychiatrists and psychologists who attend to them. Interestingly, the health framework that psychiatrists and psychologists often promote in Oaxaca—that to be healthy "one doesn't just need to take care of the body, but also one's mind and one's emotions," as one psychologist put it—is not dissimilar from many indigenous healthcare frameworks. As I discussed in Chapter 2, however, in indigenous medicine the mind, body, and emotions have not been traditionally been conceived of as separate entities in need of care but as part and parcel of the person. With regard to Mixtec medicine, for example, "illness, health maintenance, religion, and social relations are all intimately interwoven (Bade 2004: 234). Based around the concept of equilibrium in all aspects of the organism, the self, and the community, Mixtec medicinal culture—as well as most other indigenous approaches to health—is central to and inseparable from life in general. With illness, "one's spiritual, social, and cosmic positions are considered to affect both cause and cure" (Bade 2004: 234).

Understandings of distress and explanations of its etiology are central to patients' 'illness realities' and thus to how illness is expressed and experienced (DelVecchio Good & Good 1982). In her study of Mexican medical practice, Kaja Finkler writes that

> To know the cause of a sickness is to make sense of one's suffering. A people's etiological explanations shape their expression of sickness and sickness behavior. Such explanations are assertions about human behavior and human interaction, about moral failures, and about social relations gone sour. The typical symptoms people present and the explanations they give for their suffering are culturally molded, and they furnish a window to people's ideologies, morality, social interaction, as well as their relations to themselves, their bodies, and their environment. Their physical pains are statements made, in a cultural way, of perceived existence and of unresolved contradictions by which they are confronted (Finkler 2001: 35).

Patients at Cruz del Sur are confronted with what often seems like a sea of ‘unresolved contradictions’ and ‘social relations gone sour’—through violence and loss, through the ravages of poverty and emigration. As Jenkins (1988) points out in reference to the general Latino population, “throughout the literature on this vast and heterogeneous ethnic group, no single observation is more common than the overwhelming importance of the family for an individual's notion of the self, relations to others, and world view” (Jenkins 1988: 306). Similarly and specifically in reference to Oaxaca, Murphy and Stepick write that “the household and family, not the individual, form the cornerstone of Oaxacan social life” (1991: 138). When family and social relations encounter crisis, which they regularly do in Oaxaca, the consequences can be severe for emotional and mental health. In turn, when mental health problems arise, the familial response can be crucial to recovery (Jenkins 1988). The new services being introduced in Oaxaca do not always take this focus on social and familial relations into account, which could have implications for adherence to and success with various treatment interventions.

Horacio Fabrega points out that in studying and treating psychopathology cross-culturally, allowances must be made for

> alternative models of the self—wherein spiritual and otherworldly agents could normally influence subjectivity and action, wherein feelings could be seen not as properties of the self but as inductions from interpersonal relations, wherein boundaries of the self might be less permeable and drawn differently so as to accompany others of the behavioral environment, and wherein behavioral acts might not be theoretically reduced to products of an inner subjectivity and/or impulsivity but seen as connected to contexts (Fabrega 1989: 281, quoted in Hopper 1991: 310).

Rarely are such allowances made in the clinical setting, though, and Cruz del Sur is no exception. As I discussed in Chapters 5 and 6, dispelling particular 'beliefs' about 'alternative models of the self' and illness is a central goal of *psicoeducación.*

However, understandings of self, emotion, suffering, and illness do not exist in a vacuum, but are negotiated in social interaction, including clinical encounters. As DelVecchio Good & Good (1988) argue, "[m]eaning is constituted in the interpretive experience, through which subjects make sense of some part of their lived-in world…medical idiomata provide interpretive frameworks used in the construction of personal and social realities" (147). The clinical diagnostic and treatment process can be quite powerful for patients' understandings of their own suffering, often either supplanting initial explanatory models or coexisting alongside them. Indeed, though patients often use available diagnostic biomedicine to interpret their discomfort, they are not solely constrained by the ways in which biomedicine "authorize[s] the 'real'" (Das & Das 2007: 76). Rather, they explore various ways of knowing and interpreting the experience, and juxtapose different explanations.

A similar story can be told of contemporary Oaxacan experience of psychiatric care, at least as evidenced at the psychiatric hospital. I will show how patients at the psychiatric hospital tended to manage several explanatory frameworks for their emotional distress and diagnosed disorders, focusing especially on the ways in which they understood afflictions as rooted in social and familial crises. Faced with perceived cultural, linguistic, educational, and geographical barriers, hospital psychiatrists struggle to promote an alternative, medical explanation for mental illness, which patients usually at least partially accept and weave into their illness narratives, meanwhile maintaining

understanding of illness as socially constituted. The efficacy of psychotropic medications—specifically, their power to enable patients to rejoin social and familial life—is central to patients' faith in and appreciation for psychiatric care.

Patients' narratives bring into relief the ubiquity of 'social suffering' (Kleinman, Das, & Lock 1997) in Oaxaca, as well as the dangers of conflating cultural difference and structural violence (Farmer 2005). Indeed, while most patients' stories are profoundly relational and embedded within the close ties of familial relations, many of them simultaneously "have their origins and consequences in the devastating injuries that social force can inflict upon human experience," as Kleinman, Das, & Lock define social suffering. As such, patients' accounts of illness draw attention to the "close linkage of personal problems with societal problems" (Kleinman, Das, & Lock 1997: ix). The particular processes patients invoked as pathogenic in their lives are inextricably linked to broader questions of political economy, inequality, and social disintegration—which themselves can exacerbate problems like domestic violence, and substance abuse (ibid). Subsequently "translated into personal distress and disease" (Farmer 2005: 30), such social pathologies wind up being treated as individual psychiatric problems through the process of medicalization.

It is tempting to interpret the processes at hand in Oaxacan institutional psychiatric care as examples of dangerous medicalization, but such a reading would, I believe, do an injustice to both patients and the practitioners providing access to treatment for patients who are immensely grateful for the excellent care and transformative medications they receive at Cruz del Sur. As Byron Good (2010) points out, psychiatric treatment with new generation psychotropics is not even a remote

possibility in many regions around the world, and patients are quite thankful for them. For patients, being listened to, provided a firm explanation for illness, and prescribed medication to aid with symptom relief seemed to vindicate, or at least confirm, the validity of the suffering they had experienced. Granted, treatment does not resolve the factors patients see as the *causes* of their illness, but this does not seem to undermine the hope that treatment generates.

PATIENT CHARACTERISTICS

General Characteristics

The sample of patients I interviewed at Cruz del Sur was quite diverse, representing people from all eight regions of the state (see Table 7.2) and ranging from eight years old to mid-sixties (see Table 7.1).[1] Patients were nearly evenly split between males and females (24 females and 26 males), and of those for whom I have educational data (N=26), nine had completed high school. About a quarter of the sample had migration experience themselves, and several more attributed illness to migration of a close family member. Twelve of the 50 participants mentioned speaking an indigenous language or spoke one in the interview.

[1] I describe the methods utilized in the hospital phase of the study in Chapter 1.

Table 7.1: Age & Occupations of Sample (N=50)[2]

Age		Occupation	
8-19	4	Unknown	8
20-29	10	Unemployed	9
30-39	20	Campesino	13
40-49	9	Student or *Hogar*	8
50-59	4	Informal/Service	7
60-75	3	Professional	5

Desperate Expeditions

Despite the enormous challenges the trip presents geographically, economically, linguistically, and time-wise, patients come. In fact, the record-keeper at the hospital estimated that about 200 patients a week attend appointments with the outpatient psychiatrists and psychologists. According to hospital data, 9,026 patients received consultations in 2009. As table 7.2 shows, 24 out of the 50 patients interviewed traveled over two hours to reach the hospital; 11 of them traveled five hours or more. Often, patients would have to make another trip into Oaxaca City to get prescriptions filled (Cruz del Sur has a pharmacy but its supply varies and they usually stock generics; when patients needed brand-name medicines, they often had to seek them elsewhere). Unless they were hospitalized or had a family member in the area with whom they could stay the night, all of these patients would have to make the return journey home in the same day.

[2] In the table, 'Unemployed' includes unemployment due to disability. '*Campesino'* refers to a rural farmer who grows food for the consumption of the family and who may or may not sell it at local markets. 'Student/*Hogar*' refers to those who are not employed but who are attending school or who describe themselves as keeping house (*hogar).* 'Informal' refers to participation in the informal economy through selling wares at markets as a vendor or offering informal services such as housecleaning. 'Service' refers to offering formal services such as construction, restaurant work, and small business. 'Professional' refers to occupations such as teachers, government workers, and lawyers.

Table 7.2: Geographical Origins of Hospital Participants (N=50)

Location of Pueblo	**Distance from Hospital (in travel hours)**	**Number of Patients**
Valle Central Metropolitan	Less than two	19
Valle Central Rural	1.5-3	5
Sierra Sur	2-4	3
Mixteca Baja or Alta	2-6	7
Sierra Norte (includes Mixe region)	2-5	3
Coastal Region	5-8	6
Cuenca del Papaloapam	7-8	2
Isthmus	5-7	3
Unknown	n/a	2

When I asked these patients why they made such extraordinary journeys, they almost invariably responded that there were no other options, that other options had failed them, or that it was worth it because of the excellent treatment offered at Cruz del Sur. Psychiatrists frequently complained that Cruz del Sur was a last resort for patients, who (according to psychiatrists' perceptions) generally think psychiatry is for *locos*. Whether due to preconceived notions about psychiatry, logistical issues, lack of awareness, or lack of resources, the majority of patients in my sample had indeed wound up at Cruz del Sur after having sought other forms of care or treatment, most frequently general doctors and/or psychologists who ultimately referred patients to the psychiatric hospital, but also *curanderos*. Most patients in the current sample were referred through practitioners (e.g. doctors, nurses, counselors, or psychologists) at community health centers (Centros de Salud) or general hospitals, though oftentimes family members or friends had heard of

mental health services and either brought their loved one to the hospital or told the family they should do so.

The popularity of the hospital can be attributed to several factors. Firstly, people with state provided healthcare (*Seguro Popular* for the general population and *Seguro Social* for employees) receive most of their treatment at the hospital—often including medications—free of charge or heavily discounted. Even for those without insurance, the hospital is, in a very real sense, the only relatively affordable option for psychiatric care in the entire state. As discussed n Chapter 2, only a few other public hospitals are staffed with a psychiatrist, and their service is usually dedicated to attending to patients who are at the hospital for another coexisting medical condition. In total, only about 30 psychiatrists practice in Oaxaca, and of those only 12 work in an institutional capacity (as opposed to private practice). Although private psychiatrists often mention that patients from lower-income brackets utilize their services, paying the appointment fees of 350-500 pesos (about $25-40 USD) is unthinkable to most Oaxacans. Even when consultations and medications are free, as they often are at the hospital, patients regularly complain that the cost of the trip from their place of origin to the hospital is a serious financial burden that sometimes prevents them from making their appointments or taking their medications.

The other main reason people continue coming to the hospital after their first consultation is for medication. Patients must have a current, officially stamped prescription in order to access psychopharmaceuticals, and if they want discounted prices they must get them at the psychiatric hospital pharmacy or the pharmacy at the public hospital in city center. All but one of the patients in the sample were taking at least one

psychotropic medication, and usually two or three; the one who was not taking medications had only suspended them because she was pregnant. One of the psychiatrists at the hospital estimated that 99 percent of patients who come to the hospital need medication. As we will see, psychotropic medication is, from both patients' and doctors' points of view, one of if not the most important aspect of recovery, regardless of patients' understandings of their illnesses.

Doctor-Patient Interactions

Hospital Psychiatrists & Psicoeducación

Although relatively few patients in the current sample attributed their problems to supernatural forces, hospital psychiatrists report that this is a major issue: in addition to the fact that patients frequently speak an indigenous language rather than Spanish, patients often understand their experiences according frameworks which doctors see as contrary to the psychiatric model. As I describe at the outset of Chapter 5, psychiatrists describe patients' illness understandings as a type of "*pensamiento mágico*," or 'magical thinking.' This 'magical thinking,' like the opinion that witchcraft or a severe fright (*susto*) might have caused the illness, doctors say, often causes patients and their families to utilize "alternative treatments," i.e. traditional healing from *curanderos*, herbal remedies, and spiritualist practices, of which the psychiatrists are normally disapproving. Additionally, they express that such 'beliefs' cause patients to postpone much-needed treatment and seek care at Cruz del Sur only as a last resort—thus exacerbating illness.

The hospital thus acts as a prime site of diffusion for *psicoeducación* and the 'psychiatric imaginary' discussed in Chapter 4. Psychiatrists and staff make concerted

efforts to educate patients about mental illnesses and the necessity of medicines to treat them, emphasizing the importance of compliance. Nursing students contribute large educational billboards and posters about mental health generally, like how a person with depression feels or what constitutes domestic violence, as well as materials about specific mental illnesses, such as "myths and realities about Schizophrenia" (Figure 7.5); pictures of healthy and diseased brains (Figure 7.6), and risk factors, signs, symptoms, and treatments for various disorders. Psychopharmaceutical promotion materials—mugs, calendars, notepads, magnets, pens, folders, and posters about mental illness—are ubiquitous, and piles of medication samples build up in administration offices.

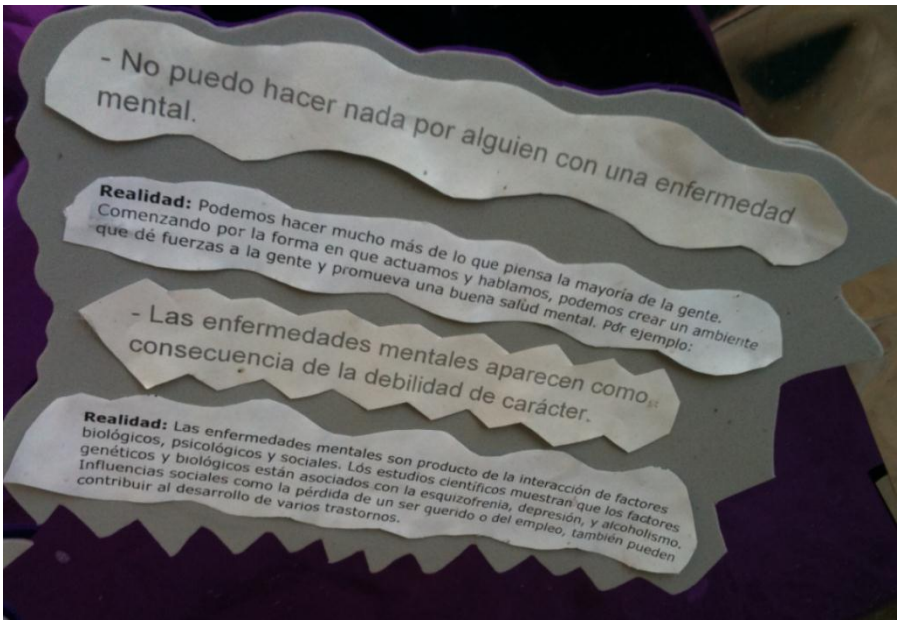


Figure 7.5: Myths and Realities about Mental Illness: *Psicoeducación* at Cruz del Sur

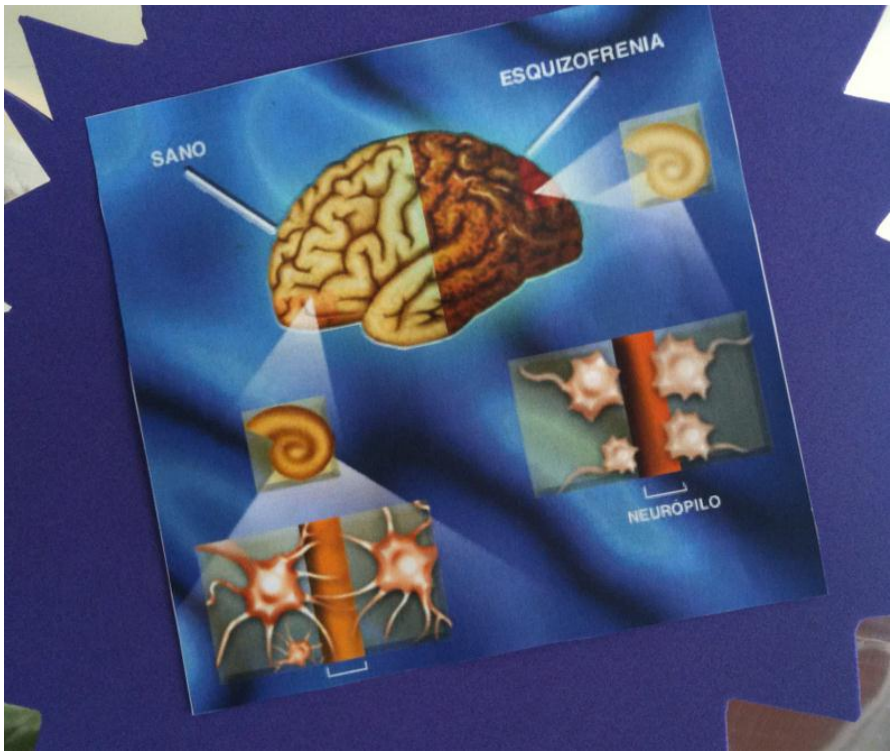


Figure 7.6: The Brain and Schizophrenia, Cruz del Sur *psicoeducación*

Psychiatrists at the hospital said that when patients came to the hospital not knowing about mental illnesses, they would take great pains to educate them. As Dr. Álvaro González put it,

> [I'll say] 'look, this is a mental illness that will not be cured, only controlled, but don't go around wasting money.' I explain to them that at the cerebral level there are certain chemicals which are altered, and this is why they hallucinate or get depressed. That there are also hereditary factors, and if there were mentally ill people in the family this will also be part of one's inheritance. Social questions also influence these illnesses, right? [I explain] that that this is an illness like diabetes, hypertension, cancer. You have to explain gradually so that little by little they come to understand.

He went on to say that most patients have completed primary school at the most, so that every time he saw them he would have to continue "raising awareness [*concientizando*], raising awareness, raising awareness about the mental illness." Usually, though, there

was at least one family member who is "on our side, to put it one way," and who could explain the illness to the patient and the other family members.

It is not surprising that psychiatrists sought to educate patients about mental illness; after all, nearly all patients at Cruz del Sur have psychiatric diagnoses and are being treated with psychopharmaceuticals. But psychiatrists seemed particularly preoccupied with the possibility that patients did not subscribe to the biomedical understanding of their mental health problems and that they might seek alternative, non-psychiatric treatment. In her study of biomedicine in Mexico, Kaja Finkler discusses Mexican doctors' social position and suggests that they have less clout and social capital than doctors elsewhere (Finkler 2001: 77). If this is the case, then psychiatrists occupy an even lower position on the hierarchy, and their awareness of this informs the way they discuss their own practice and the medical and alternative practices of others. They seemed always to be defining themselves against something else, whether it was against general doctors who neglected to refer mentally ill patients because the doctors themselves were unaware of the importance of mental health or whether it was against *curanderos*, Reiki practitioners, or other healers who psychiatrists though were duping patients out of adequate treatment. As I have discussed elsewhere, psychiatrists feel quite marginalized in Oaxaca's more general culture of health.

Psychiatrists' preoccupation with alternative and traditional forms of care related to their social positioning in another way, as well: my impression was that even relative to other psychiatrists in Mexico, Oaxacan psychiatrists working in the public setting felt marginalized. Because there is no psychiatric specialization in Oaxaca's medical school, all Oaxacan psychiatrists received training in other states, most frequently Puebla and

Mexico City. In Mexico, many perceive the southern states (Oaxaca, Guerrero, Chiapas) to be rural and backward, and ethnic and racial slurs relating to the indigenous population abound (for example, '*no seas indio*,' or 'don't be Indian' is used by *mestizos* even within Oaxaca to mean 'don't be dirty' or 'don't be sloppy'). Of course there are indigenous populations throughout Mexico, most if not all of whom have been historically marginalized. But the concentration of indigenous populations in the southern states—along with these states' devastating poverty relative to the rest of the country—contributes to such stereotypes. Many Oaxacans, perhaps particularly those who have received a college or graduate education, seem compelled to define themselves as 'modern,' educated, and civilized, in contrast to what is perceived as Mexico's uneducated backwater population.

To do so, many mobilize discourses around 'culture' as a means of differentiating themselves, as Chapters 5 and 6 showed. 'Culture' is thought to be stronger and more determinative in indigenous communities, and the culture concept often serves as a euphemism for behaviors and tendencies perceived to be negative—including anything from domestic violence to bride-selling to the utilization of traditional medicine. "It's a question of culture" was a phrase I heard over and over again. Oaxacan doctors, perhaps psychiatrists in particular, seem to be actively struggling against being perceived as 'backwards'—a struggle which was likely reinforced in medical school outside the state. I came to read their stances toward 'culture' and their insistent rejection of 'traditional' ways as part of their pursuit of social status, respect, and legitimacy in both the medical and broader community.

A related point that bears repeating is that many hospital psychiatrists see their endeavor as altruistic, as a way to give back to their state (all but one of the hospital psychiatrists are Oaxacan). They constantly struggle with the lack of funding and what they perceived to be a lack of interest in mental health on a governmental level. During my first tour of the hospital, the staff member guiding me summarized the hospital's mission statement, which is "to provide high-quality, warm, and humane medical-psychiatric and psychological care to the general population. Medical services should be provided in a timely and efficient manner both in outpatient and inpatient services, according the current regulations, and respecting the human rights of patients and families." He informed me about the regulations governing psychiatric hospitals in Mexico, adding that unfortunately the hospital lacks the economic resources to be in compliance with those regulations:

> You'll see that according to the regulations, hospitalized patients have the right to wear civilian clothing. But it doesn't say anything about who's going to give us the money to buy the clothing…It also says that at this point there are not supposed to be any bars or metal doors, but they don't hire enough staff to take care of the patients…We're supposed to have one nurse for every six patients…and in some morning shifts we comply but at night, no, sometimes it's more like one for every ten…Right now there's one [nurse] with 20 male patients—we lack personnel, so we don't comply with the norms and regulations like we're supposed to.

I heard similar lamentations from a number of staff, psychologists, and psychiatrists, many of whom have made considerable personal sacrifices to offer treatment in the public setting.

Diagnoses & Strained Communication

In addition to more symbolic differentiations, substantive educational, economic, and often cultural and linguistic divides do structure interactions between patient and doctors at Cruz del Sur. As mentioned above, many patients come from rural indigenous communities and speak Spanish as a second language—or do not speak Spanish at all. I was very struck by the lack of interpreters, which meant that non-Spanish-speaking patients were dependent upon family members to translate. Many patients have not had the benefit of finishing primary school; on several occasions signing the consent forms presented a challenge because patients were unable to read and write.

In most medical encounters patients see doctors as authority figures, and given these divides, this is even more so in Oaxaca, Thus, communication between patients and doctors seem to leave both confounded at times. Time constraints on the doctors, who usually have more cases than they can handle in a day, play a part in patients' limited understanding of their diagnoses—and therefore constrain their understandings of the psychiatrists' points of view. Twelve of the patients I interviewed did not know the name of their diagnoses, and several of those who did know the name of their diagnoses did not know what they meant. Table 7.3 shows diagnoses of study participants in descending order, as explained by participants. Unfortunately, because the psychiatrists were almost always in consultation and rarely had time to discuss particular cases, it was not always possible to check patients' understandings of their diagnoses for consistency with their official diagnoses.

Table 7.3: Participant Diagnoses in Order of Occurrence as reported by patients, including concurrent diagnoses

Diagnosis in order of Occurrence	**# of Patients**
Depression	14
Schizophrenia	13
Didn't know	12
Anxiety	7
Bipolar Disorder	5
Personality Disorder	4
Mental Delay/Retardation	3
Panic Attacks	2
Epilepsy	2
Obsessive Compulsive Disorder	1
Insomnia	1
Asperger's	1
Alzheimer's	1

One patient named Clara, diagnosed with depression and bipolar disorder, told me that she and her husband had little understanding of such disorders: "No, I don't know much about these illnesses, they haven't explained very well what this illness or what the other is—I only know because they wrote [the diagnosis] on this paper." The paper was her prescription for Sertralina (Zoloft, an anti-depressant) and Valproata (Depakote, a mood-stabilizer) bearing a small line on which the diagnoses were printed. Normally, though, the diagnoses are represented by their diagnostic codes, so patients would have no way of knowing for what illness they were taking medication.

Another patient, Silvia, came to the hospital after a suicide attempt, explaining that she felt sad, lonely, depressed, and empty. She told me had been experiencing profound depression. When I asked her what her diagnoses were, she said she did not know because Dr. González had not explained them to her. I asked if she would like to know and told her that she could probably ask him, as he was not currently in an

appointment. She went back to his office and came back with the Dr. González, who explained to me—not to Silvia—that Silvia was suffering from borderline personality disorder, dysthymia, and recurrent depressive disorder. After he left, Silvia told me she did not understand what borderline personality disorder was, and asked if I could explain; I told her it would be better if the doctor explained, and went back to his office myself to ask if he could elaborate for the patient. He told me that Silvia's appointment had already gone too long and that he would explain it to her when she came back for her next one.

Both Silvia and Clara were from areas in or around Oaxaca City, neither attributed her illness to witchcraft or supernatural forces, and neither had sought alternative treatments, at least according to what they revealed in our interviews. One day I asked Dr. Silva about a patient's diagnosis and mentioned that the patient had not known what it was. "We don't always tell them," she said, "because sometimes they don't understand what it means." The lack of understanding regarding Clara and Silvia's diagnoses appears to be more attributable to time limitations and perceptions that patients lack the education to understand their diagnoses than to "*pensamiento mágico*."

Out of the 50 patients in the current sample, all but three of whom were asked, only 15 said that they had sought treatment from a *curandero* for the problem they or their family member was suffering, and only eight thought their illness might be due to witchcraft, envy, *susto*, *mal aire* or a combination of the latter. Eight saw alternative healers, such as a priest, an herbalist, a spiritualist, and a few had attended Neurotics Anonymous meetings. Several said they had sought alternative treatment but that they did not "believe in" it, that it had not helped them, or that the *curandero* did not know what

they were suffering from so could not help them.[3] Others had had better experiences with alternative treatments, but patients were much more likely to attribute their afflictions to social problems than to supernatural causes. Those who did attribute their problems to supernatural factors always connected those factors to social experiences, as we will see in patients' narratives below.

[3] It is possible that patients disavowed use of traditional medicine because they were in the institutional hospital setting and were aware of doctors' disapproval of such care—or because they thought I might disapprove, as well. I sought to make patients feel comfortable enough to discuss such matters, emphasizing that what they told me would not be shared with their doctors or impact their treatment. However, there is always a possibility that the interview setting and issues of rapport with a foreign researcher will color respondents' replies. Generally speaking I felt as though I established good, open rapport and a comfortable interview setting where patients felt they could speak freely.

Table 7.4: Illness attributions, usually multiple[4]

Illness attributions/factors contributing to problem	**# of Patients**
Experience of Physical or Sexual Abuse/Assault	11
Migration (of self, child, or spouse)	10
General relationship/family problems	8
Death of a loved one	7
Alcoholism (of pt or relative)	7
Injury/Accident	5
Problem with brain/Chemical Imbalance/Congenital	5
Separation/Divorce of pt or pt's parents	5
Shame/Insecurity/Self-esteem problems	4
Genetic factors	4
Thinking too much	3
Money Problems/Unemployment/Poverty	3
Co-existing chronic illness	2
Natural disaster	2
Witnessing Violence	2
Envy	2
Drugs	2
Spurned love	2
Infidelity of Spouse	1
Susto/Espanto	2
Possible witchcraft	2
Aire	2
Nervios	1
Feelings of persecution in community	1
Childbirth Problems/Pre-eclampsia	1
Punishment from God	1

Nos atiendan: Recovery, Gratitude, and Word of Mouth

Despite these communicative barriers and the somewhat authoritarian dynamic

[4] 'Illness attributions' refer to factors patients and family members theorized as contributing to experience of distress and disorder. Illness attributions are distinct from symptoms; for example, a patient might attribute his illness to low self-esteem (illness attribution) or mention low self-esteem as a symptom of the illness. Only the former are included in this table.

which seemed to emerge in encounters between doctors and patients, patients overwhelmingly express gratitude for what they describe as excellent treatment from the practitioners at Cruz del Sur. This was, in fact, one of the most striking aspects of my interviews with patients. The phrases *"nos atiendan"* and "*atiendan a uno"* came up frequently in patients' accounts, and the word 'atender'—which can mean 'attend to,' 'pay attention to,' 'provide a service for,' 'serve,' 'care for,' or 'listen to'—nicely encompasses the sense of being truly heard and cared for that patients seemed to regularly experience at the hospital. Even after traveling all day and waiting hours for a short appointment, patients almost unanimously discussed how well the psychiatrists *atendien,* saying that they would certainly recommend the services to anyone in need.

Granted, the patients who wound up speaking to me were either first-time patients very hopeful that psychopharmaceuticals would aid in recovery or patients who had seen improvement and thus had continued treatment. My sample therefore does not include those whose negative experiences at the hospital or with medication caused them to abandon treatment. Still, patients' gratitude toward psychiatrists and psychopharmaceuticals was extremely prominent. As Rosalba, the mother of a Cruz del Sur patient, put it,

> Well yes, I see that the doctors work well, they work well and they give very good medicines…They are good doctors and they give good care. I've never had to see a doctor [here] who scolded me…No, they always treated us with kindness and respect. At least we've always gotten along with our doctor – she is a very good person. So for me, I think they work well. I have nothing bad to say against them: they attend to us, whenever it may be, but at least they attend to us [*nos atienden*].

The power of being attended to, listened to, respected, given a diagnosis, and prescribed a medication came across powerfully in many patients' narratives. Their positive treatment experiences frequently seemed to set into motion a ripple effect: 'early adopters,' or the first members of a community to be treated at the hospital, would often spread the word about the exceptional care offered there.[5] Patients seemed to be doing a great deal of practitioners' de-stigmatization work, since an account of recovery from an esteemed neighbor or family member would act as a powerful draw to the hospital for other suffering community members. Rosario, another mother of a patient whose case is presented below, discussed how she first heard about the by 'chatting' with friends and neighbors who had experienced relief from Cruz del Sur treatment:

> [A friend said] 'look, Fulana got better there'…Three people mentioned it to me…They said people were getting better here. They said they spent lots of money going to doctors but doctors always say there's nothing wrong with them, there's nothing wrong with them. But here, here they're getting better…[People find out through] chatting, chatting…Armando's wife María said, 'I want to go [to the hospital] too,' and she told me that they had gone around spending lots of money with doctors, and all the doctors told her nothing was wrong with [Armando], but he really felt badly. So then María told me that 'there [at the hospital] they're curing people [*ahí están curando*], there they're curing people,' she told me. 'Take your son there,' she told me. I told her, 'Rafaela already told me to go [to the hospital],' so I told Orlando, my husband, to go by the hospital and see if they'd treat us there.

CASE STUDIES: NEGOTIATING EXPLANATORY FRAMEWORKS

The first part of this chapter provided an ethnographic description of the hospital, an overview of the outpatient sample I interviewed for the current project, and a discussion of hospital practitioners and doctor-patient relations. Now I will move on to a

[5] I thank Dr. Claire Brindis of UC-San Francisco for suggesting the phrasing 'early adopters' in her comments on my presentation at the UC Global Health Day in 2011.

series of case studies which illustrate the chapter's main claims regarding (a) the centrality of social and familial crises to patients' illness narratives and histories of treatment seeking, and (b) the vital role of psychopharmaceuticals in helping mitigate such crises and allowing patients to rejoin social life. These case studies illustrate how, in the psychiatric context, patients craft pharmaceutical selves and actively engage the pharmaceutical imaginary (Jenkins 2010). At the same time, while patients integrate aspects of the 'bionarrative' suggested in psychiatric treatment, such narratives do not necessarily displace those in which social relations and breakdowns are more central (Carpenter-Song 2007). Thus psychiatrists' project of 'emotional modernization'—the cultivation of psychiatric subjectivities I discussed in Chapter 5—remains partial in this setting.

Social Disruptions & Pharmaceutical Selves

Directo al nervio central

In the prior chapter I began to discuss the case of Verónica and Emiliano, a married couple from a small town three hours south of the hospital who had been receiving treatment for four months at the time of our interview. In that chapter I showed how Verónica interpreted her experience of depression in the framework of 'trauma' resulting from abuse on the part of father growing up. Here, I would like to elaborate on Verónica and Emiliano's narrative to tease out the role of social suffering and psychopharmaceuticals.

Verónica became aware of psychological services through her sister-in-law, also a participant in the current study, who told Verónica that "it could be that your mind is

sick." At the time, Verónica did not know what 'trauma' was, and attributed her horrible feelings to personal weakness and character deficits. Soon, though, she said "I felt so horrible I just couldn't go on." She sought psychological care with a psychologist in Miahuatlán "and started to treat myself with medicine, as well. It wasn't until then that I started to control myself." The medication—Rivotril (Clonazepam, an anxiolytic/benzodiazepine)—made a huge difference, as Verónica explained:

> …it was a change for me. I had felt that I was in my own world, but from there, I went to a much better place. It was a life change. I started to feel good, good. [Before the treatment] I had always felt insecure, scared of talking, of doing things—I didn't feel well. [The psychologist] started giving me medicine and—well now I've been taking medicine for a long time—and I saw such a change. I started being able to walk around talking with my neighbors and didn't feel badly, like I was bothering them. I started to feel more confident and to sense a change.

At that point, Verónica began to refashion her self-understanding and her understanding of her emotional distress around the idea of 'trauma,' an illness brought on by her father's abuse and alcoholism. No longer was she so insecure, shy, and fearful: once she knew it was an illness that could be treated, she could separate herself from the problem and begin to act and feel differently. Having a name for her problem—and a medication to treat it—are central to this shift in thinking about her problems and her self.

Verónica began treatment at Cruz del Sur when she learned it would be cheaper than the psychological care she was receiving in Miahuatlán. She did not identify with the diagnoses she was given there, depression and anxiety, but instead continued to attribute her problems to trauma caused by her father's abuse. The Prozac she was prescribed at Cruz del Sur seems to have been as effective as the Clonazepam, though, Verónica continued to experience immense relief.

Verónica had initially feared what Emiliano would think about her seeking help from the psychiatrists at the hospital:

> He was always negative, like he didn't believe in the illness, but then finally he started to come with me. I cured myself so I told him 'cure yourself, too' from that sleep problem…it's bad. He told me no, I already suffer from this problem, but then it started to get worse for him so he began with the doctor and started to come [with me]. Now he's changing, becoming more reasonable, learning about this type of illness and how the brain needs medicines, how you don't win control over them with just pure talking [*pura plática*].

For his part, Emiliano had for many years experienced insomnia, occasional sadness [*tristeza*], and fears [*miedos*]. However, according to Verónica, he had not "believed in" her illness until he came to the hospital for treatment himself. Upon experiencing relief from psychopharmaceuticals (Prozac and Clonazepam), Emiliano's understanding of his and his wife's illnesses shifted, as well; like Verónica, Emiliano began attributing illness to his own father's alcoholism and abuse.

Both Emiliano and Verónica agreed herbs and other non-biomedical treatments were too weak to treat the illnesses they have. The couple had gone to a naturopath, a homeopath, a spiritualist, and a *curandero*; although they reported that homeopathy was not effective, the herbs the *curanderos* gave them were helpful in restoring sleep for Emiliano and in assuaging some other symptoms, as well. Emiliano recounted how *curanderos* "started to do a type of curing with herbs and mezcal sprays…I think that these do some good as well, but finally [Verónica] came here to cure everything in the hospital," Emiliano said. Herbal treatments "are not sufficient. What they have here [at the hospital] goes straight to the central nerve, and it's [the central nerve] that is failing us. That's why [these medicines] do us good…[They go] directly to the central nerve.

The [herbal] medicines work a little bit at a time, but these medicines go straight to the nerve." Emiliano mentioned some concern that these potent medicines might be harmful, but their positive effects seemed to outweigh any fears of long-term damages they could cause.

Emiliano had also seen a psychologist, and he shared Verónica's opinion that "*pura plática*," or 'pure talking,' was insufficient to cure them. "Yes, I found psychology and they treated me for a few months, like three months, but I didn't feel any relief. It was the same, because then you see that the psychologist is pure talk, pure…therapy. No, no, there's no medicine…and things were different with the medicine. With that, really quickly, in two or three weeks, I was able to sleep…" Clearly, a recurrent theme in Verónica and Emiliano's narrative is the potency of the medications at the hospital, which seems to be the only thing they believe can help them. Both simultaneously believe that their illnesses occurred due to abuse they suffered from their fathers *and* due to problems with the brain which require medication in order to function correctly. The latter represents an idea that Verónica and Emiliano had not imagined before seeking mental healthcare.

Verónica did not seem especially concerned that she did not understand her diagnoses at the hospital, as long as they continued to prescribe the medication that enabled her to live her life without so much debilitating pain. However, as is typical in the hospital, their psychopharmaceutical regimen is only recommended for a short period—one year for Verónica, nine months for Emiliano. Only patients diagnosed with schizophrenia or mental delays reported being told they would have to take their medications for life.

The medications have helped Verónica feel capable of maintaining a role in social life, which is perhaps their most important function in her opinion. As she stated above, she feels more comfortable and less fearful talking to neighbors. As for family, Emiliano explained that her father does not have such a strong effect on Verónica now, that she does not comply with his every demand anymore, and she does not come home angry now after seeing him. Verónica expressed that her illness has had an impact on her own kids, though, especially one of her daughters:

> I was sick with my kids because … when I talked, the first word out of my mouth would be to order them to do things for me. They couldn't, and I would get angry. I wasn't happy, and I was harming them with that kind of talk. Later, when my daughter was about ten years old, I was acting very ugly with her because I felt awful. Any little thing she did would make me despair; I would yell at her and scold her horribly…And she didn't understand me. It's only recently that I've begun to control myself that I can see I harmed my child, I hurt her a lot. So I brought her here too, and she's in treatment.

Like her parents, the daughter was taking an antidepressant/anxiolytic (Zoloft), for an illness that Verónica believed originated in familial conflict.

In fact, Verónica and Emiliano have a number of family members who have sought treatment at the hospital and who are currently taking medications: their daughter; Emiliano's mother; Emiliano's sister (also interviewed for the present study, whose main reason for seeking treatment was depression brought on by her husband's infidelity and the death of her niece); and Emiliano's brother, who had migrated to San Quintin in Baja California and had sickened there. After returning from San Quintin the brother had been admitted six times as an inpatient at the psychiatric hospital, and though the family had attempted to suspend his psychiatric medications and utilize natural medicine instead, every time they did so his symptoms—talking to himself, throwing things, angering

easily, not recognizing his family members—would re-emerge. Now he lives and works in the *pueblo* with his family, and never misses a dose. Emiliano attributes the illness to his brother's malnourishment during his tenure as a farmworker in Baja California and to having smoked marijuana upon his return.

Verónica and Emiliano's story illustrates a common explanatory framework through which patients understand their problems: as illnesses caused by social suffering, but only treatable through potent medicines. Therapy, Verónica and Emiliano suggest, gave them a way of understanding their problems—as traumas—but did not provide relief from the suffering that those problems generate. The psychiatrist did not explain their diagnoses or offer *psicoeducación* beyond telling them that they have illnesses, but it does not seem to bother Verónica or Emiliano: as long as they leave the hospital with a prescription refill, the six hour roundtrip journey is worth it. The complicated source of the problem—abusive fathers and childhoods characterized by fear and violence—are central to their illness narratives but are not addressed as part of the healing process.

Their story also shows how the hospital works as a site of diffusion for mental health ideology and how it creates early adopters who spread the world to family members and acquaintances. Once the family saw that one person was successfully treated there, it seems the rest of them began to open to the idea of treatment and to identify their problems as meriting psychiatric intervention. Six people in Verónica and Emiliano's family were receiving medications from the hospital, and it seems as though each success consolidated their confidence in the efficacy of treatment at Cruz del Sur.

Por tanto pensar

Antonia and her brother Mauricio are siblings from the Mixe region of Oaxaca (about 5 hours away) who began utilizing hospital services over ten years before our interview, at which point both were inpatients for several months at a time. Mauricio did the talking: he said that Antonia didn't understand or speak Spanish because she was monolingual in the Mixe language. During the interview, Antonia gazed off to the side, looking troubled and quite sad, but alert. If I addressed her she rubbed her face and giggled a little, then looked at her brother to translate.

When I asked why they had come to the hospital for treatment, Mauricio told me the story of a dramatic thunderstorm that had occurred 12 years ago. Taking cover from the storm, Mauricio, Antonia, their mother, and some other family members ran to a cave they thought would protect them. The cave collapsed, however, and a large piece of rock crushed their mother, killing her. First Mauricio became ill; "my mind failed," he said. He began thinking a great deal, having nightmares, and "walking around like a drunk" even though he had not been drinking: "Yes, my mind was failing me and I didn't want to do anything, no work at all…cutting firewood, all the household duties, I couldn't do anything anymore but walk around like a drunk." Finally, because he could not function in his everyday life, an aunt from Oaxaca City told him to go to the psychiatric hospital, where he was admitted as an inpatient.

Antonia soon fell ill as well, with similar symptoms in addition to talking to herself, vomiting, having trouble sleeping, and wanting to 'go out alone.' Apparently she, too, received treatment many years ago from the hospital, but only recently had come back because she had started to feel badly again. She was prescribed Clonazepam, Risperidone (anti-psychotic), Biperiden (controls side-effects of anti-psychotics), and

Depakote (anti-convulsant and mood stabilizer). Mauricio did not know the name of his sister's diagnosis, but told me he thought they both got their illnesses from "thinking" [*por tanto pensar*]. He said the psychiatrist confirmed this impression by saying both of them were "thinking too much" [*pensando demasiado*]. Mauricio also conjectured that the fright [*espanto*] from the storm had caused their illnesses, then later said it might have been witchcraft. He attributed the witchcraft to the envy of others, explaining that they often had work and "passed their days well," such that others may have hired a witch out of spite. The *curandero* they went to had opined that the problem was due to an *espanto,* and had prescribed a ritual spiritual cleansing, or *limpia. Limpias*, Mauricio explained, "only help a little." Medications from the hospital were the only thing that seemed to provide real relief. "[W]hen we have medicine we get better and do things well. Without medicine the illness kills us…" Mauricio said they had had no problems with the medications and that neither of them had experienced side effects.

When I asked Antonia's psychiatrist Dr. Silva what Antonia's diagnosis was, she said it was a "*retraso mental*," a mental delay or retardation, and that she hadn't explained it because they would not understand. I asked if she knew that Mauricio had been hospitalized there too, ten years ago. She looked surprised. "Him?" she asked. "It was probably for alcoholism."

In this case, as in many others, Mauricio manages several different explanations for his and his sister's illnesses, all social and/or supernatural, the most central being *espanto* from the death of their mother in the thunderstorm. As he put it, "When we were all together [the family], this illness didn't bother us." After the accident, Mauricio said they had both fallen intensely ill [*nos caíamos mucho*]. Following this event, both

Antonia and Mauricio had suffered other terrifying experiences, too, including nightmares, encounters with animals, and falls—not to mention the potential witchcraft due to envy. Neither of them had ever had problems before the storm, Mauricio explained, but since then they have suffered a series of difficulties. Beyond saying that he and his sister suffer from illnesses, Mauricio did not articulate his or his sister's suffering in medical, psychiatric, or psychological terms, and repeated several times. However, he strongly articulated their necessity for medications.

Ahí curan nervios

Rosario lives and runs a *taquería* [taco shop] in a nearby town in the Central Valley of Oaxaca. The day we met, she was at the psychiatric hospital seeking help for her 12 year-old son Jorge, who began to have convulsions before he turned two years old. His problems had mounted in recent weeks, and Rosario said he was suffering from *nervios*. He told her that his head and body were burning and that he felt as though rocks were inside his nose, eyes, and ears. He angered easily; he suffered from *coraje*. His limbs hurt, the bones in his feet hurt, and he generally felt like an old person. Rosario said that Jorge heard voices and knocking on a wooden door, even though their door is made of aluminum. He also saw faces in the window. When this began, Rosario went on a search for treatment, and had gone to a variety of doctors—a pediatrician, neurologist, a nose specialist—and three different *curanderos*, most of whom told her "there's nothing wrong with the kid" [*el chamaco no tiene nada*]. They tried massages, herbs, x-rays, and *limpias,* to no avail.

Finally, a woman Rosario knows told her about the psychiatric hospital: “they cure nerves there [*ahí curan nervios*], and there they’re going to be able to cure your son.” Rosario’s inability to find confirmation from other doctors that her son was ill was one of the hardest parts ordeal and formed the basis for her extreme gratitude to Dr. González, the psychiatrist who attended to them at Cruz del Sur. Finally, someone confirmed that her son was sick, that he had an illness, and that he could be treated. “I give thanks to God that the doctor treated us well, and that I have hope he’ll get better. It makes me very sad to see my son that way,” she said, choking back tears. “The doctor here said my son is sick, but all the other doctors said there was nothing wrong with him.” Rosario said she thinks the hospital mostly serves ‘*locos’* but that she does not think her son will lose his mind, especially if the medications function as they are supposed to.

As our conversation proceeded, Rosario posited several explanations for her son’s illness: general *nervios,* a bad air [*mal aire*] that entered him when he fell down, a back injury. She also talked about how her separation from Jorge’s father had ‘traumatized him’ [*se traumó*] because he fears his parents will remarry and that the new spouse will beat him. After this, Rosario began to talk about how jealous her husband was and how much he would beat her due to his theory that when Rosario went out selling *tortillas* and *atole,* she was actually visiting a lover. He also thought she was involved with the men who patronized her *taqueria.* “He hit me for many years many years…Until finally he said if I didn’t leave, he would kill me.” Oftentimes he beat her in front of the children:

> I used to lock them in a room, but the room had windows and my kids would scream through the windows, they’d crowd around the window and they’d see

> him hitting me. He hit me so much—he hit me so much in front of [Jorge]. But I couldn't say anything [to my husband]. I told Jorge that I was against this, and he'd say, 'What I don't like about life is that my parents fight. Why do they fight like this…Why couldn't I have a different mother and father so I wouldn't have to see this?…' I told [Jorge] that with me, there wouldn't be any more fighting. [Your father] isn't going to say anything else to you, but even now when [the father] comes to eat, he scolds [Jorge] a lot; he treats him badly…He calls him an idiot, a donkey, and 'I've had it up to here with your fucking mother,' he'll say.

At the time of our interview Rosario had separated from the father, but—as the excerpt above indicates—he still comes by the house to eat and aggressively chastise Rosario and Jorge. She tries to protect her son from such strong words [*palabrotes*], but feels as though the whole situation has damaged him. "It's because of all this that he was traumatized, he was traumatized—by a trauma [*se traumó, se traumó, por un trauma*]. And maybe that's why all this stuff came to his head." The most important thing to Rosario was that her son experience some relief from his symptoms and that he be able to attend school, "because I never did," she said. Rosario was regretful that she had never received an education, and that as a result she could never help her kids with their schoolwork; she emphasized over and over how important an education was.

I asked Rosario if she had spoken to Dr. González about the family situation, but she said she had only described the symptoms. She did not know what her son's diagnoses were (Dr. González told us after the interview that they were epilepsy with secondary psychosis), but the doctor did say that after a month of taking his newly prescribed medicines, Risperidone (antipsychotic) and Depakote (an anticonvulsant and mood stabilizer), Jorge would start feeling better and getting back to his old self. Rosario had faith that this would happen, and held the prescription reverently.

Discussion

These case studies begin to illustrate the central importance of social and familial crises—particularly violence, loss, and relationship breakdowns—to patients' illness understandings and perceptions of recovery. Verónica and Emiliano explicitly attribute their illnesses to domestic violence on the part of their fathers, and both see psychopharmaceuticals as central to their ability to rejoin social life and resume their appropriate social roles. Like Mauricio, Antonia, and Rosario, Verónica and Emiliano pursued plural medical pathways, moving pragmatically between *curanderos,* spiritualists, doctors, and psychiatrists according to the efficacy of the treatments prescribed. This pragmatism is consistent with the findings from the literature on medical pluralism: by and large, patients make decisions based on a number of criteria, from cost to efficacy to illness understanding to the pursuit of social capital (Bade 2004, 2006; Crandon-Malumud 1993; Dein & Sembhi 2001; Finkler 1985). At Cruz del Sur, although medications can be expensive, their efficacy—or even the hope that they *will* be efficacious—is often sufficient to outweigh hesitation, perhaps particularly when patients have spent time and money pursuing unsuccessful treatments elsewhere. Families described saving up each month to be able to purchase medications for themselves or their relatives, and clearly they were willing to travel all day to get their prescriptions. Notably, very few patients complained of bothersome side-effects.

Mauricio juxtaposes a number of explanations for his and Antonia's illnesses, the most salient of which was witnessing the death of their mother in the thunderstorm and the isolation that loss engendered. Witchcraft was another distinct possibility from Mauricio's perspective, but losing family cohesion after the accident seemed a more

powerful explanation. Similarly, Rosario conjectures that her son Jorge's illness could be due to anything from falling down to *aire*—and she seems more concerned with determining the *cause* of the illness than are Verónica, Emiliano, and Mauricio—but the explanation she elaborated upon in most detail and with the most fervor was the 'trauma' that Jorge had suffered as a result of his parents' separation. Central to the separation was, of course, a situation of chronic violence to which Jorge was repeatedly exposed. None of these explanations are fully hegemonic, and they seem to shift even in the course of their telling.

Another important point is that in none of these cases are patients particularly concerned with diagnoses: Verónica knows what they are called—depression and anxiety—but does not know what they are, and Emiliano and Rosario do not know the names of their family members' diagnoses. This is partially due to the fact that psychiatrists do not seem to think such information is important; far more crucial from their perspective—and, apparently, patients' perspective—is medication compliance. These findings contrast with other studies which show that diagnoses can have important implications for patients' sense of moral status within the community (Brodwin 1996; Jenkins & Carpenter-Song 2005, 2008). Cruz del Sur patients were certainly concerned with the moral dimensions of their suffering, but diagnoses did not seem to play into their accounts or evaluations beyond affirming that their suffering had a name and could be treated.

To interpret these cases as pure medicalization of social suffering would thus miss several important aspects of patients' narratives: they do not fully embrace the biomedical model or identify themselves with their illnesses, but rather continue to

attribute problems to social breakdowns. Even more important, and as Rosario's case illustrates, part of patients' satisfaction with psychiatric treatment is the feeling that they have been listened to. They do not express being reduced to the 'clinical gaze'; on the contrary, they seem honored to have the time and space in which to tell their stories, even if doctors only hear the illness stories and not the social stories which frame them. Patients strongly desire psychopharmaceuticals and thus transform into 'pharmaceutical selves' (Jenkins 2010), but the degree to which selves are "oriented by and toward pharmaceutical drugs" (ibid: 6) seems contingent upon the degree to which pharmaceuticals create a space for hope, the possibility of recovery, and the ability to participate in the ebbs and flows of social life.

The following case study of Valerio contrasts with those presented above in that Valerio expresses profound ambivalence about both his diagnoses and about the medications. But he, too, attributes his 'problem of the mind' to socially rooted problems—in his case, discomfort speaking Spanish and undocumented migration to the United States. Also central to his narrative is the crisis of self and social relations his illness evokes.

Counter-Case: Medication Ambivalence

Todavía llevo esa mente en mi cabeza

My interview with Valerio was one of the more emotionally challenging interviews I conducted, mostly because Valerio was actively struggling not only with debilitating symptoms and paralyzing, obsessive thoughts, but also because he was so clearly struggling with what they meant about him, why he was sick to begin with,

whether he would have to take medication for life, and what significance his illness had for his life prospects, his family, and his sense of self. While most patients were sanguine about pharmaceuticals and hopeful about their potential to help them, Valerio was skeptical—even fearful—about the medications and their effects.

Valerio is a 28 year-old man from a village near the Zapotec market town of Tlacolula, where he lives with his wife and two children. He wore a royal blue 'Hollywood, California' t-shirt with a black baseball cap and sported a thin mustache with a goatee. He was quiet, shy, and somewhat withdrawn, tending to look down at his hands while he spoke in sad tones. He began his story from the beginning, saying that growing up, his family was composed of just four people living in the country, his father a poor *campesino.* The family spoke Zapotec at home, and when Valerio went to school as a child he was afraid and nervous [*me daba mucho nervio*] to speak Spanish; he said he would shake when the teacher spoke to him. This seems to have been the beginning of Valerio's unwanted symptoms; at about age 13, "Ideas came to my head about insulting God, and then I started feeling even worse. I started thinking horrible thoughts, like that God was going to send me to hell, or that He would punish me. Lots of negative thoughts started in my mind." Valerio's father took him to a doctor and he began taking medications, but he was overcome with guilt over the thoughts he was having.

Around that time, in the late 1990s, Valerio stopped his medication and decided to migrate to the United States. He said he was worried about crossing the border without documents, '*como mojado,*' and when he arrived in California his illness came back [*volví a recaer*]. His horrible thoughts returned, and he became obsessed with the fear that he had AIDS. He started washing his hands compulsively and was afraid of the toilet;

he was unable to work. His uncle in the U.S. sent him back to Mexico, saying they could not seek medical care in the United States because they would get caught, fined, and perhaps deported for being undocumented.

> When I got back to Mexico we still didn't know what my illness was, so we went to a *curandero.* We went to a—what are they called? The ones who divine things, but I don't remember that well what it was like. The man told us to go to the psychiatric hospital. Here, my illness started to get under control, but only because of the medications, nothing else. When I stop taking the medications, my illness comes back again.

At Cruz del Sur Valerio was hospitalized for two months and diagnosed with Obsessive Compulsive Disorder. He became perplexed and angry about the illness, preoccupied with questions around why he had it (in addition to the anxiety of speaking Spanish and migrating to the U.S., he opined perhaps a violent fall he suffered when he was young contributed to the problem), whether he would always have it, and whether his children would have it. The following interview excerpt begins to illustrate the extent of Valerio's anguish around the disorder:

> V: I want to be healthy without any problems. It hurts me so much to have this problem. Sometimes I get angry and then I stop taking the medication, but then my illness gets worse. I can't stand being like this, needing medication for my mind to be calm. Without it, my mind is disturbed. I go to church, and when I get to the altar, well…I don't know. It's like more and more ideas start coming to my mind and I can't control them. They come like a flood to my head, and then I start thinking that maybe God won't forgive me because I have these thoughts. Then, sometimes I feel like killing myself because of this problem.
>
> Whitney: Have you felt better with the medications, though?
>
> V: Yeah, a little, but I still carry this mind inside my head [*todavía llevo esa mente en mi cabeza*].
>
> W: Do you agree with the diagnosis that the doctor here gave you, or do you think your problem could be rooted in something else?

> V: Yes…Sometimes I think the doctor isn't sure. Because sometimes I feel like my head is burning and itching, and my vision starts to blur. I feel like I have a brain defect, but the doctor says, 'You don't have anything in your brain, it's just pure sensations.' But I, sometimes I don't believe what the doctor says. Sometimes I think about going to other doctors to get a brain scan.

Unlike most other patients I spoke to, Valerio was quite preoccupied by the nature of his illness and was not sure whether to trust the doctor. He urgently wants to understand the source of his distress, so much so that he feels a brain scan is necessary. And while Valerio does say that the medications—Zoloft (antidepressant/anxiolytic), Clonazepam (anxiolytic), and Ponteride (antipsychotic)—help 'control' symptoms, they do not seem to be effective enough to allay his doubts and apprehensions about them. About the medications Valerio says:

> I've had this problem of the mind [*problema de la mente*] for 15 years that I can't control. Sometimes medication manages to control it a little, but I don't lead a normal life. I feel like the medication controls my *nervio,* the mind, but, well, sometimes it doesn't manage to control it. Sometimes I just break down and because of this problem I have.

The medications scare him, Valerio says; they "block" his mind and augment his anxiety. Further, the medications interfere with his duties in his village; he was giving his obligatory community service when we met (required of all males in the village), and at the *fiestas* he said everyone has to drink beer and mezcal. He knows he should not mix alcohol and medications, so he stops the medications for a day to comply with expectations. The doctor has switched his medications a few times, but they have never helped "100 percent."

Valerio shyly asked me if I knew people with his illness who had had success with medications, or who had been cured; he seemed desperate to hear a success story, to

be able to cultivate some hope that he might find relief someday. I asked him why he felt so badly about having to take the medications, and he said "they don't get rid of the thoughts I have…Yes, it's because of that that I feel so badly. I'm taking medications and they don't work, and that's what pains me the most." He said he does not share his problem with anyone in his community; only his wife and parents know. "I don't tell anyone what I feel," he said. "I feel that my illness is something incredible, like no-one else in my village feels like I feel…If someone were to find out, they would make fun of me. They don't know about these problems, that there are people like me who have problems."

This sense of isolation seems to contribute to Valerio's anguish and anger over being afflicted and forced to take medications, which themselves contribute to feelings of guilt and inadequacy. The day we met, the doctor had doubled his dosage of one of the medications and had recommended he seek therapy with a psychologist once a week. He said that would be extremely difficult given that he has to work to support his wife and kids, but he was open to the idea. He seemed open to anything that might help him feel better.

> That's what I hope for, that one day will come, a moment in which God will illuminate my mind so I can go on with life, with everything. This is, how would I say it? This is the faith I have. That someday I will be like other people. That I'll be well, without problems.

Again, Valerio's preoccupation with his diagnosis and medications was not typical of patients with whom I spoke, most of whom did not tend to dwell on the crisis of meaning that psychiatric treatment represented. Much more central was the crisis of meaning that social breakdown occasioned and the sense of isolation that mental illness had created.

Valerio does, indeed, express feeling isolated, but the medications and diagnosis seem to exacerbate rather than relieve such sensations.

Like other patients, though, Valerio sees the etiology of his 'problem of the mind' as firmly rooted in social problems, including feeling marginalized as an indigenous language speaker and living as an undocumented migrant. The following case studies focus specifically on undocumented migration and its implications for mental health and treatment in Oaxaca.

RETURNED MIGRANTS AT THE PSYCHIATRIC HOSPITAL[6]

As indicated in Chapter 6 and as I continue to discuss in the following chapter, migration has become a major mental health concern in Oaxaca. This is exceedingly apparent at the psychiatric hospital, where according to psychiatrists about a third of outpatients are returned migrants. While some of those patients do not directly attribute their mental health problems to migration, my interviews indicate that many do—and that many actually return to Oaxaca for the express purpose of seeking mental healthcare due to unexpected and bewildering mental health crises *brought on by* the migration experience. Patient narratives indicate the extent to which structural conditions of vulnerability in the United States—including 'illegality,' lack of access to healthcare, traumatic work conditions, and persistent states of anxiety—contribute to distress, constrain migrants' possibilities for treatment, and shape their experiences and

[6] I am currently developing a research paper on this topic alone. There, I present additional case studies, extend my analysis, and review the literature on 'illegality' and on migration and health more thoroughly.

understandings of mental illness. These stressors and the disordered states they produce can prompt migrants to return to their towns of origin for help and support.

These findings are consistent with findings from recent studies on migration and health, but add a new dimension to them. With regard to the public health literature, the "Latino Health Paradox"—the epidemiological finding that recently arrived Latino immigrants have better physical and mental health than others with whom they share a similar sociodemographic profile—has been widely reported and debated. It is considered a paradox because SES is a well-known correlate of health status; in other words, "socioeconomic status is expected to correlate positively with elevated mortality and health risk factors" (Calvario et al. forthcoming). One explanation put forth to explain the paradox has been the so-called 'salmon bias' effect, the theory that ill migrants may be more likely to return to their countries of origin than healthy migrants, and thus fewer ill Latinos would be counted in American epidemiological studies.

However, to my knowledge no study has attempted to ascertain why exactly migrants would choose to leave the U.S. or what happens when they do return to their countries of origin.[7] Related to the salmon bias is the phenomenon of 'medical returns'—migrants returning to their home countries explicitly for health treatment—which seems to be a growing trend among Mexican migrants (Calvario et al. forthcoming, c.f. Bergmark et al. 2008; Horton & Cole 2011; Wallace et al. 2009). Though primarily reported among migrants residing near the U.S.-Mexico border, our CCIS findings and my findings from Cruz del Sur indicate that even Oaxacans—who live 1,500 miles from

[7] Investigating these processes are part of my research plan moving forward.

their home state even if they are in a border town—may be prone to returning to their hometowns in cases of illness.

A number of reasons could prompt a Oaxacan migrant to make the long journey home in the case of illness—reasons which speak to the condition of 'structural vulnerability' in which most Oaxacans exist in the United States:

> Defined as a positionality that imposes physical/emotional suffering on specific population groups and individuals in patterned ways, structural vulnerability is a product of class-based economic exploitation and cultural, gender/sexual, and racialized discrimination, as well as complementary processes of depreciated subjectivity formation (Quesada, Hart, & Bourgois 2011: 340).

Structural vulnerability is central to the ways in which many undocumented migrants come to experience themselves in the United States, and to the reasons migrants might decide to return to Mexico in cases of illness. From the perspective of Oaxacan mental health practitioners, these conditions can generate a profound sense of 'culture shock' among migrants, leading to PTSD (see prior chapter) and to a disorder they have come to call 'transcultural psychosis.' Once ill, many factors limit both documented and undocumented migrants from accessing health services: language barriers, unaffordability and economic constraints, transportation problems, lack of 'culturally competent' care, and unfamiliarity with healthcare options (Berk et al. 2000; Arcury & Quandt 2007; Holmes 2006, 2007; Castañeda 2010). The undocumented population faces additional barriers related to immigration policy given that many avoid health services due to fear of apprehension and deportation.

Returning to Oaxaca for treatment, sometimes in states of confusion and usually in states of despair, these migrants face yet more barriers in their struggles to

communicate with family members and healthcare practitioners on the Mexican side. All parties seek to reconstruct the returned migrants' illness narratives and accounts of treatment-seeking in the United States, but such efforts are problematized by the often bewildering and dramatic circumstances of illness and return migration (sometimes in the form of deportation), competing discourses about the nature of mental illness, as well as the lack of infrastructure for transnational healthcare and record-keeping. The following two case studies illustrate these themes.

Como si fuéramos un animalito

Bartólo is from the Mixteca region (Putla de Guerrero), about six hours from the hospital, and has been seeing a psychiatrist at Cruz del Sur for five years. He said he was receiving treatment for "sadness and anxiety," and that only recently was he able to travel the eight hours from his home to the psychiatric hospital by himself; before, he was so ill that family members had to accompany him. His problems began ten years ago when he was harvesting tomatoes as an undocumented migrant in Madera, California. Bartólo went to work in the United States to earn money to pay for his daughter's medical treatment; she was on the verge of death when he left, and the family had already sold their land. Bartólo described the border-crossing experience as terrifying: he suffered from hunger, dehydration, and heat exhaustion; he encountered snakes and other animals; and once he arrived in the U.S. he was constantly afraid of being apprehended by the *migra* and sent back to Mexico:

> Even when we knew [*the migra*] wasn't going to catch up with us, this is a fear. We were always afraid that we'd come across a snake—there's a lot of risk [at

> the border], a lot. That frightened me, as well. I suffered from hunger, from thirst, and that's another huge thing—you're dying of hunger because you can't go out and buy something to eat, for fear that they'd send you back to Mexico, right? That's how it is. The truth is that we weren't doing anything wrong, just looking for work. But it's a question of the laws of both countries. That's how it is—you can't do this and you can't do that—you don't know what to do. So that's what I felt most, and that's why I got this illness. So much fear on the border and the worry that there wouldn't be enough money for the family. That's what caused the illness.

Even when he did manage to cross successfully, he and other workers had to flee border enforcement repeatedly, running into the woods to hide from helicopters or officers in vans. He said they were treated "as if we were animals" [*como si fuéramos un animalito*], chased and thrown into the vans. It was not clear whether Bartólo himself had been apprehended or not, but his fear—and the traumatic memories those experiences left behind—were evident.

Living in an agitated state of fear and uncertainty in the United States, Bartólo began developing symptoms he had never felt before, which he characterized as sadness, anxiety, and crippling fear. One day, in the van on the way to the fields, Bartólo began to feel dizzy and asked if the van could stop for him to step outside for a breath of fresh air. He was told that if they stopped, it would be his fault if they were all apprehended by the *migra*, so they left him there in the middle of nowhere. Three hours later the boss came and picked him up again, but the damage was done: from then on, Bartólo's symptoms became chronic. He expressed that despite his health problems he had to continue working so as to pay off a debt in his village—and besides, he could not have afforded to go home for treatment and then pay a *coyote* to pass him over the border again.

Bartólo's first language is Mixteco, but he taught himself to speak Spanish, as well. When he sought help in the United States, though, he found no doctors or nurses

who spoke Spanish. They did not understand what he was trying to explain, and sent him home with a hydrating beverage and no further recommendations. He said, "I couldn't tell them that what I felt was sadness, fear, that I felt nostalgia, fear of being alone, sadness, that I wanted to cry. And all of this alone, alone, and I felt so much fear [*miedo bastantísimo*]. Fear, that's what I felt. And that's what I tried to tell the doctor but I couldn't—I couldn't speak English." He said he received no help from his boss on the farm where he worked in Southern California:

> I always worked but then when—there, they want us when we can work. But when you don't work, they don't want you. [Work is] what they want. It shouldn't be this way, but *ni modos*…There are so many people who need work, so when someone gets sick, well, they have to figure it out. So I got no support from the boss, the contractor. No support at all…[they said] we can't help you because you're a wetback [*mojado*].

Bartólo's experience vividly illustrates the expendability of migrant bodies (Holmes 2007), which represent cheap labor in the context of economic globalization. Simultaneously condemned and yet relied upon for the smooth functioning of economic markets and production (Castañeda 2011: 6), undocumented migrants are consigned "to zones of legal, social, and political marginality and vulnerability" (Willen 2005: 60). With little recourse to social services of any kind, migrants like Bartólo are forced to endure on their own.

When—after 'forcing himself' to work for some time—Bartólo finally made enough money to return to his home in the Mixteca, he was incapacitated by his symptoms for five years. Because he had never heard of mental health problems like anxiety and depression, it did not occur to him to seek psychological or psychiatric treatment. He and his family thought someone had cursed him with witchcraft, and he

received a number of *limpias* and other curative treatments. None of this helped, however, and he was bedridden when finally an aunt of his—whose *comadre*'s daughter works as a nurse in the psychiatric hospital—told him he should go to Cruz del Sur to get help.

Bartólo reported that his medications—Otedram (Bromazepam, a benzodiazepine) and Zoloft—are a great relief, and that since beginning treatment he has been able to resume functioning in everyday social life. Because he has had such success with pharmaceutical treatment and therapy—he travels several hours each week to see his therapist in a nearby town—Bartólo has taken it upon himself to teach his fellow Mixtecos about mental health and the emotional dangers of migration. In conjunction with nurses and doctors who give *pláticas* in his community, as well as with his local Catholic church, Bartólo gives talks in Mixteco about emotional and psychological health. He said that if he had been able to identify his own problems sooner, he would not have wasted years and years with a condition no one understood; rather, he could have sought appropriate treatment from the beginning. Thus, he wants to share this information with others from his community. Bartólo also said how helpful his psychologist had been in teaching him to 'think positively,' and that now he is teaching others from his church to not 'worry' so much—he thinks the course of his illness was exacerbated by his preoccupation with money and his resistance to asking for help out of fear people would know what he "thought and felt."

Another important aspect of Bartólo's story is the way in which his newfound faith in psychiatry supplants his faith in indigenous medicine, which provided little relief (he was very critical about the work of *curanderos*, particularly how much money they

charge. They are "never, ever right," he said). Although many Mixtecos utilize plural medical pathways, Bartólo is a convert to biomedical and psychological understandings of mental health, the only approaches that have enabled him to function in socio-familial life.

Se cayó

Manolo, another Mixteco from an area not far from Bartólo's home town, had been receiving treatment at the hospital for four years when we met, and came to the hospital with his brother Humberto. They were both neatly dressed in collared shirts and clean-shaven, with closely cropped hair. Humberto did most of the talking, though both were soft-spoken and serious. Manolo had a troubled look on his face throughout our conversation, and mostly looked at the space in front of him as he spoke. The brothers recounted how Manolo had been fine until he suddenly "fell" (*se cayó*, meant not literally but that his mind failed him, that he became sick) while working as an undocumented migrant in the U.S. He had been there before without any problem, and this time lived in Southern California for eight years. He was working a night job at some kind of grocery store, in charge of inventory, and said he had to use his head and focus a lot—which may have affected him, as did the graveyard shift. He didn't sleep much and finally could not handle it anymore, so quit. Unemployed for a month, he started to feel sad, lonely, and lethargic. Humberto was also working in the U.S., and begin to worry when he noticed that Manolo was not talking as much as he had, was not socializing or working.

Because Humberto had an agricultural job, the brothers only saw each other in the evenings. Humberto had trouble understanding what had happened to Manolo, and Manolo himself seemed to be struggling to understand, as well. They did not seek any treatment in the U.S., thinking it would be too expensive for them; instead, they waited until they were back in Oaxaca, at which point the whole family worried and a family friend told them about a psychiatric hospital in Mexico City. At great expense they travelled there, and it was there that they learned about the Oaxacan psychiatric hospital, which was more economical and not as far from them. Still, it required a three-hour trip to get there and the transportation costs were mounting.

Manolo is being treated for schizophrenia, an "enfermedad de la mente" that he had not heard about before he himself fell ill with it. The medication—Risperidone, an anti-psychotic—is greatly helping him, he said, and he has hopes that one day he will not have to take it. Humberto's view was more sober; I got the impression he thought Manolo would always need it, because when he lowered the dosage Manolo started to '*recaer*,' to sequester himself in his room and not talk to the other family members, and to act somewhat like a child. Humberto says that although the medication helps, Manolo is very different from how he used to be. Many family members and acquaintances think it is witchcraft that has caused this, not a mental illness—Humberto mentioned that people had said an ex-girlfriend might have cursed him. But this is "illogical," he said, insisting that he and Manolo did not believe that. Humberto also mentioned that some people said this illness comes from having gotten into drugs in the U.S., and he seemed to insinuate that perhaps Manolo taken drugs. There was no proof of it, however, and Manolo himself denied it.

The two seemed confounded by what could have brought on such an extreme change in character, and it did not seem as though they felt the illness had been explained to them. They seemed frustrated by not having an explanation, but the only explanation that made any sense was that something had happened in the United States related to working too hard or using the brain too much. This confusion about the source of the problem raises an important issue in treating emotional distress occasioned by the migration experience: whereas in daily life in Mixteco and other Oaxacan communities one is rarely far from family and other community members, in the United States migrants' jobs can be much more isolating and may contribute to circumstances in which only the migrant is aware of his or her daily activities and challenges. Migrants often move from a lifestyle in which social activities with the family and community form the centerpiece of daily activity to a circumstance in which they are working extraordinary hours every day of the week, often deprived of social interaction. This was the case with Manolo, and it is easy to understand how such a shift would be jarring, an extreme form of 'culture shock.' Furthermore, Manolo's isolation led to a circumstance in which not even his brother can fathom what might have happened to him. Drawing upon the common assertion that migrants are susceptible to the lure of drugs and alcohol, Humberto subtly accused his brother of having brought his illness upon himself by abusing such substances. Manolo firmly denied this, and Humberto conceded, looking unconvinced.

Psychiatrists, like migrants' family members, must recreate migrants' stories based on often quite fragmentary information. If migrants bring medical records back from the United States, a relatively rare phenomenon, psychiatrists attempt to translate

them and from there derive a diagnosis and treatment plan. However, I never heard a case in which mental health practitioners in the U.S. and Mexico collaborated to understand a migrants' case. Such coordination would at least provide contextual information for the Oaxacan psychiatrists, whose understanding of the migrants' plight is often limited to patients' bewildered recollections and family members' similarly scattered accounts.

DISCUSSION AND CONCLUSIONS

In this sampling of case studies, we see patients positing various explanations for their illnesses, frameworks through which the harrowing experience of emotional anguish and disorder can be understood. The hospital provides both a firm explanation—that these problems are the result of organic illness—and a treatment pathway that promises some relief from the symptoms, if not from the factors that patients see as the sources of their illnesses. Patients integrate the psychiatric framework to varying degrees, usually allowing—and often insisting—that they have illnesses requiring medications, but the medical interpretation of their suffering does not replace social and moral interpretations. On the contrary, speaking about illness seems to provide a space in which social suffering may be expressed, explored, and juxtaposed to other ways of understanding problems. Though the stories doctors tell about patients indicate patients operate within the framework of 'magical thinking' in their illness attributions, the stories patients tell about themselves indicate that no one vision or mode of interpretation is fully hegemonic. Rather, patients adhere pragmatically to explanations and forms of care which resonate depending on the context.

Especially in the context of the hospital, where consultations are swift and

focused most intently on medication management, psychiatric treatment cannot address the structural reasons for which many patients are raised with abusive alcoholic parents, or for which people live in enough poverty to have to travel thousands of miles to the United States to seek work, often without documentation. Nor can it address the grief that patients feel at the death of their loved ones, the terror they feel after assaults, rapes, or natural disasters, or the anger and hurt they feel as a result of an unfaithful spouse (all were problems presented by patients in my sample). In short, psychiatric treatment cannot—and does not try to—address the sources of social suffering in Oaxaca. Though practitioners are aware of the formidable social determinants of mental disorder and emotional anguish in the region, Cruz del Sur operates according to a highly medicalized understanding of patients' problems, one that acknowledges but does not attempt to broach those determinants.

Particularly in combination with the emphasis on social and cultural difference discussed in Chapter 5 and 6, the receptivity to psychopharmaceuticals among patients and the readiness of practitioners in public settings to dispense them in "99 percent of cases," as one psychiatrist at the hospital put it, is troubling. Cruz del Sur is by and large utilized by poorer Oaxacans whose lives do not necessarily allow for group or individual therapy with a psychologist; thus, medication is often the only form of therapeutic intervention to which they have access. Just as the emphasis on 'changing culture' can shift attention away from other aspects of social, economic, and political life in need of change, so too can the overly fervent distribution of drugs. Medicalization can indicate widespread forms of misrecognition regarding embodied distress and structural violence—and thus can undermine possibilities for broader social change.

To use Jenkins' words, the question becomes whether psychiatric treatment and specifically psychopharmaceuticals "alleviate personal and social suffering that is otherwise overwhelming, or do they merely mask and dislocate the source of such suffering and impede personal and institutional action that could more broadly transform disordered social and biological conditions?" (Jenkins 2010: 4). I would argue that in the present case of Oaxaca, both of these processes are happening at once. As I have sought to illustrate, patients are extremely vocal about both the social determinants of their distress *and* the importance of psychopharmaceuticals in mitigating their experience of distress. The ability of medication to transition isolated, suffering selves to social, stable selves seems to patients nothing less than miraculous, and their gratitude was humbling.

Despite the long distances traveled, the miscommunications with practitioners and the sense of not understanding one's diagnoses, and despite—or perhaps even because of—the cultural, educational, and economic disparities between doctors and their patients, it seemed patients are relieved to be 'attended' to, listened to, offered an explanation, and especially to be offered a potential path toward relief and recovery. If a specialist—an authority, after all—confirms that one is ill, or that one's son or sister or father or uncle is ill, it is a validation of suffering and an act of compassion—whether or not the treatment addresses the breakdowns that patients feel caused the illnesses in the first place. For the most part, patients did not seem to be preoccupied by the paradoxes often inherent to ingestion of psychopharmaceutical drugs (Jenkins and Carpenter-Song 2005): they rarely complained of side-effects, and—with the exception of Valerio and a few other patients—their accounts emphasize the ways in which such drugs aid in re-assuming participation in normal social life rather than how they impede function or

contribute to further suffering in any way.

The hospital acts as a central site of diffusion for *psicoeducación* and for the 'psy imaginaries' I described in Chapters 4 and 5, and patients engage many aspects of these imaginaries in their experience of treatment and re-fashioning of self that treatment inspires. As I have shown, however, they continue to imagine and situate themselves and their illnesses within the moral matrices of sociofamilial life. Treatment is individualizing and reduces complex expressions of distress to biological disorders, but patients are not reduced to 'biotechnical identities' (Ecks 2003) or psychiatric subjects; rather, these are only a few of the many ways in which they come to understand themselves. In this setting, we can see how both patients and doctors are enveloped in what Mary-Jo DelVecchio Good (2007) calls the "biotechnical embrace," itself fueling a "political economy of hope," the enthusiasm for biomedicine that drives its rapid global expansion (DelVecchio Good 2007: 364). Patients are not fully consumed by this embrace, but it is nothing if not hope that patients give their family members, friends, and neighbors when they report back about the effective care offered at Cruz del Sur.

CHAPTER 8

MENTAL HEALTH IN MIGRANT SENDING COMMUNITIES

INTRODUCTION

In this chapter I examine Oaxaca's 'culture of migration' and its perceived impacts on emotional well-being, mental health, and social life in the region. I begin by offering some reflections on the social meanings of migration in Oaxaca and on the experience of conducting research in a place where migration is ubiquitous.[1] Next, I review the literature addressing mental health in migrant-sending communities, which tends to emphasize migration's repercussions for gender roles and its deleterious impacts upon emotional well-being and mental health for non-migrating women whose spouses go to the United States. However, this literature also indicates that migration may in the long run contribute to gender equality and thus emotional benefits for women in migrant-sending communities. In this section I also summarize our health-related findings from the Mexican Migration Field Research and Training Program (Duncan et al. 2009; Calvario et al. forthcoming).

In the second half of the chapter I examine how mental health practitioners in Oaxaca City and the Mixteca region perceive of migration, in particular the impacts of migration-induced family separation and the return migration of young migrant males. I argue that migration is perceived and treated as a pressing *matter of mental health* and as a *source of social and moral decline*. From practitioners' standpoint, migration-induced family separation puts into motion a cycle of abandonment, family disintegration, and the

[1] See Chapter 1 for additional migration-related information and statistics.

abnegation of social roles. It creates both resentful, emotionally unstable women and alienated, deviant children; both women and children are viewed as prime candidates for mental health intervention. For their part, young migrants returning to their towns of origin are viewed as moral 'Others' who are further eroding the social fabric and contributing to surges in violence and mistrust. Put together, practitioners' discourse around migration frames it as a pressing moral and public mental health emergency contributing to societal and individual 'imbalances' as well as increased demand for mental health services. The chapter as a whole sheds light on the theoretical and evidential link between migration, mental health, and Oaxaca's growing field of mental health services.

BACKGROUND

Meanings of Migration: Reflections from the Field

It is difficult to overstate the role of migration in Oaxacan everyday life. For many Oaxacans with family members and friends in the United States, migrants' absence is—somewhat paradoxically—omnipresent: a source of constant thought, worry, hope, and ambivalence. For those with a history of migration who have returned to Oaxaca, memories of the journey—often recounted in extraordinary detail—tend to remain fresh, and the option of going back north seems to hover as a distinct possibility. I was hard-pressed to find anyone who had no experience of migration personally or by having close relations who had emigrated, but even those Oaxacans for whom migration was a more distant phenomenon had strong opinions about it and were well aware of many of the effects decades of emigration had had on their communities.

Migration carries huge symbolic weight in Oaxaca, and is the source of a great deal of ambivalence. Politically, migration is a central concern and a means of procuring capital on the part of politicians who promise to enact programs to reduce the need for emigration or to provide aid to communities where migration is the only option. Economically, migration-generated remittances are a main source of subsistence for thousands of Oaxacan families. Socially and culturally, migration can contribute to both prestige and marginalization; it sets the stage for new relationships and networks; it alters family structures; it creates fodder for stories, conversation, and debate. It contributes to intensified and rapid social changes, hybrid configurations, and new forms of identity and communication. Emotionally, it can create reason for hope, fear, or both: it can act as a source of distress, illness, and conflict and it can act as a source of comfort, a means for self-care and care of others. Migration at once symbolizes a life possibility and a threatening option of last resort.

Countless Oaxacans started casual conversations with me by asking where I was from, and upon hearing that I was American proceeded to volunteer histories of migration or the migration of a family member: the states they had lived in, the work they had done there, whether Americans had treated them well or poorly, or what they thought about America's immigration policy. Several of these interactions led to richly detailed and often very disturbing descriptions of border-crossing experiences. Others led to pragmatic questions about how family members might obtain documents or legal residence. Sometimes people asked more critical, interrogatory questions, such as, "Why do Americans treat my *paisanos* so poorly?" "Why do Americans hunt migrants like deer?" or "Why don't your politicians understand that our countries need each other?" Though

quite pointed and often meant to provoke, these questions usually yielded fruitful discussions about what a better immigration policy might be, what rights migrants should have while in the United States, or philosophical reflections about what impact decades of immigration has had upon the psyche, culture, and life prospects of Oaxacans. I was frequently struck by the *absence* of direct confrontation regarding what many Oaxacans (and Mexicans more generally) see as degrading conditions for and policies toward migrants in the United States. Not only that, but many of the Oaxacans with whom I spoke—particularly in high-emigration communities like San Miguel Tlacotepec—expressed some form of gratitude to the United States for economic opportunity or for the kind treatment they had received from Americans.[1] While many had had extraordinarily difficult experiences in the United States, few openly expressed rancor or explicitly anti-American sentiment.

Interestingly, however, I noticed a change in these conversations as more anti-immigrant legislation and sentiment emerged in the United States. Many Oaxacans were well aware of Arizona's SB 1070, which angered people and invited more questions centering on why the United States "hates" Mexicans.[2] I also noticed that young Oaxacan college students with whom I interacted were eager to tell me that they had no interest in going to the United States. They noted how difficult—nearly impossible—it was to get a

[1] Of course, such cheerful representations of experience in the United States could reflect a reluctance to offend me or to cause discord in interactions with me; however, it seems more or less understood that the types of Americans who visit Oaxaca are not typically those who are anti-immigrant or likely to be offended by criticism of U.S. immigration policy.

[2] SB 1070, or 'The Support Our Law Enforcement and Safe Neighborhoods Act' is an extremely restrictive anti-illegal immigration measure Arizona Governor Jan Brewer signed into law in April, 2010. It requires law-enforcement officers to determine immigration statuses during a 'lawful stop, detention or arrest' and restricts those engaging in commercial, public services, and other interactions with undocumented migrants. Its constitutionality has been challenged and the law continues to be hotly debated in the courts (along with other anti-illegal immigration state measures introduced around the country in recent years).

visa to study in the U.S. or even to visit for a few weeks as a tourist, concluding that they would much rather visit or study abroad in Europe—if only it weren't so expensive to get there.[3] While during my earlier visits to Oaxaca (in 2007 and 2008) I noticed an air of either resignation regarding migration or a sense that people considered the U.S. and Mexico—for better or worse—to be mutually dependent, in 2010-2011 I noted a subtle shift toward disappointment, irritation, and sometimes anger.

I also realized early on that my very presence in Oaxaca could act as a palpable reminder of the dramatic imbalance between Mexico and the United States. My presence there—and my ability to visit the United States when I had the need or inclination—meant I could freely cross a border that many Oaxacans have risked their lives to cross. This clearly impacted my relationships with friends and research participants, who were keenly aware of the fact that they would likely never be permitted to visit me in the United States as I was visiting them in Mexico. The night before I left Oaxaca at the conclusion of fieldwork, Carmen—one of my closest friends and also a participant in the project—commented on the situation. She said that someday, she hoped we would live in a world without borders so that we wouldn't have to be separated, so she could come see me, meet my family, help take care of my future children. We both choked up, and I

[3] It is extremely difficult for Mexicans to obtain temporary tourist visas to visit the United States. As the U.S. Department of State website puts it, "The presumption in the law is that every visitor visa applicant is an intending immigrant. Therefore, applicants must overcome this presumption by demonstrating that: The purpose of their trip is to enter the U.S. for business, pleasure, or medical treatment; That they plan to remain for a specific, limited period; Evidence of the funds to cover expenses in the U.S.; Evidence of compelling social and economic ties abroad; and That they have a residence outside the U.S. as well as other binding ties that will insure their return abroad at the end of the visit" (travel.state.gov). In other words, to visit the United States as a Mexican tourist one must demonstrate lack of incentive to overstay a visa and become an undocumented immigrant. This can be done through bank statements, proof of income, proof of home ownership, and other means. Few Oaxacans I know could provide such 'proofs.'

wrote in my fieldnotes later how the border had never felt so real, so arbitrary, and so insurmountable.

At that point I had listened to hundreds of migration-related stories, and had tried to imagine as fully as possible what it would be like not to be able to cross freely, particularly if I had close family and friends on the other side. The issue had been presented many times as not only political, but also—as this chapter discusses—as one that is profoundly emotional. The closer my relationships became with those lacking such freedom of movement, the more I understood the weight of the border as a symbolic and actual force of rejection, as a physical manifestation of inequality. Carmen, as a poor Oaxacan with HIV who could not possibly 'prove' that she would have no incentive to remain in the United States, had virtually no chance of ever obtaining a tourist visa to even visit friends in the U.S. for a few days. To Carmen, this fact represented not only political and legal injustice, but also a permanent fixture in her emotional experience, particularly in her emotional experience of relationships with the many Americans she had met.

Not only was my presence in Oaxaca a physical reminder of such imbalances, but so too was my own freedom of movement and the luxury of the work I was conducting. Though frequent whispers or yells of '*guera*, *guera'* [loosely translated as slang for 'white girl'] reminded me I was an outsider, I could walk the streets of Oaxaca unafraid to be seen or questioned regarding my immigration status. I could drive a car legally with my American license; I could see a doctor; I could conduct a research study. To many Oaxacans, the idea that I had the time and money to pursue an advanced degree and spend my days talking to people rather than using every ounce of energy to put food on

the table for my family no doubt seemed like an absurd excess. And not only did I have the legal and financial means to live, drive, and work in Oaxaca (though had I been gainfully employed in the formal economy I would have had to change my immigration status and obtain a work visa), but I was actually encouraged and welcomed. While I did encounter hostility in some corners—usually in the form of contrived bureaucratic hoops I had to jump through with public health services—for the most part I was welcomed with open arms and extraordinary hospitality.

Clearly, this is not the type of reception a Oaxacan living in the United States could typically expect to receive. More frequently, Oaxacans encounter blatant discrimination, restrictive laws which limit their freedom of movement both within the United States and between the United States and Mexico, and endless barriers to conducting even the most mundane activities. Aware of the formidable challenges Oaxacans and other Mexicans face in the United States, particularly in cases of undocumented immigration, many of my informants and friends questioned why anyone would choose to emigrate to begin with. They were critical about a culture of dependency they thought immigration had created: rather than make opportunities at home, people took it for granted that they could leave and make money. From this perspective, migration signaled a kind of laziness and reluctance to search for more sustainable options. Additionally, and as I discuss below, I encountered among many community members (some of whom had relatives in the United States themselves) a perception that migrants are more susceptible to alcoholism, prostitution, drugs, and family abandonment. Such impressions seemed only to be confirmed by young male migrants between the ages of 15-25 returning to their small communities due to the financial crisis

and lack of opportunities in the United States. As I discuss below, their presence invited commentaries from community members and health practitioners regarding the tendency of these young men to act like '*cholos*,' wearing oversized clothes, marking towns with graffiti, selling drugs, playing loud music from their souped-up vehicles, and drinking all day instead of searching for gainful employment.

The overall impression that comes through in my migration-related data indicates a tendency among many informants to blame all of Oaxaca's societal ills on migration. For some, the topic of migration contributed to a type of moral commentary not unlike the moral commentary so central to American political and social discourse around undocumented migration. However, while in the United States immigration-related moral debates center on legality (crossing an international border illegally, utilizing services meant for legal residents and citizens, obtaining driver's licenses, etc.), the moral issues at stake in Oaxaca tend to center on the roles Oaxacans could or should have in Oaxaca and Mexico—as productive citizens, parents, bearers of culture, and community members; the unfairness of life and immigration policy in the United States; and the ways in which migration and the influence of the United States corrupts Oaxaca and/or Oaxacans in the United States. In this light, migration comes to represent a kind of abnegation of responsibility and a source of moral and social decline.

Of course, from the perspective of many migrants and families of migrants, migration is not a choice but a matter of survival, an economic imperative in an intractable context of widespread poverty. In these cases, migration represents a decision between hunger and having food on the table—the least bad option in a place characterized by poverty, economic disenfranchisement, ecological erosion, and constant

exposure to the *idea* of the United States as a wealthy land of possibility. (Often, people were surprised to hear that poor, white Americans exist, as well; their impression was that only Latinos and African-Americans suffered the woes of poverty in the United States.) In villages with long histories of migration and thus strong networks with towns in the United States, emigration often represents the most promising (and quickest) path toward making a living, being able to buy a home, and starting a family. To many Oaxacans with whom I spoke, migration was the most natural and sensible life choice available.

However, whether critical or accepting of migration, nearly all of my informants lamented the ravages of migration on the social fabric of Oaxaca. Additionally, as I will discuss below, poverty and resultant immigration were—along with violence—the most important social issues impacting Oaxacan mental health from the perspective of psychologists and psychiatrists in the state. Indeed, as I will argue, migration has decidedly become a *matter of mental health* in Oaxaca, one which—like domestic violence, as I argued in Chapter 6—is increasingly dealt with in the clinical setting and which is contributing to the growth in mental health services. Before discussing the theoretical and evidential link between migration, mental health, and Oaxaca's growing field of mental health services, I will provide a background on research addressing the emotional impacts of migration in migrant-sending communities. Most of this literature is focused around family separation and its repercussions for emotional experience, mental health, and gender roles.

Transnational Families

Although there are robust medical anthropological and epidemiological literatures on migrant health, there is a dearth of work addressing health contexts—and the impacts of migration on health—in migrant sending communities. This is a considerable oversight since migration is a matter of global health that impacts not only migrants themselves but also their non-migrating counterparts in sending communities. Additionally, a thorough understanding of migrant health (and its apparent deterioration with time spent in the United States (Alderete et al. 2000a, 2000b; Escobar 1998; Vega et al. 1998) is difficult without an understanding of the health contexts from which migrants originate (Horton & Barker 2010).[4]

As I will discuss, migration-induced family separation was a central concern and preoccupation for both community members and mental health practitioners in Oaxaca. This is unsurprising given the ubiquity of emigration in Oaxaca, but it is surprising that so few studies of migration, anthropological or otherwise, qualitatively explore the emotional impacts of such pervasive—and often longstanding—separation. This is beginning to change, but as of 20 years ago Salgado de Snyder and colleagues "were unable to locate any studies addressing the psychosocial aspects of the family members (wife and children) who remain in the immigrant's community at home" (Salgado de Snyder 1993: 391). Salgado de Snyder did note that as of the early-1990s, migration researchers had begun to observe changes in family structures due to the absence of men and husbands in rural Mexican communities. Ranging from aspects of so-called "female empowerment," such as increased decision-making and "transfer of power and authority

[4] Several longitudinal and multi-sited projects have sought to fill this gap: the Mexican Migration Field Research and Training Program at UCSD's Center for Comparative Immigration Studies, and the Health and Migration Survey, part of the Princeton Mexican Migration Project.

from the immigrant male to his wife" (Salgado de Snyder 1993: 392, c.f. Gonzalez de la Rocha 1989) to family disintegration and psychological distress, such changes seemed to be clearly making their mark on communities of emigration—and they continue to do so.

More recently, the phenomenon of family separation has begun to draw the attention of researchers from a number of disciplines in various countries impacted by emigration and immigration, including Mexico and the United States. This literature, which is for the most part thin in qualitative, experience-near accounts, can be roughly divided into work focusing on spousal and partner separation and work focusing on transnational parenting (i.e. parent-child separation), though these configurations often happen simultaneously. I will discuss each separately, and then move on to discuss my own findings regarding perceptions and experiences of family separation.

Spousal and Partner Separation, Gender Roles, and Mental Health

A growing body of work examines the ways in which migration contributes to changes in gender relations, roles, and women's status in cases of and partner separation in a range of global settings. Some have found that women tend to become more independent and 'empowered,' taking on additional responsibilities and roles (Aysa & Massey 2004; Gonzalez de la Rocha 1989; Goodson-Lawes 1993; Gulati 1992; Khaled 1995; Parreñas 2005; Pribilsky 2004; Salgado de Snyder 1993). Others have found that far from emancipatory, the migration of a spouse creates additional anxieties and burdens for women, sometimes even contributing to gender inequality (Bever 2002; Salgado de Snyder 1993; Menjívar & Agadajanian 2007).

In their comparison of nonmigrating women in Guatemala and Armenia with spouses abroad, Menjívar & Agadaganian find that though women do tend to take on additional roles and responsibilities in the absence of their husbands, "the division of labor established through the husbands' migration further reinforces gender inequality" (2007: 1260). In her study of 'split households,' as she calls them, Kanaiaupuni (2000) argues that non-migrating women are central to the maintenance of male labor migration; they maintain and cultivate family relations and social networks which "ensure family cohesion and enduring social ties across borders" (2). Kanaiaupuni conceptualizes these relations and networks as "fundamental to the web of economic and political relations that undergirds transnational labor systems" (ibid). As such, nonmigrating women are powerful agents; at the same time, however, the additional labor responsibilities they take on can contribute to increased gender-based marginalization (ibid: 8), tensions, and compromised well-being. In all of these studies, changes in women's roles are mediated by local sociocultural contexts and such factors as pre-existing male-female relations, family dynamics, the feasibility of women finding work or seeking education, the level of remittances women are receiving, and frequency of communication between the partners (Menjívar & Agadajanian 2007; Aysa & Massey 2004).

With regard to emotional well-being and psychosocial impacts specifically, the literature is less robust. This is partially due to the fact that emotional well-being is in many ways encompassed by the work on women's experience and gender relations mentioned above, which captures the emotional tenor of women's experience in the absence of their migrant spouses and details various positive and negative emotions, changes, and transformations. At the same time, those concerned with global mental

health have frequently noted the dearth of literature on how, specifically, migration impacts the mental health and emotional well-being of non-migrating members of high-emigration communities, particularly immediate family members of migrants. The following studies do explicitly examine mental health and well-being, but they accomplish this using epidemiological approaches which still fail to capture the texture of emotional experience in migrant communities.

Salgado de Snyder reports a wide-range of both positive and negative impacts of spousal migration: satisfaction due to material gains through remittances; fear of abandonment; "loneliness and lack of support from the absent husband" (Salgado de Snyder 1993: 395); relationship problems between spouses and other unwanted or negative changes in family relations; increased 'empowerment,' decision-making, and economic responsibility (c.f. González de la Rocha 1989); and dissatisfaction with such 'empowerment' due to the breakage of "traditional and very structured gender roles found in Mexican societies" (Salgado de Snyder 1993: 398). She finds that women with husbands in the United States overall report high levels of emotional distress as measured by the Center for Epidemiological Studies Depression Scale (CES-D; Radloff 1977).

Other studies have indicated similar negative emotional and psychological impacts for non-migrating women. Analyzing data from the Mexican Family Life Survey, Silver (2011) finds statistical evidence that migration contributes to depressive symptomatology among women with husbands, mothers, and/or children in the United States. In their comparison of women with and without migrant husbands in a rural Mexican village, Wilkerson et al. (2009) find that women whose husbands are in the United States have lower mental health scores than women residing with their husbands,

and that shifts in ‘gender role ideology’ exacerbate these differences. Specifically, using statistical analyses of mental health surveys and surveys regarding gender role ideology, the authors argue that migration of a husband can both negatively impact mental health and contribute to more egalitarian gender relations—which they, along with Salgado de Snyder & Maldonado (1993)—theorize as detrimental to mental health due to shifts away from ‘traditionalism.’ While these studies represent first steps in the attempt to understand how migration impacts the well-being of non-migrating spouses, they lack sophisticated analyses of local dynamics and values and do not attempt to provide qualitative accounts of lived experience. It is thus hard to gauge the validity of the findings reported.

Overall, the literature suggests that the impacts of migration-induced spousal separation are far from uniform. Ranging from a gender equalizer to a force exacerbating mental health, migration’s effects on women depend upon a number of factors, from legal status of the husband while in the United States to the degree of financial support women feel their husbands’ migration has afforded the family.

Transnational Parenting

The phenomenon of parent-child separation due to parental migration has recently been the focus of a number of anthropological, sociological, and clinical studies. Most of this work focuses on how parental migration restructures family relations and how it impacts both parents and children, most of whom have been left in the care of kin and friends in migrants’ communities of origin. This work reveals just how difficult and challenging such “shifts in care arrangements” are for both parents and children

(Schmalzbauer 2010: 1860), though families in general show remarkable resiliency. Family disintegration does occur (see Oaxacan mental health practitioners' impressions in the following section), but sometimes the "hardships arising from separation paradoxically reinforce family members' commitments to each other" (Dreby 2010: 4).

In her examination of how both parents and children "find ways to make their relationships with each other meaningful" across borders in cases of Mexican parental migration, Dreby (2010) writes that

> The lives of parents and children divided by borders are essentially unequal. Parents and children live in different worlds, with different daily routines, different opportunities, and different sources of tension. As their lives unfold in the United States, parents are unable to meet the expectations of migration as quickly as they had hoped. Unmet expectations, particularly of migrant mothers, cause tensions and hurt feelings in parent-child relationships. Meanwhile, children in Mexico feel resentful of parents' absences. They have a difficult time proving their parents' sacrifices worthwhile. The emotional fallout of parents' work decisions is a great source of hardship in families.

Family structures change in situations of migration, and both parents and children must readjust their roles and expectations of each other. Often, remittances and gifts become main means of nurturing from abroad, though children often resent such gifts as inadequate stand-ins for parental presence and affection (Horton 2009; Hondagneu-Sotelo & Avila 1997). Children often perceive their parents' lives in the United States as privileged; exposed to American ways of living through media and correspondence, they assume their parents enjoy the luxuries of consumerism abroad even when in actuality many parents are barely scraping by (Schmalzbauer 2010: 1873). Many studies suggest that parents, for their part, also tend to struggle with such expectations and with the difficulty of explaining to children that migration is a sacrifice to ensure their well-being,

not a privilege (Schmalzbauer 2004: 1328). Such misperceptions and miscommunications contribute to the already tenuous nature of the familial bonds being negotiated across borders.

Like the research on spousal and partner separation reviewed above, research on transnational parenting emphasizes gendered expectations and changes in gender roles and ideologies due to migration and experiences in the labor market. Parreñas' (2005) work with Filipino children whose mothers are in the United States suggests that children's experiences of maternal migration are shaped by patriarchal gender roles which—despite the fact that mothers are engaged in international labor migration to be the breadwinners of the family—are only reinforced through migration processes (see Horton 2009 for a critique of Parreñas' approach). Judged for 'abandoning' their children, Parreñas finds that Filipina transnational mothers are marginalized and blamed for a range of societal woes. Similarly, Dreby notes that women suffer the brunt of criticism for migrating without their children more than men do (33), and Schmalzbauer notes a great deal of "gendered blaming" and accusations that 'left behind' children are inadequately cared for. "Other-mothers" (Schmalzbauer 2010) or "middlewomen" (Dreby 2010) take on much of this care, though transnational mothers frequently worry about the quality of such care and whether their children are receiving adequate food, education, discipline and guidance (Hondagneu-Sotelo & Avila 1997).

Hondagneu-Sotelo and Avila's study of Central American transnational mothers working as nannies shows the ways in which migration is can become a "radical gender-transformative odyssey" (Hondagneu-Sotelo & Avila 1997: 552). Migrant women reshape their own understandings of motherhood and duty to fit with the exigencies of

their lives as migrants and caretakers of others' children by sometimes transferring their longing and love to the children they care for in the U.S. (Hondagneu-Sotelo & Avila 1997). Their understanding of their own roles as mothers to children abroad broadens to "encompass breadwinning that may require long-term physical separations" (562). Thus they do not understand mothering from afar as an abnegation of traditional roles, but as a new means of fulfilling them. But such arrangements represent in many cases "a division at the very core of…personhood" (Horton 2009: 22) for transnational mothers, and dramatically illustrate the irony of global capitalist economies which "separates reproduction from production" (ibid). Horton shows how such separation produces gendered forms of 'embodied distress' among undocumented transnational mothers, which then feeds back upon and informs that of their children abroad. Though their children are absent, mothers' suffering is articulated in relation to that of their children; they maintain intersubjectivity across borders largely by virtue of their shared sense of vulnerability and loss (Horton 2009).

These intra-familial dynamics play out over longer periods of time than both parents and children expect them to, partially because changes to U.S. immigration policy have impeded circular migration among the undocumented by making the costs and risks of crossing the border too great to justify trips home (Cornelius 2004, 2006). Parents and children seem to adapt in many cases, finding various alternative means of nurturance; at the same time, transnational family arrangements—themselves resulting from global structural inequalities—can give rise to alienation, anxiety, and demoralization on both sides of the border. Such consequences should, as Hondagneu-Sotelo & Avila point out, "give pause to the celebratory impulses of transnational perspectives of immigration"

(567).

Health in San Miguel Tlacotepec

I have co-authored two chapters on health and migration based on community-wide studies in the Mixteca Baja town of San Miguel Tlacotepec and among Tlacotepense migrants in California (Duncan et al. 2009; Calvario et al. forthcoming), conducted as a part of the Mexican Migration Research and Training Program through UCSD's Center for Comparative Immigration Studies. In both our studies from 2007 and 2011, we find that health status among residents of Tlacotepec is significantly worse than among their migrant counterparts in the United States (Duncan et al. 2009; Calvario et al. forthcoming).

Our findings regarding *overall* health status in 2007 indicate significant disparities between the two groups: Tlacotepec residents were likelier to have been diagnosed with every disease included in our survey (Duncan et al. 2009: 175). Even controlling for age, gender, and income, we found a statistically significant disparity between the health statuses of California-based and Tlacotepec-based Tlacotepenses. Similarly with regard to mental health, Tlacotepec residents reported having received treatment for depression and other mental health problems (including *nervios,* which does not always indicate a perceived mental health problem per se) at higher rates than U.S.-based migrants, 11.8 percent and 7.4 percent, respectively (Duncan et al. 2009: 192). In 2011 when we conducted a study of mental health specifically (as measured by the short-version, 10-item CES-D, or Center for Epidemiological Studies Depression Scale), we found that Tlacotepec residents (e.g. non-migrants and returned migrants) were more likely to report

significant depressive symptoms than current migrants residing in the United States. We found a prevalence rate of 23 percent for depressive symptomatology among non-migrants; 21 percent for returned migrants, and 9 percent for current migrants (Calvario et al. forthcoming). Again, these disparities held even when controlling for other factors such as wealth, gender, marital status, age, and education level.[5]

We suggest a number of explanations for these disparities, among them sampling biases such as the so-called 'salmon bias' and 'healthy migrant' effects (see previous chapter). Important too, and consistent with the aforementioned literature, are the clear impacts of family separation and lack of social support in Tlacotepec. Our 2009 data show that "married women whose husbands live in the United States were over twice as likely to have been treated for depression (27 percent) than married women who live with their husbands (13 percent)" (Duncan et al. 2009: 192). Not only were women with husbands in the United States more likely to have been treated for depression, but so too community members (men and women) with at least one immediate family member in the United States (17.5 percent, compared to 8.8 percent without a close family member in the U.S.) (Duncan et al. 2009: 196). In the 2011 study using the CES-D, 32 percent of non-migrating women in Tlacotepec with husbands in the United States reported significant depressive symptomatology, compared to 25 percent living with their spouses in Tlacotepec.

[5] I tend to be skeptical of mental health scales, especially when administered by a large group of researchers among a population not necessarily accustomed to answering questions such as how many times in the past week they had felt sad or optimistic. However, our findings were consistent with mental health-related findings from the first study, as well, in which we found that non-migrating Tlacotepec residents were more likely to have experienced and received treatment for depression and other psychological problems than were migrants (Duncan et al. 2009: 192-193), and both studies were supplemented with in-depth and open-ended qualitative interviews with community members and health practitioners.

These disparities between U.S.-based migrants and Tlacotepec residents, as well as the disparities between Tlacotepec residents with and without immediate family members in the United States, merit further investigation. There are a number of factors at play—and, as we point out in our forthcoming chapter—many reasons a "small, poor, migrant-sending community such as Tlacotepec might be conducive to poorer mental health outcomes than relatively wealthy communities in California," including the sense of emptiness and desolation in the Mixteca region (Calvario et al. forthcoming). Family separation is a factor in the lives of migrants, as well, but while migration can undermine social support in communities of emigration such as Tlacotepec, migrants in the United States often develop strong social networks which could potentially ease distress related to family separation.

We must question the characterization of non-migrants as "left behind" (e.g. Salgado de Snyder 1993; Aysa & Massey 2004) given that many choose not to migrate, whether or not their close family members leave. Such a decision can indicate agency and, in some cases, allows for liberation from unwanted relationships, increased independence, and/or economic solvency, as some of the literature reviewed above indicates. Further, the structural conditions of vulnerability within which many migrants exist in the United States should not be understated. At the same time, and as the following sections help to illustrate, both family separation and a more general culture of migration can contribute to particular sense of isolation and experiences of emotional distress in high-emigration communities. The sense of desolation comes through in community members' accounts of their lives, and, when imagining and commenting upon

their family members' experiences of migration, so too do sentiments of longing and embodied anxiety (see next chapter).

I will expand upon these aspects of emotional well-being through two separate lenses. In the remainder of this chapter, I will present the perspectives of mental health practitioners, all of whom have confronted the issue of migration in multiple ways through their clinical and community practices. In the following chapter, I will shift to community case studies and examine the ways in which community members discuss migration and its implications for their everyday lived experiences.

PRACTITIONERS CONFRONT MIGRATION

As I developed this project, I theorized that migration-related distress would be an important concern in Oaxaca and that the state's growing field of mental health services could in part be tied to increased demand due to such distress. However, I had not anticipated the degree to which mental health practitioners would emphasize migration as a pressing *matter of mental health*. In my interviews with both practitioners and community members it became clear that not only was migration a central social concern which could quickly elicit debate, moral commentary, outrage, and reflection, but that migration was actually seen as a pathogenic force in the emotional and psychological lives of Oaxacans, potentially contributing to mental illness. Almost across the board, practitioners discussed migration as a determinant of emotional and mental health problems, a kind of public mental health emergency whose psychological repercussions they felt called upon to address. As such, migration was central to practitioners' theory of Oaxaca's changing culture of mental health.

Returning to the model I presented in Chapter 2, migration is represented as one of the most important social determinants of illness and distress [SD] in Oaxaca. In practitioners' view, migration is contributing to increased rates of emotional distress and mental disorder; as such, demand for mental health services is increasing [D]. To respond to this need, services [S] are growing in volume and visibility. While there are few public mental health programs designed specifically to deal with the impacts of migration,[6] migration is discussed in state public health documents and training manuals as a main contributor to mental illness and psychosocial distress.

Migration is of course not the only social determinant of distress practitioners described encountering and intervening upon in the clinical setting. Violence—both domestic and political—was also central, as Chapter 6 discussed. So too were the more general effects of poverty, modernization, urbanization, and globalization. There were exceptions to the portrayal of migration as contributor to mental health problems, particularly with regard to migration's perceived potential to contribute to female 'empowerment,' and I will discuss such exceptions below. On the whole, however, though different practitioners emphasized different aspects of migration's impacts, they regularly detailed its desultory effects on the psyche and emotional state of Oaxacans and reported the ubiquity of migration-related issues presented in the clinical context.

[6] Notably, though there are no public mental health programs for families of Oaxacan migrants or for returned Oaxacan migrants that I know of, there is a new humanitarian aid program for undocumented Central American migrants in the state (and passing through the state on their way to the U.S.). Announced in February 2011 by Oaxaca's governor Gabino Cué and implemented in conjunction with Doctors Without Borders, the program creates a Mobile Unit for Migrant Care and provides free medical and psychological care. The program is one of several outcomes of the recent *Modelo Integral de Convivencia Pacífica con Migrantes* Cué established to protect undocumented migrants' human rights after a series of reports on migrant abuses by authorities in the region.

Related to this perception of migration as a mental health threat, practitioners' accounts also reveal the ways in which migration is seen a source of moral and social decline in Oaxaca. In general, practitioners describe Oaxaca as deeply demoralized—full of dispirited individuals, but also as a society whose moral order is under assault. As we will see, practitioners view migration as central to this assault in several senses: it undermines domestic (parental and spousal) and community bonds through family separation and abandonment; it creates the conditions for deviance, aggression, and abnegation of social roles; it invites unsavory practices from the United States; it unglues people from their present circumstances and prevents them from investing in their communities. In this sense, practitioners' discourses around migration portray it as what Desjarlais and Kleinman, in their discussion of situations of chronic violence, call "regimes of social disintegration." Such regimes can create a "collective sense of demoralization…when a *society* loses its moral bearings" (1994: 11). Such societal demoralization "then folds back on the everyday exchanges and dispositions of families and individuals," reproducing itself in a kind of feedback loop (ibid). Like chronic violence, migration "both contributes to, and undermines, the very act of 'making sense'" within communities (ibid). For their part, Oaxacan mental health practitioners see themselves as called upon to intervene, to 'treat' demoralization in both senses of the word: by protecting individual mental health and by preserving (sometimes mandating and reconstituting) the societal moral order, guiding their patients back to the 'act of making sense.'

Practitioners invoke four interrelated aspects of migration in their discussions of Oaxaca's migration-related mental health and social-moral decline: (1) family separation,

abandonment, and 'disintegration,' particularly their repercussions for non-migrating women, children, and elderly community members; (2) the return migration of young migrant males, who are seen as threats to the public and moral order; (3) the more general 'culture of migration' in Oaxaca and its implications for identity and a sense of belonging among both migrants and non-migrants; and (4) culture shock and psychosocial distress for migrants, as discussed in the prior two chapters. For the purposes of the present chapter I will focus on the first three of these themes, which are intimately entwined. The following chapter will show how these themes are also present in the narratives of community members reflecting upon migration.

Interviews with practitioners do, of course, beg the question of whether emigration actually contributes to mental health problems or whether this is simply the natural perception of professionals whose job it is to diagnose and treat such problems. It is not my intent here to weigh in on whether practitioners are 'right' in their diagnoses of children and of the societal impacts of migration more broadly, but rather to convey how practitioners talk about migration as a social pathology contributing to mental health pathology and moral decline, and how they have mobilized to treat it.

Familias Abandonadas: **Practitioner Perspectives on Family Separation**

Like other aspects of migration, mental health practitioners in Oaxaca simultaneously represent migration-induced family separation, 'disintegration,' and 'abandonment' as threats to the local moral order and as concerning matters of mental health. As we will see, the two cannot be separated in practitioner accounts: what threatens the moral order of things on the societal level—particularly with regard to the

sanctity of the family—also threatens individual mental health. Concerns about family 'disintegration' were most pronounced among practitioners in the Mixteca region, which is unsurprising given the ubiquity of family separation in the region. However, the issue was also salient according to practitioners in the city who had had cases involving family separation and abandonment, who had conducted their social service in a rural community, or who were commenting on the phenomena more anecdotally.

Adolescents & Children

Both sets of practitioners (in the Mixteca and in Oaxaca City) expressed particular concern for the impacts of migration upon the behavior and mental health of adolescents. Jorge Díaz, a Huajuapan-based psychologist in charge of coordinating *Servicios de Salud* (SSO) mental health services in the Mixteca region, described the situation (as of January, 2011) as follows:

> J: We have statistics already. In 2010 we had seven suicides [in the Mixteca public health jurisdiction], so basically we're talking about a very elevated rate. There shouldn't have to be any deaths, but to have seven is alarming…We realized that those who committed suicide most often were women more than men in this situation, according to the cases. Depression is the prelude to suicide among adolescents, and adults get depressed too, right?
>
> Whitney: Uh-huh.
>
> J: [At a rate of] 70 percent.
>
> W: A 70 percent [depression rate]?
>
> J: Yes, who you find with at least a moderate or light depression. It has a lot to do with addictions, with violence, and, well, overall it has to do with the population's lifestyles. With our style of life [*estilo de vida*].
>
> W: So the rates have gone up? The rates of depression? Or…
>
> J: The rates of depression have increased over the past five years.

> W: Why?
>
> J: There are many factors. In this case…
>
> L: We're talking specifically about the Mixteca, right?
>
> J: Yes. In this case the most noticeable circumstance is emigration, where families remain here, abandoned [*abandonadas*]. Where the family often stays without the father or the mother…The parents go to work, and so they start dysfunctional families. Lots of times the father doesn't return, right? Due to various situations that arise in his life. So, you find families for whom poverty has created the need to migrate to the United States or to other places in search of work. So, this is the situation that we [as mental health practitioners] encounter, and—due to lack of guidance, our young people are unprotected. They're vulnerable to addiction to tobacco, alcohol…

To Jorge, the entire panorama of life in the Mixteca—and by association, the panorama of mental health statuses and outcomes—centers on poverty and resultant migration. By leaving, parents create 'dysfunctional families' and children lacking 'guidance,' thus setting into motion a cycle of separation, abandonment, and the creation of wayward children and adolescents susceptible to substance abuse. He theorized that elevated rates of suicide were also connected to the 'style of life' in the Mixteca—a style of life structured by poverty and emigration.

Both private and public mental health practitioners in Juxtlahuaca had similar opinions of the impacts of migration on adolescent mental health in the Mixteca region. Discussing her experience as an intern psychologist at Juxtlahuaca's IMSS hospital, Zoila Jiménez told me that they focus most on adolescents, because adolescents are "the most vulnerable population" to addiction and violence, "partially because they are in situations of abandonment." I asked her whether she meant abandonment due to emigration. She responded:

> Zoila Jiménez: …Exactly. To begin with, well, many parents are…they emigrate to the United States with the idea of having a better quality [of life], apparently. A firmer economic livelihood. Mothers sometimes have many children, and they can't give them the attention they should. The older sons will stop going to school and start working. And if they have friends, well, they hang out with the friends and sometimes they're not the best friendships. Sometimes young people will come back from the United States and bring back customs from *Mara Salvatrucha* [a transnational gang composed mostly of Central Americans]…I don't know, *cholos.* Vandals. So they bring lots of new ideas, sometimes they seek to imitate so they can identify, to feel like they belong to a group. Unfortunately, sometimes they fall into vandalistic acts. They assault, they rob, they kidnap—there's been a little bit of everything, you know? There have been young people involved in very delicate cases recently, even though it seems like a tranquil community.

By this account, although parents are 'apparently' seeking a 'better quality of life,' they are also subjecting their children (of which there are too many to begin with, Zoila implies) to abandonment. Without parental support and role models, these children begin to identify with the 'vandals' and '*cholos*' coming back from the United States.

Similarly, psychologist, researcher, and head of Oaxaca's psychological association Julio Castro recounted his findings from both clinical practice and research he has conducted in Oaxaca:

> Julio Castro: What we've seen with migration has been more than anything the effects upon families, which disintegrate because family members go to work on the other side [the U.S.]. So we've seen what this produces, which is childhood conduct disorders. We've seen that it creates anxiety reactions, important reactions of depression, and that the money that people working on the other side sends does not resolve these problems in a direct manner. It can make these problems worse, because families who receive money are seen with a certain resentment by families who don't receive this money. So this leads to more division in class struggles, even within the same populations. Also, when people come back from the other side, they bring with them various problems that they experienced as they were integrating into that society. So this generates the so-called *cholos,* gangs that come from the lowest strata of the continent…from El Salvador, Nicaragua, Honduras, you know? And [Oaxacan migrants] live with these populations in the United States, in California particularly. So we've seen that when a family member goes to the United States to look for work, something similar happens to when a family member ends up in jail. It's more or less the same. That's what our data show, our studies.

In addition to producing 'childhood conduct disorders,' 'anxiety reactions,' and 'important reactions of depression,' Julio echoes Zoila's impression that abandonment often leads children to engage in dubious behavior—perhaps precisely because they have abandonment-related mental health problems. Such dubious behavior is not only portrayed as family-level problem: it threatens the broader social fabric, transforming 'tranquil' communities into scenes of violence and disorder. Growing up without role models, confused about why their parents have left, and generally lacking the type of support practitioners think necessary to thriving development, these children are decidedly "at risk" from the viewpoint of Oaxaca's psychologists and psychiatrists: at risk mental health-wise, and at risk morally.

With regard to childhood and adolescent mental health specifically, as Julio indicates above, the prevailing view among practitioners is that parental migration and family separation is productive of individual pathology. Zoila described disturbing symptoms among Mixteco children:

> Z: [Migration has had effects] in every sense…principally depression, anxiety disorders for kids, you know? These are kids who…who begin to pull their hair out, who suffer from night terrors, who suffer from enuresis [bedwetting], who bite their fingernails. They're really anxious kids, depressives who are self-absorbed [*ensimismados*]. Why? Because they lack affection, attention, no? There are many, many aspects. They suffer more—more anxiety, in the case of children, and a lot of depression in the case of adults.

Zoila's comments begin to shed light on the degree to which childhood emotional distress generated by parental migration is perceived as a pressing issue of mental health. Whether they have elevated levels of anxiety which they manifest by pulling their hair out, biting their nails, wetting the bed, or suffering night terrors, or whether they become

self-absorbed, rebellious, or violent, the problems are viewed as matters of mental health best dealt with in the clinical setting, where they are likely to be diagnosed as anxiety disorders, depressive disorders, and behavioral and conduct disorders. Importantly, embedded in these impressions is also a moral evaluation regarding the parents who subject their children to such suffering.

In addition to mental health problems, practitioners emphasize the more diffuse resentment young people with migrant parents develop. Adriana García, a psychologist in Oaxaca City with a private practice focusing on children and familial therapy, said that many of her young patients were in situations of family separation and abandonment. Speaking about migration's impact for them, she emphasized the resentment and the emptiness of remittances as a gesture of affection:

> Adriana García: [Globalization and migration] generate a lot of anxiety in young people. Like, maybe the parents go to seek a better life, but, well—psychologically there's abandonment, you know? They leave the kids in someone else's hands…I have a lot of patients who are children and they're left under the care of their grandparents, and the grandparents aren't really in the position to educate them, no? They're not in the mood to educate the child, and this generates a lot of resentment. No? Toward the parents who aren't there. They send money, but they're not there.
>
> W: They're in the United States?
>
> A: Yes, I have patients, 6, 7, 12 years old, because their parents have to leave—there's no psychological understanding of why the parents need to have a better life. The child always needs his parents, and, as an adult, this [the absence of the parents] generates resentment…
>
> W: …So even if they're giving—perhaps receiving money, it's not enough psychologically.
>
> Adriana: Psychologically, no, no—because they always hope that the father or the mother will come back, and sometimes they don't. So there's disappointment after disappointment after disappointment. I have an 8-year old patient, a little girl, who's already lived four years without her mother or her father. She really doesn't know them. She knows they exist, that they're in the United States, and

> they know that they send dollars, but she doesn't know them…She wants to be with them. She's with her grandma but the truth is that she wants to be with her parents. It's a feeling any child would have. How's it generating—or what problems is it going to generate for the future? We don't know.

Here again, practitioner perceptions of both the mental health and moral implications of parental migration come through. In addition to the loaded term 'abandonment'—used over and over again in reference to migration—there is the dubious choice of leaving children in 'someone else's hands,' generating 'disappointment after disappointment after disappointment' in children, who 'have no psychological understanding of why the parents need to have a better life.' This view is somewhat consistent with clinical literature on migration indicating that in cases of family separation, such disappointments may lead to a "continual pattern of rejection and counter-rejection" between parents and children, potentially contributing to families seeking psychological treatment and support (Glasgow & Gouse-Shees 1995; Suárez-Orozco et al. 2002: 626). Practitioners express that children feel rejected by the parents who leave them, and—as we see below—may themselves may begin to reject their children out of frustration and alienation.

Of course from the perspective of many migrants, going to the United States is explicitly *not* a decision to have a better life personally, but to be able to provide a better life for one's children. While migrants can attempt to show affection, commitment, and devotion through financial support, both practitioners and community members viewed such affection as insufficient to sustain non-migrating children and partners on an emotional level. As Adriana put it, her patient knows her parents 'send dollars, but she doesn't know them…She wants to be with them.' Even when remittances provide

opportunities which would be otherwise unattainable, practitioners express that the mental health costs outweigh the financial benefits.

Indeed, resentment on the part of migrants' children is a commonly reported aspect of transnational parenting, as ethnographies of migration-related child-parent separation have shown (Horton 2009; Hondagneu-Sotelo & Avila 1997). Horton finds that a complex system of 'bargaining' emerges between children and their migrating parents, in which parents seek to send money and gifts, which "serve to bridge national borders" (2009: 33). For their part, however, "children themselves refuse the logic by which a parental presence is transubstantiated into possessions" (ibid). Though Horton's account of children's reactions to parents absence is based upon the reports of mothers rather than children themselves, her findings are consistent with the resentment—the 'disappointment after disappointment after disappointment'—Oaxacan mental health practitioners report in their young patients.

Parental emigration here carries a great deal of moral weight: though many of the behaviors in which the abandoned, lonely, and resentful children of migrants engage are themselves represented as morally dubious, it is ultimately the parents' 'choice' to leave and thus they are viewed as responsible for such problems. 'Abandonment' itself—initiated by parents and contributing to the creation of 'dysfunctional families'—is seen to have negative implications for emotional experience and mental health, initiating a cycle of disappointment, resentment, and disillusion that may then prompt young people to engage in 'vandalistic acts,' violence, and substance abuse.[7] Migrant parents are thus

[7] Schmalzbauer (2010) makes a similar observation: "In addition to the blame mothers put on themselves, and the blame that their children may place on them, absent mothers are frequently held responsible for

subject to harsh moral evaluations: the overall impression seems to be that migration-induced family separation has created a society of troubled youths who do not know who they are—or, for that matter, who their parents are—and who are susceptible to emotional issues, behavioral problems, and moral failings. Such perceptions are not surprising, per se, but given that many Oaxacans emigrate with the explicit purpose of providing a better life for their children, they are tragically ironic.

Spousal & Partner Separation

Long-distance romantic relationships (to which the excerpts above also allude) are another important aspect of family separation. Adriana García, quoted above, sees this as a problem particularly because it often means infidelity and the creation of what she calls "double families":

> A: There's a lot of family disintegration, right? 'Double families' [*las dobles familias*]. The family they have there and the family they have here. And the two families both know that the other family exists, and this generates a lack of control as much for the wife as for the children, you know? As much [lack of control] for the woman over there as for the children over there. And there are many families like this, of half-siblings or stepmothers, a lot of them, and this psychologically affects people, no? Because they don't understand.
>
> W: Do most of your patients have situations like this?
>
> A: Yes, yes, actually where I did my social service was in a town called San Lorenzo Cacaotepec, Oaxaca, 20 minutes from here, and it's a city where all the men are gone because they're in the United States, you know? It's only women, so truly, they know who the husband's lover is because it's a small pueblo. It's something they have to live with. And the kids, well they want to go to the U.S. to be with their fathers, and sometimes [neither the father or the mother] is there, so this generates resentment toward the figure who's gone…Really, these are devastating cases. The mother depressed because her husband has another woman, the kids aggressive and violent because they don't have a paternal figure.

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many of the social ills befalling youth in Central America and Mexico, such as gang violence and promiscuity" (1870).

> This divides the family, and, well, psychologically there are many things that [migration] does to unbalance them [*desequibilarse*].

So, in addition to their children becoming 'resentful,' 'aggressive,' and 'violent,' mothers deal with abandonment and fears of infidelity on the part of their husbands. Interpreted through the lens of mental healthcare, this abandonment contributes to both 'lack of control' and to 'imbalances'—both in families and in individuals. Also related to the moral resonance of migration-induced spousal separation, practitioners mentioned health-related fears and the quite common suspicion that migrants were bringing sexually transmitted diseases back to their hometowns and infecting their wives. As we report in our 2009 chapter, Tlacotepec-based physicians and public health workers created awareness-building initiatives, in part to warn women of the risk that their returned migrant husbands might infect them (Duncan et al. 2009).

Several practitioners mentioned the problem of spousal infidelity going the other way, as in non-migrating women being unfaithful to their migrant husbands. They discussed angry returned migrant husbands wondering who impregnated their wives, thus contributing to both community and marital tensions. "Because of all the family disintegration," one doctor said, referring to patients she had seen, "there's this conflict, and [the non-migrating women] look for someone to give them love. They find someone and then they get pregnant, because there's no awareness of these issues." I asked if those women's husbands were also unfaithful. "Well, I don't know—they're in the United States!" [8]

[8] Horton (2009) notes yet another potential configuration of family separation, in the case of migrating Salvadoran mothers who start "duplicate families" in the United States, thus generating additional resentment on the part of children remaining in El Salvador. This phenomenon did not seem to be common

Perhaps the most elaborate account of these processes came from psychotherapist and hypnotherapist María Cruz. Based on cases she has dealt with in her private practice in Oaxaca City, she details a series of repercussions stemming from paternal migration and the 'lack of control' it generates:

> María Cruz: Migration, I think, has been accentuated in recent years. Maybe in the past ten years it's become more accentuated, and in kids and adolescents is where the problems, the repercussions are most notable. On the level of the father's absence, there's family disintegration and the mother is going to feel alone. She begins to feel lacking [*carente*], she begins to feel resentment as time begins to pass, and within two to three years she begins to feel frustrated…With rancor toward the person she considers has abandoned her…And they recognize that all of this begins to build up in their kids.
>
> Then the woman begins to look for a way to rebuild her life emotionally—she begins to toy with the idea of looking for another partner…She begins to look for another family. The kids of the other family feel isolated—sometimes they grow up with grandparents or aunts and uncles, sometimes in another physical place altogether, not close to the mother. The mother goes somewhere else and this begins to affect the kids…They begin to want to see their mother, and they begin to feel more distant. This rejection begins to affect them. So when we have a rebellious adolescent, an adolescent who doesn't want to go to school, who has very antisocial conduct, in this moment they bring it to the other's attention or to the attention of other close family members, but the process keeps happening. It has repercussions for the mother, and if the woman had a healthier attitude toward this it could help her kids more, but unfortunately there's a lot of ignorance, a lot of misinformation about how to manage this—how it could be a healthier process for the women who are far from the fathers [of their children].
>
> More recently, we begin to realize that women are emigrating, and so their kids are staying with family members and there is a huge lack of control. They don't form adequate identities, their self-esteem is altered, and then we start noticing kids or adolescents at young ages already suffering from depression, or stress, or an eating disorder…And for me, the fundamental basis of it all is the affective deficit [*carencia afectiva*] on the part of the mother in these first years. This, I'm telling you, is very well-documented by Freud…

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among Oaxacan families: I never heard of a case of a mother leaving children in Oaxaca and beginning a new family in the United States, though I do not doubt that it may happen. I did, however, know of several cases of husbands/fathers who emigrated and began new families in the United States. My impression was that if a mother were to emigrate and leave her children in Oaxaca, she would in most cases eventually reunite with their children, either on the Mexican or American side of the border.

In María's view, it is not so much the absence of fathers which causes problems for children, but the ways in which fathers' absence affects mothers, causes loneliness and resentment, and ultimately leads them to desire new mates and new families. The root of the problem according to this account is unaffectionate, unavailable mothers who cannot offer the type of emotional connection children need, in María's opinion, to fully form identities and self-esteem. As a result, they develop mental illnesses such as depression and eating disorders. Like other practitioners, María offers moral evaluations of mothers who—in attempts to 'rebuild' their lives 'emotionally'—abandon their own children, to whom they never offered adequate affection to begin with. These children, in turn, become 'rebellious' and 'antisocial,' with malformed identities and altered self-esteem, thus further undermining the moral and social order.

Lara Hernández, a psychologist in Oaxaca City with a private practice and a position working at a non-profit helping young women from indigenous communities receive college educations, had a similar view of the connections between partner/husband migration, problems for mothers, and childhood mental health issues:

> Lara Hernández: If a couple, for example, if the husband goes to the United States—which is a really frequent problem, migration—the mother stays alone. So the mother has to work like crazy because the father isn't present, and sometimes they send [money] and other times they don't. So this implies abandonment of the children, and the abandonment of the children then leads to sequelae for the children as they grow up. For their part, there are mothers who aren't tender, or who are full of resentment or insecurity. So depression comes up for different reasons, but I think at the root of it is low self-esteem and lack of tenderness, of acceptance…

In Lara's opinion, which is consistent with many of the views presented above, 'abandonment' and family separation has repercussions for both mothers and children,

though these repercussions may take a number of different forms. Here, the absence of the father is portrayed as a type of trauma which leads to continuing problems (sequelae) for children and mothers—and for the relationships between them. If mothers are bitter and resentful for taking on a number of new responsibilities and lacking the affection of their children's fathers, they then lose the capacity to care for their children, to be 'tender,' nurturing, and to accept themselves and their children. As I have pointed out, such accounts add an important dimension of moral judgment to the understanding of migration as a mental health phenomenon—a judgment that falls upon 'abandoned' mothers, whose own troubles and difficulties expressing affection lead to problems for their uncared-for children.[9]

A vision of what the ideal mother might look like according to Oaxacan mental health practice begins to emerge from these accounts. The ideal mother is clearly not one who risks her life to go to *el norte* to send money back for her children's well-being, but rather one who—whether there is enough food to eat or not—is fully able to nurture, express affection, and experience a strong mother-child bond, which is seen as paramount to children's development. Although these accounts widely acknowledge that migration occurs due to the widespread condition of poverty in Oaxaca, how mothers might sufficiently 'nurture' in situations of scarcity and insecurity is rarely addressed. Mothers

[9] Suárez-Orozco and colleagues note that an understanding of maternal migration as potentially detrimental to childhood development, sense of self, and emotional functioning are largely based upon psychological object relations theories and attachment theories—'Western models' that may not be applicable in situations where parenting is a shared responsibility between kin groups. Such models may overemphasize the "pathogenic potential of ruptures in the parent-child dyad" (Suárez-Orozco et al. 2002: 628). My study did not children's experience of parental migration, so I cannot say whether such models would be appropriate in the Oaxacan setting; however, it is notable that Oaxacan psychologists themselves base their understandings of migration's effects on such models. They nearly unanimously emphasized the negative impacts of parental migration and did not see 'foster parenting' by other kin as an adequate alternative.

are simultaneously considered victims of a larger system, responsible for its effects, and responsible for managing the moral fallout such effects produce.

One practitioner suggested that migration is a symptom of disordered priorities among migrating Oaxacans:

> Migration has an impact [on mental health] because the family disintegrates, and there's no room for mental health...There's no space, no area—it's not valued. Human relations aren't valued...the father…the father's role with children, and with the wife—money is much more important. Money. Of course there is a lot of poverty around Oaxaca, lots of poverty, so who's going to worry about mental health? But it has an effect—sometimes there are those who leave for years, some member of the family who goes for 5, 10, 20 years. Relations change.

Though this practitioner acknowledges that "there is a lot of poverty around Oaxaca," he sees a preoccupation with money as undermining "mental health" and "human relations."

Many practitioners also discussed changes in women's roles due to partner and spousal emigration, and responses to this process on the part of practitioners were mixed. Dr. Pérez, a Gestalt psychologist and general doctor from the Mixteca who had a private practice in Oaxaca City, described the situation as follows:

> Dra. Pérez: As a society, we are living the impacts of migration very intensely. There is a lot of abandonment. One of the characteristics of our population is what women do—they stay with the children and [for them], migration has had a huge impact. As heads of family, women in Mexico are the mothers, the ones who do everything, and migration has affirmed this. There's an incredible percentage of towns where the majority are women, adolescents, and young people who can't yet migrate, and the workforce, those who are organizing are women or the elderly, the very old. So this creates a role change that you never saw in earlier generations, in which this power was given to men. Now women are carrying these huge responsibilities, with a great deal of solitude, with a lot of abandonment.

Dr. Pérez spoke at length about women's compromised position in Oaxaca, particularly with regard to *machismo* and domestic violence. But to her, the aspects of

'empowerment' that come along with heightened responsibility when fathers migrate are unwanted and burdensome, even contributing to women's isolation.

While the above practitioner accounts represent partner and spousal emigration as a major contributor to both mental health problems and abnegation of morally valued social roles, some practitioners thought partner and spousal migration was a huge benefit for women, one of the only ways they could occupy more powerful roles in their communities. Toward the beginning of my fieldwork I was invited to speak with a group of psychologists at the *Centro Humanista* (described in Chapter 2), and we discussed the issue at length. The psychologists present had all done a great deal of work in different types of communities, and had strong opinions about the emotional advantages men's migration created. Irma, one of the psychologists, began talking about a community in the coastal Mixteca region where many of the men have emigrated.

> Irma: What happens to the women when the men migrate? What we see when we do work there, generally, ummm, when an indigenous woman from this region stays and is in charge of the family, she makes many decisions. She takes part in all aspects of work, and she participates in [community] meetings. But then the husband only needs to show up, just show up one day, and her role goes back to complete dependency. The person changes completely in this moment—she's someone else. So when the husband is gone she performs perfectly well, but then the husband just shows up the next day, and already—
>
> Dr. Zaragoza: You mean like widows—the 'widow effect.'
>
> [Everyone talks and many begin laughing]
>
> I: But this is something you notice…or at least something that I notice.
>
> Z: Have you heard that about the widows?
>
> Whitney: No.
>
> Z: In Mexico they say that there's no widow that's worse off than when she was married.

> [Laughter]
>
> W: [laughing] Oh yeah?
>
> Z: Which is to say, their emotional state improves [without their husbands].
>
> I: [The woman's] emotional state is different, her behavior in the house is different, right? They develop well, very very well in their work. And then the husband shows up and it changes things completely. It's really, really powerful.
>
> W: Very interesting. So you haven't seen women who have had emotional problems when their husbands leave—on the contrary?
>
> Z: When [their husbands] come back.
>
> [Everyone laughs]
>
> Mario: It elevates their self-esteem.
>
> I: On the contrary. On the contrary. In the case of women. I don't know—I see it from the perspective of who's taking the active role. Who's the boss of the family. Now I don't know what happens to the kids, with that part of the family, but the woman becomes boss of the family and her behavior is totally different. It's for the better, from what I've seen. It's been very good for them. I don't know about the kids, but for women it's totally for the better.

We continued discussing the topic, but the consensus among this group was that women were more independent, more active, more involved in their communities, and more self-confident when their husbands were in the United States. "Their world opens," one psychologist in the group said. Another said "the [remittances] gives them power and freedom—they feel freer and they *are* freer." The emotional problems start when husbands come home, not when they leave, because women's newfound independence and roles are compromised. Irma said that then, "they regress to dependency, and it's automatic. They don't question it. The dependency is automatic. It's cultural."

This is a very different view of migration's implications for non-migrating women than those recounted above, and I encountered similar impressions among some

community members and healthcare practitioners in San Miguel Tlacotepec. Remittances in this view are not a type of weak metaphorical affection on the part of the husband, but rather a ticket to autonomy and freedom which is completely compromised when husbands return.

Much more prevalent was the view among practitioners that migration contributes to both individual and social pathologies, which, put together, contribute to moral decline in Oaxaca. Table 8.1 summarizes these perceived effects.

Table 8.1: Practitioner Views on Migration's Effects

	For Children & Adolescents	**For Women**
Individual social impact	- Abandonment - Missing role models - Lack of affection - Family conflict - Resentment - Loneliness & isolation	- Abandonment - Overwork - Change in gender role - Bitterness, resentment - Loneliness & isolation - Infidelity
Individual pathologies	- Behavioral disorders - Anxiety, depression - Eating disorders - Low self-esteem - Insecurity - Identity problems - Aggression - Antisocial behavior - Rebellion & opposition	- Depression - Inability to nurture, show affection to children →Negative impacts on children's mental health, social functioning
Societal Pathologies	- Imbalances - Aggression - Criminality - Substance abuse -General moral decline	- Erosion of family - Lack of control - Imbalances

'Tengo poder, traigo dólares' [I have power, I've got dollars]

Another very important aspect of Oaxaca's 'culture of migration' is return migration: what happens when people come home? One might expect that, given the

painful family separations migration can create as well as the propensity of migrants to send remittances to their family members, return migrants would be given hero's welcomes. As we will see, however, responses to return migration are much more mixed. While statistical analyses do not find evidence of increased return migration to Mexico during the financial crisis (Rendall et al. 2010; Fitzgerald et al. forthcoming), I certainly noticed the growing presence of young returned migrant males in San Miguel Tlacotepec and Juxtlahuaca, and local community members and practitioners confirmed that they had seen a growth in this population, as well. Anecdotally, residents of the Mixteca region seemed well aware that employment options in the United States were limited and that migrants without established ties to jobs might be likely to make the return trip. These young, returned migrants are largely portrayed as moral hazards, further endangering the well-being of the community.

The quotations from both Zoila and Julio above are indicative of this general impression. Julio describes the people coming back "from the other side," bringing with them "various problems they experienced as they were integrating" into the United States. Both he and Zoila opined that young returned migrant *'cholos'* are a negative influence upon other young people the region who identify with and seek to copy their style and behavior. As quoted above, Zoila says that

> Sometimes young people will come back from the United States and bring back customs from *Mara Salvatrucha* …I don't know, *cholos.* Vandals. So they bring lots of new ideas, sometimes [young people] seek to imitate so they can identify, to feel like they belong to a group.

For his part, Julio compared the impacts of migration to the impacts of a family member being incarcerated: "When a family member goes to the United States to look for work,

something similar happens to when a family member ends up in jail. It's more or less the same." He is referring to how the family experiences the migrants' absence, but given that the comment comes directly after commenting upon migrants getting involved with gangs, the association of migrants with criminals is clear.

Like Zoila, Tania Sánchez is a psychologist working in Juxtlahuaca, where such portrayals were most common and forceful. Tania described how she sees the situation:

> Tania Sánchez: Here in Juxtlahuaca…most of the young people here go to a city, and they come back with a different mentality. Guys who go to the United States adopt other beliefs, and they come here…where we see the famous *cholo,* no? … There are *cholos* who study, who work, and who wear a certain type of clothing, but here—no. A *cholo* is someone who's armed, who assaults, who harms, who rapes, who kills…

I asked her why returned migrants come back this way, whether she thinks something happens in the United States to bring on such apparently horrible behavior.

> T: They think that the fact that they're coming back as *cholos* from the United States gives them a certain power. So they come here to intimidate people from the *pueblos* and they begin to inti—to pull more guys [into it], and begin to talk to them about how they lived in the United States, what they experienced, about the beliefs that all the *cholos* have, like having some tattoo that gives them a certain authority, and that that's a way to have a kind of power, right? Everyone in Juxtlahuaca is really intimidated by them. They're boys who look for distraction, and they simply don't accept—they don't look for help. Here in Juxtlahuaca there have been many rapes, but they're at home. Because the idea of going to the authorities and denouncing, well what if people find out? It's a dishonor to the family, and there's no one who takes it seriously. Authorities here unfortunately don't do anything, you know? I mean, they can assault you at ten in the morning, they can assault you at six in the evening, they can go in and rob at eight at night, and the authorities don't do anything. These are kids you find on the street, no? Ten year-olds, 15 year-olds—you find these 11 year-old guys drugged, and the authorities don't do anything.

Tania went on to say that before, you could go out at 11PM and feel safe, but that now everyone is afraid because of the '*cholos,*' the gangs, and their violence. She said they

were boys who "don't come to treatment, they're boys who bring the mentality of, 'I'm coming from the United States, I have power, I'm bringing dollars back,' you know?" Tania did say that not all the returned migrants were like this; some

> start fixing up their homes, they're with family, they go to church all the time with the family—some adopt that mentality…They might be guys who go out and have fun, but they come back to their wives, to their kids. These are the ones who go out to the market with their wives and go to church, they're with their family and they're dedicated to their families, but there are guys who aren't like that. They come back and join gangs, rob for the simple fact of having money, of having power.

Here, Tania makes a direct comparison between virtuous return migrants who spend time with their wives and children, who fix up their houses, and who go to the market and to church to deviant '*cholos*' who come back to Oaxaca to 'rob for the simple fact of having money.' The association of returned migrants with extremely violent acts—assaults, rapes, killings, kidnappings, robberies—is striking in these accounts.

Such perceptions were quite widespread in the Mixteca. In San Miguel Tlacotepec, there were reports of increasing crime and of gang activity—one gang, known as the *arribas*, apparently had as its turf the upper part of the village, while the *abajos* had laid claim to the lower part of the village. What role return migrants might have in crime increase and in the kinds of frightening behaviors Tania describes is a question better suited to a different type of study, but talk among mental health practitioners about young returned migrants were almost unanimous in representing them

as wayward, dangerous criminals. They are associated with violence, drug and alcohol use and addiction, and even an increase in STDs.[10]

Sociologist David Fitzgerald reports similar impressions in his study of Los Altos, Jalisco, in which he investigates "how Mexican institutions try to prevent the *dis*integration of the community of origin when emigrants leave and return. Those efforts involve a delicate balance between trying to take advantage of the economic and cultural advantages of emigration while trying to prevent the seepage of undesirable foreign ideas and practices in the home community" (Fitzgerald 2009: 127). Far from a cohesive transnational community, Fitzgerald finds that Alteños have very mixed feelings about the cultural influences of the United States and migration on Los Altos. On the one hand, Norteños are viewed nostalgically as "hijos ausentes" [absent sons] when they are gone, and beneficial when they return in that they "bring home dollars" (ibid: 129). On the other, they are viewed as menaces in that they also bring back "arrogant attitudes" (ibid: 129) and are described as young, male, and '*cholo,*' wearing "baggy or short pants, tattoos, earrings, and gold necklaces" (ibid: 130). Fitzgerald writes that all his informants viewed *cholos* negatively, and—like in Oaxaca—many blamed the apparent increases in local problems like drinking, drugs, and STDs on them.

An interesting aspect of the representations of returned migrants Fitzgerald encountered in Jalisco as well as those I encountered in Oaxaca is how they resemble portrayals of migrants in the United States, particularly the undocumented. The *New York*

[10] These perceptions can filter into mental health treatment for returned migrants, as the prior chapter began to discuss. Migrants' first-time psychotic breaks are frequently attributed to the negative influences of the United States and to drug and alcohol experimentation in the U.S. Culture shock is another frequently mentioned contributor to mental health problems for migrants—and is perceived to prompt migrants to drink and use drugs.

Times ran a piece in January of 2012 making a similar comparison in its documentation of new immigration flows contributing to dramatic growth in towns near urban centers like Oaxaca City. Rather than go to or remain in the United States, would-be migrants choose to live and work in towns like Santa María Atzompa, just outside Oaxaca City, which has grown from 5,791 people in 1990 to 27,000 people currently. As *New York Times* reporter Damien Cave writes,

> The shock might seem familiar enough in countless American towns wrestling with immigration, but this is a precolonial Mexican village outside Oaxaca City, filling up with fellow Mexicans. Still, grimaces about the influx are as common as smiles.
>
> 'Before all these people came, everything was tranquil,' said Marcelino Juárez, 61, an artisan at the local ceramics market. "They bring complications. They don't bring benefits' (Cave 2012).

Cave reports that Atzompa's poverty rates are high, strip clubs are common, there is a drug rehabilitation center, and "longtime residents complain about having too many young men with different values in their midst. 'They're not from here,' said Mr. Juárez, the artisan, explaining the enduring divide" (Cave 2012). While xenophobia and resistance to new influxes of immigrants are everyday occurrences in the United States—perhaps particularly in the current political climate—Mexican communities responding negatively to domestic and returned migrants is a newer phenomenon, and one which is contributing to tensions. Migrants returning to their communities of origin, like Mixtecos in Juxtlahuaca and San Miguel Tlacotepec, are in a somewhat different position than migrants from elsewhere in Mexico landing in places like Atzompa. The latter may be from potentially very different types of communities with very different values and practices, and thus conflicts with local communities might be more predictable. Mixtecos

returning to hometowns like San Miguel Tlacotepec, however, are ostensibly returning *home,* to the places they were raised and to which we might expect them to identify—and where we might expect community members to receive them with open arms.

Many of these migrants likely left Oaxaca with the expectation of success in the United States, and we can imagine how difficult it might be to return empty-handed in the context of an economic crisis. Tlacotepec residents mentioned pressures upon migrants to send remittances and come home with money and gifts; as one teacher put it,

> Everybody expects you to bring something or for you to send them something. If you don't, people even tease you with jokes like: 'look at him, he just went on a trip for fun.' It's a huge responsibility for those who go. So it's a problem for those who are [in the United States], knowing that 'How am I going to go home?' or 'I'm not going to go home, because I haven't done anything' and 'if I don't find work, what am I going to do?' Their whole world comes to an end, thinking about people in Tlacotepec, who expect them to return with something (quoted in Calvario et al. forthcoming).

Such pressures come through in narratives from community members with migrants in the United States (see next chapter) and from migrants themselves. Expectations to provide for family members back home, combined with the structural positions of vulnerability in which many migrants exist in the United States, can contribute to overwhelming sensations and expressions of anxiety and insecurity. Then, upon returning home, many migrants find they are treated as morally dubious 'Others,' contaminated by questionable values and practices on 'the other side.' In his discussion of undocumented migrants in the U.S., Chavez (2007) writes that "[the] condition of illegality and the social responses" to immigrants recall Mary Douglas' conception of 'matter out of place' (Chavez 2007: 193). It seems returned migrants are often perceived as 'matter of out of place' in their own communities.

‘Ni de aquí, ni de allá’ [From neither here nor there]

Family separation, return migration, perceptions of migrants and of life in the United States—all of this contributes to Oaxaca’s ‘culture of migration,’ or the ways in which migration is “deeply ingrained into the repertoire of people’s behavior, and values associated with migration become part of the community’s values” (Massey et al. 1998: 47, quoted in Cohen 2004: 6). In their study of ‘the culture of Mexican migration,’ Kandel and Massey observe that in Mexican migrant-sending communities, “migrants come to evince a widely admired lifestyle that others seek to emulate, and international migration comes to be seen as a tractable and accessible strategy of upward social mobility” (2002: 982). Migration, they suggest, “becomes a rite of passage, and those who do not attempt it are seen as lazy, unenterprising, and undesirable as potential mates” (ibid). There is, indeed, a culture of migration in Oaxaca, but the meanings, reactions, and experiences it evokes can in no way be encapsulated by accounts which portray it primarily as a source of economic and social capital. As I have sought to illustrate, in some sectors of society such as mental healthcare, migration is also frequently viewed as an act of moral irresponsibility which can have negative impacts for emotional functioning and mental health.

Kandel and Massey’s discussion underlines the ways in which migration represents a potent life possibility for young Mexicans in high emigration communities—one which can impact their likelihood of investing in their home communities psychologically and of pursuing education and finding work there. Aspirations are linked to families’ histories of and involvement in U.S. migration: “[t]he more a community’s families become involved in migration, the higher the likelihood that children will aspire

to work in the U.S., which causes them to look northward rather than locally for opportunities and social mobility" (Kandel & Massey 2002: 1002).

Mental health practitioner accounts capture migration's ubiquity as a life possibility and as a potential deterrent to a sense of belonging and investment in one's own community. As private psychologist Gloria Ramos put it:

> [Migration affects] everything. Everything, truly. In many people it provokes worry, and even more when you hear 'Now there's no work in the United States,' 'The *migra*, the border-crossing…' and so all of this leads to people feeling uncertainty, or 'What's going to happen? What's going to happen?' So there's a lot of change in people in this sense. Among children who grow up without a paternal figure, and what I'm starting to see now [in my practice], is that the first things they start to think about are how they just need to grow up a little and 'now I'm off to the United States,' you know? It starts to become something normal, wanting to go to the United States.

Gloria points out preoccupations generated by rumors of what is happening in the United States—increased *migra* activity, lack of jobs, etc.—which are made meaningful by the always-looming possibility of migration. If going to the United States is 'something normal,' then changes in U.S. immigration policy, the general attitude toward migrants, and increased border enforcement become part of everyday lived experience for would-be Oaxacan migrants. As psychologist Lara Hernández puts it, "they have their heads there":

> …to be living with the idea of, 'And if I go, too? So I think that leads to a lot of disquiet, so people don't concentrate their energy on saying, let's see, I'm going to find work here. That's only a possibility for the wives, you know? Sons, daughters, they say I'm going to go with my uncles. We had a grantee [in their college support program for young indigenous women]…who went with her uncle to the United States—of course, she lost her grant. But she was very restless, like not completely here. Because there's always that possibility, you know? They tell me that over there this, over there that, and I think that this is really exhausting because sometimes they go and they get results, sometimes

> they go and they don't get results, or sometimes they don't go, but they have their heads there.

Worry, uncertainty, disquiet and restlessness, feeling 'not completely here': these are important aspects of the 'culture of migration' which can add to our understanding of what I call 'transnationally shaped sentiments' and anxieties (see next chapter for discussion). These are anxieties of everyday life in Oaxaca, but—importantly—they are structured in part by processes taking place on 'the other side,' whether they be changes in U.S. immigration policy, the well-being of migrant family members, or the availability of work. From psychologists' perspective, this sense of having one's 'head' in the United States can lead to identity crises and loss of cultural roots. As Gestalt psychologist Mariana Pérez put it, "Now there's confusion, in the sense of 'Who are we? Where are we from?'"

If these impacts upon one's ability to be present in Oaxaca, to invest psychologically and materially in one's community, are so compromised by the *idea* of migration, they are even more so in the case of returned migrants. As Pérez put it, returned migrants are "from neither here nor there…They don't feel accepted here, and there's a [sense of] confusion in them. There's a permanent rejection from both their own people and from others [in the U.S.].

Such reflections bring to mind what Suárez-Orozco (1989) termed 'dual frames of reference'—the ways in which migrants consider and evaluate their experiences in host countries in light of the circumstances they left in countries of origin—but from the reverse perspective. Here, residents of the country of origin also have a 'dual frame of reference': Oaxacans evaluate their circumstances in Oaxaca in reference to what *could*

be in the United States or in reference to the perceived moral decline in Oaxaca caused by migration to the United States. In her study of Mexican immigrant parents in the United States, Reese (2001) finds that

> on the one hand, these immigrants look to their home country as a place where, no matter how hard they worked, they would not be able to earn what they earn in the United States…On the other hand, they yearn for the healthier, simpler, purer way of life that they left behind…Mexican immigrants not only experience nostalgia or the life left behind, but in a profound way experience that nostalgia in moral terms (457).

From the perspective of mental health practitioners, this 'healthier, simpler, purer way of life' in the country of origin is eroding due to migration, which is perceived to be undermining the social and moral fabric of Oaxaca.

MIGRATION, MENTAL HEALTH, AND MORALITY

Migration clearly takes on a number of different meanings and resonances for mental health professionals. I have sought to illustrate how their accounts specifically highlight migration's *moral* weight: just as migration and resultant family separation are seen as central contributors to mental health problems—and thus contributors to the surge in the mental health 'industry'—they are also seen as potential moral transgressions, breaches of shared values. For their part, young returned migrants are frequently represented as threatening Others who prey upon society and take advantage of children abandoned by migrant parents. Migration thus presents numerous moral hazards: parental 'abandonment' of children, who are consequently susceptible to deviance, drug addiction, violence, and the influence of '*cholos*'; deception and infidelity on the part of fathers in the United States or mothers remaining in Mexico, who therefore cannot adequately

nurture their children; abandonment of the elderly, who are meant to be cared for and revered; crime, violence, and societal disruption on the part of returned migrants. More broadly, migration is seen as contributing to a community of young people whose minds are elsewhere and whose ability to be present and invested in Oaxaca is severely compromised.

With regard to family separation—specifically parental migration and separation from children—Horton discusses the "moral ambiguity inherent in the difficult choices presented by immigrant parents" (2009: 27), noting that literature on family separation has failed to fully imagine the subjective challenges such choices represent. In her study, migrant women who have left their children in El Salvador express feeling "profound moral failing" for not being able to reunite with their children or succeed in providing for them through remittances (ibid: 28). One might expect that in a place like Oaxaca where migration is commonplace, community members and practitioners would be able to fully grasp and imagine the moral ambiguities that migrants, returned migrants, and would-be migrants navigate. Practitioners do fully acknowledge the potential emotional consequences of migration for everyone involved, and perhaps we can view their accounts as attempts to navigate such ambiguities.

What comes across more strongly, however, are evaluations of migration as a morally questionable individual act which has repercussions for the broader society. While we can certainly see how the 'decision' to migrate would impact the social and moral order as well as individual mental health, and while we can appreciate that mental health interventions may help to mitigate some of the distress such situations create, the immorality of a global system which contributes to inequality and the need to emigrate in

the first place is frequently left unexamined and "absolved of blame" in these accounts (Schmalzbauer 2011: 1970).

These findings are also striking in light of the way culture is apprehended by mental health practitioners in other contexts. Whereas in many ways 'culture' is viewed and represented as contrary to 'mental health' in Oaxaca, as the prior several chapters discussed, it seems that the 'culture of migration' is in this case viewed as detrimental to other forms of culture holding positive moral valence in the mental health setting, such as the strength of family ties and commitment to the community. Chapters 6 and 7 discussed how 'culture shock' and 'transcultural' psychosis have become important diagnoses for returned migrants in the state; there, too, a more positive view of 'culture' emerges—one in which culture may be protective, and when subject to disintegration and assault by exposure to foreign ways of life in the United States, can cause severe mental health problems.

Overall, from the practitioner perspective, mental health and the moral order are viewed as intimately linked, and the 'culture of migration' is severely compromising both. Migration is thus a polysemic category perceived to have a number of implications for mental health and morality in the region. As a source of family separation, it creates 'abandoned' children susceptible to mental health, behavioral, and developmental problems; it creates 'abandoned' wives with compromised ability to nurture their children and develop adequate levels of self-esteem. Represented in this way, migration is akin to a chronic condition slowly eroding social roles and psychological resiliency, ultimately leading '*los abandonados*' down wayward paths of crime (for young people) and infidelity (for non-migrating women). Returned migrants themselves are almost lost

causes, so corrupted are they by American society and the painful exigencies of migrant life. Rejected by both societies, seen as moral, social, and cultural 'Others' both in the United States and Oaxaca, they are represented as almost beyond help—better, from practitioners' viewpoints, to protect other members of society from them. Finally, as an omnipresent social fact, migration is thought to undermine belonging and investment in Oaxaca, creating people who exist 'neither here nor there'.

Given these alarming portrayals and interpretations, it is not surprising that practitioners see themselves as specially called upon to intervene, ramp up services, travel to communities, and provide *psicoeducación*. Practitioners seek to spread the 'regime of the self' and other psy imaginaries as tools for confronting and providing relief in the face of seemingly intractable social problems like migration. In the process, migration becomes a pressing 'matter of mental health,' its impacts interpreted in psychological terms and dealt with in the clinical setting. As we will see in the following chapter, migration-related distress also feeds into community members' desire for emotional support and psychological services.

CHAPTER 9

TRANSNATIONALLY SHAPED SENTIMENTS

INTRODUCTION

In this chapter, which centers on case studies from San Miguel Tlacotepec in which mothers reflect upon separation from their undocumented children residing in California, I examine migration-related discourse and distress among non-migrating community members in the Mixteca region. I argue that emotional health and well-being in this context may be usefully conceptualized as transnational—rooted in sociopolitical processes, emotional experiences, and movements occurring on both sides of the border and beyond—particularly among community members with close relatives residing in the United States. Building upon the critical phenomenology of 'illegality' (Willen 2005, 2007; Horton 2009), I show how 'transnationally shaped sentiments' compose an important aspect of non-migrants' mode of being-in-the-world. Simultaneously constrained and produced by sociopolitical and economic inequalities, stretched across borders, and pulled taut by longing and concern on either side, sentiments are powerful gauges of how community members confront, experience, and make meaning of migration.

Furthermore, I theorize that migration-related distress is tied to Oaxaca's growing field of mental health services in several ways. First, as the prior chapter discussed, practitioners see migration as an important matter of mental health and are attempting to intervene by providing more services in rural regions where emigration is ubiquitous. Second, distressed community members—exposed to 'psy-imaginaries' through various

means, including public health *pláticas*, media, and local doctors—express desire for increased access to psychological care to mitigate the painful emotional impacts of migration.

THE CRITICAL PHENOMENOLOGY OF ILLEGALITY

As discussed in Chapter 1, the call for anthropological engagement with experience, on the one hand, and structural configurations of power and politics, on the other—as well as the hazy and often violent spaces between them—has been central to recent theorizing within psychological and medical anthropology. Studies of 'subjectivity' provide an analytical and theoretical bridge between the "acting subject"—as an agent with desires, intentions, "(culturally constituted) feelings, thoughts, and meanings," as well as "cultural and historical consciousness" (Ortner 2006: 110)—and the broader formations and power relations which both constrain and give shape to experience. In this vein, anthropologist Sarah Willen (2005, 2007) proposes "a critical phenomenological approach" to the condition of migrant 'illegality.' A critical phenomenological approach, she argues, "demands attention to two interrelated dimensions of social life: first, to the conditions of structural inequality and structural violence that shape migrants' position and status…and second, to the impact of these contextual factors on migrants' individual and collective experiences of being-in-the-world" (2007: 13).

Willen thus analyzes undocumented migration in Tel Aviv according to a three-dimensional analytic framework, taking 'illegality' as "a form of juridical status," a "sociopolitical condition," and as a "mode of being-in-the-world" (Willen 2007: 8, 10).

Her approach, following Robert Desjarlais and other phenomenologically-oriented psychological anthropologists (e.g. Csordas 1990, 1994a, 1994b, 1997, 1999; Good 1994; Good and Good 1988; Jackson 1996), seeks to bring together the phenomenal and political realms, to "convincingly link modalities of sensation, perception and subjectivity to pervasive political arrangements" (Desjarlais 1997: 25, c.f. Willen 2007: 12; Jenkins 1991). The resulting account draws attention to the processes by which the sociopolitical condition of 'illegality'—which constructs migrants as unwanted and dangerous Others and which is made more acute by increased deportation campaigns in Israel—not only informs the "external structure of migrants' lives and lifeworlds," but also their subjectivities, particularly with regard to embodiment and notions of time, space, and 'home'. Her analysis thus illuminates the intimate "connection between legal statutes and statuses, on the one hand, and lived, embodied experience, on the other" (Willen 2007: 12).

Following Willen's move toward the lived experience of undocumented migration, Sarah Horton (2009) explores the "embodied distress of transnational mothers" and the intersubjective means by which suffering is produced and reproduced across borders between undocumented Salvadoran migrant mothers and their children remaining in El Salvador (Horton 2009: 22). Arguing that 'illegality' is fundamentally intersubjective and that suffering is always relational, Horton shows how transnational motherhood in contexts of illegality set "in motion a concatenation of shared vulnerabilities and intimate interdependencies between family members" (ibid: 25). Her richly rendered analysis of migrants' narratives of separation from their children reveals the intense distress these women experience, often along with a sense of moral failing

(ibid: 28, 30). Importantly, however, Horton emphasizes that in addition to impacting individual subjectivity—Willen's main focus—broad socio-legal structures and the symbolic violence perpetuated by them also have profound implications for social relations across borders.

Both Willen and Horton respond to a call on the part of anthropologists working with undocumented migrants to provide more sophisticated theories of 'illegality' (e.g. De Genova 2002; De Genova & Peutz 2010; Ngai 2004), particularly since the sociopolitical formations which create the condition of illegality—e.g. number of visas issued versus number of workers needed in an economy; particular laws governing migrant bodies; human rights protocols—vary from site to site. These differences in turn engender a range of experiences among undocumented migrants themselves. The emphasis on phenomenology, ways of being-in-the-world, embodied suffering, and intersubjectively produced spaces of longing is a way of taking ethnographies of migration and illegality in a more experience-near direction through which their complexities may be understood from the perspective of social actors, whose lives are often "stretched across national borders" (Horton 2009: 22).

This work can, I argue, provide a helpful framework for also understanding the experiences of non-migrating members of high emigration communities—particularly those with close relatives living without documents in the United States. Their narratives convey worry over migrants' well-being; longing and sadness, as well as preoccupation over when they will be reunited; frustration with the laws that prevent migrants from living openly in the United States and that prevent them from freely moving back and forth across the border; fear that their migrant relatives may be harmed, injured, or

discriminated against; and moral outrage that such apparently preventable situations should exist in the first place. These sentiments are shaped by powerful transnational forces: global capitalism and neoliberal reforms enacted by both Mexico and the United States which seem to have exacerbated rural poverty in Mexico and have thus contributed to the need to emigrate in the first place; U.S. immigration policies, which are based upon the "legal fiction" created by "unwillingness to recognize the conditions that create a demand for [migrant] labour" (Chávez 2007: 192)[1] and which produce the category of the 'illegal migrant'; and the condition of structural vulnerability in which many migrants exist by virtue of being 'illegal,' which then feeds back into worry for migrants by their non-migrating relatives in Mexico.

Few studies have examined how migrants' documentation status in the United States impacts their relatives' impressions, conceptions, and experiences in sending communities. One notable exception from the public health literature is Salgado de Snyder and colleagues' 1996 research with 24 women living in rural Jalisco, over half of whom had undocumented spouses living in the United States, but they did not find differences among the two groups. The authors do report significant concerns by non-migrating women about their husbands' lifestyles, their potential loss of 'traditional values,' and the impacts of U.S. immigration policy on their husbands' well-being and ability to provide for their families through remittances (Salgado de Snyder et al. 1996). While my study does not explicitly compare women with documented and undocumented spouses and children in the United States, legality and perceived threats by border agents,

[1] Similarly, Cornelius (2004, 2006) uses the term "manufactured illegality" to refer to the disparity between demand for low-skill labor and yet "unrealistically low quotas for low-skilled foreign workers, quotas set so low for political rather than market-based reasons" (Cornelius 2004: 22).

the *migra,* and police were important in shaping impressions of migration and experiences of transnational anxieties.

TRANSNATIONAL FAMILIES: WHEN CHILDREN LEAVE

In the previous chapter, I showed how mental health practitioners perceive migration-induced family separation as an important matter of mental health and morality. These accounts emphasized the impacts of spousal and parental migration for wives and children. An important aspect of migration-induced separation I did not touch on but which both practitioners and community members frequently invoked were the impacts of children's migration for non-migrating parents and elderly community members. Zoila Jiménez, the IMSS psychology intern in Juxtlahuaca, commented on the subject:

> There are many people who, for example, their kids go to the United States, sometimes they lose contact, some remain along the way, you know? Some of their children die, some perhaps forget about their parents, because they didn't give them the quality of life they wanted…And there are adults, people who are older, eh, they stay alone without any type of economic support, and sometimes with illnesses like diabetes, hypertension, and sometimes it's like, okay, 'why am I in the world? I want to die, I'm already old, my children don't love me, they've already forgotten about me.' There are people who are alone and they can't be productive anymore. Cases like this come up frequently, unfortunately.

Family separation due to children's emigration came through as a central theme in the narratives of community members, as well. Many parents in the Mixteca were acutely aware that it was only a matter of time until their sons and daughters would likely make the trip to *el norte,* particularly if they had relatives already there. When one's children

are old enough to make the trip, parents often confront the fear that they may never see them again.

In San Miguel Tlacotepec I know three families with teenage boys who had been born in the United States and who were planning to return there as soon as they could. Although their mothers were helping them obtain the appropriate paperwork to go, they tearfully conveyed their distress over the impending separations. Those were exceptional cases in that the boys would leave Oaxaca with American passports; however, anxieties can be attenuated by situations of 'illegality.' Like anyone else, when children emigrate without documents not only is the possibility of circular migration and thus visiting family upended, but they are subject to everything from border-crossing hazards to questionable treatment by authorities to discrimination in the United States. Community members in the Mixteca noted that some parents only see their children again when they are shipped back to Oaxaca in caskets. As Zoila's comment above suggests, such tragedy can create situations of total isolation for elderly community members who quite literally have nobody—their children have either disappeared or perished in the United States, their spouses have died, and they live out their days in isolation.

Accounts of elderly community members abandoned through their children's migration processes were quite frequent and perhaps especially striking given the social position elderly tend to occupy in Mexico as revered and central to family life. One might expect that if an elderly community member were alone, he or she would be taken in by another family, or looked after by the community. This does happen; however, I was surprised and alarmed to find older women marginalized and alone in Tonalá, a small town in the Mixteca (which does not, incidentally, identify as indigenous or Mixteco)

where a friend of mine was working on a project helping the community come up with resources to feed abandoned elderly community members.

That such a project was necessary speaks to how isolated these women were. I had heard few cases of older women living alone in the Mixteca, and when I accompanied my friend on home visits, the solitude and sense of *'abandono'* were striking. Not all of them were alone due to the migration of their children, but many of them were. Some simply couldn't remember how they came to be alone; community members spoke of their husbands dying of old age and their children dying as they crossed the border, mothers never hearing from them again and remaining alone, without the benefit of remittances or family interactions. Other elderly abandonees were said to have received remittances for a time until they slowly trailed off and the migrants sending them were never heard from again.

In my fieldnotes I tried to convey the feeling of these elderly community members' homes:

> *We began by climbing the hill to Ana's house, which looks out over the valley and onto the mountains across. A lovely view. Her house is of grey adobe, stained walls. There is a bed, neatly made with a threadbare blanket. She keeps a green parakeet in a cage and a drowsy dog outside. Her altar is adorned with some dirty dolls, looking plaintively, blankly into the distance. Blue eyes that don't close. Likenesses of Jesus, of the* Virgen. *A small Christmas tree, though it is August. Her ceiling is of carrizo and her kitchen floor of earth. She is 70, and she sits attentively, back straight, nodding as K explains the project. Ana has attached a small metal cross to her door with a string. She is more or less alone. Her real kitchen is outside, with a dirt floor, sheltered by a tin roof and tarps strung up as walls. She blocks it off with the rusty shell of a mattress's innards, springs and all.*
>
> *Rosalinda has a concrete floor. A bat-sized moth flew uncertainly about the ceiling, dipping and rising and finally out the door. She had lit candles, on the floor in colored plastic cups. Many likenesses on the wall: Jesus, the* Virgen, *santitos, and others. Rosalinda has a kitchen table and three beds in the open space, though she only uses one of them, sleeping alone. Flies land on the uncut*

> *avocados. Blue plastic tarp under the carrizo, probably to catch rain. Reusable shopping bags from various tortillerías and pastelerías and political parties hang from the wall, as they usually do. She tells us that one of her babies died of* coraje.
>
> *Beatriz doesn't hear us. The taxi driver yells her name; the women we are with yell her name. She doesn't turn. She is wearing a brown wool hat out of which falls a thin grey braid. She is standing by a big tree in her backyard, under which there is a makeshift stove over a log, unlit. A wash basin. Pots and pans hanging on nails pounded into the tree. The tall milpa beyond, and her dark room behind. She wears red fleece pants and smiles at us, not hearing—she is almost completely deaf. Beatriz is living on 720 pesos a month, about 60 dollars; sometimes her neighbor will give her an extra taco. When it rains, the* alumbre [*cooking fire*] *has to go inside, where it smokes up the dark room in which she sleeps on what looks like a narrow rectangular trampoline, with a couple blankets on it. Her son is drunk; if she ever has anything extra he comes and takes it from her, yelling and sometimes hitting her. She is so arthritic her thumb looks as though it was nailed horizontally into her hand, like the nails in the tree holding the weight of her pots and pans.*

These women seemed to painfully embody both the isolation and the social changes so prevalent in the Mixteca region. Three beds lined up next to each other in a dripping house where one elderly woman, hardly able to walk—let alone work—lives alone, telling stories of the time when her children and husband's voices had brightened the space.

'You Know What They're Risking'

Arnoldo and Elena, an elderly couple from San Miguel Tlacotepec I have known since 2007, seemed to like nothing more than to show me pictures of their children and grandchildren in the United States. They had a large, cavernous concrete home to which they always seemed to be adding on. On the front door they have a sticker announcing "This Home is Catholic" [*Este Hogar es Católico*] to ward off missionaries. The living room was oddly empty, with a bench in one corner and in the other, a table full of various

candies, ‘Maruchun’ noodles, sodas, and juices from which they would very generously insist I help myself when I visited. On the other side of the room was a small table covered in family-related paraphernalia: photos of babies and proud parents, certificates, phone numbers, and presents from the United States—most memorably, a dancing Santa toy that Arnoldo and Elena left displayed in its box year-round. Every time I returned to their home, the table remained more or less the same, though the number of babies pictured seemed to grow.

Of course, Arnoldo and Elena may never meet their grandchildren, since their sons are extremely hesitant to return to Mexico for fear they will not be able to cross back into the United States—particularly with children. I asked Arnoldo about this the first time we met:

“So, your sons are in there in Vista and they can’t return because— ”

“They can’t because they can’t,” Arnoldo interrupted. “They don’t have papers…My son is very afraid of crossing the border.” He went on to tell me about the phone calls they shared every eight days which—though better than nothing—seemed a poor substitute for physical presence. Arnoldo and Elena are not ‘abandoned’: they have each other, and they are frequently in touch with their children in the United States. However, their experiences speak to the ways in which migration—and the limitations imposed upon migrants’ mobility—shape the contours of everyday lived experience for non-migrants, both young and elderly.

Sofia, another Tlacotepense, lives atop a steep hill across the highway from the main part of town. Like Arnoldo and Elena, I met Sofia in 2007 and have spent time with her and her 12 year-old daughter Julieta every time I have visited Oaxaca since. Sofia’s

household grows and shrinks according to the season, but never have I seen Sofia, her husband, and their seven children in Tlacotepec at once. The last time I visited, Sofia's husband and two of their sons were working in Ensenada, and two other children were working in Southern California. Sofia's ailing elderly father—the main reason she remains in Tlacotepec—sat silently on a chair outside the house grasping his makeshift cane and staring out at the view below. Meanwhile, Sofia and Julieta made red chile stew over an open fire outside. The three of us ate it while watching an ancient VHS copy of the animated movie "The Land Before Time"—an oddly appropriate choice, given the theme of family separation—which Julieta asked me to translate into Spanish for them. After our meal, Sofia and I sat outside looking out upon San Miguel Tlacotepec, talking about migration.

Every time I see Sofia she cries when she speaks of her children in the United States, and this chat was no exception. Roughly wiping the tears from her face with the heel of her hand, Sofia said her sons—whom she has not seen for eight years—would stay there "as long as the *migra* don't catch them." She went on:

> When your children leave, you suffer because you know what they're risking. While they're en route, you don't do anything other than think. Actually you cry more than you think, because you don't know how things are going. When they're there [in the U.S.] you give thanks to God, because they got in and they can find work as long as the *migra* doesn't catch them. But it's a huge source of suffering for [mothers] and also for them. Life is difficult: here there is no possibility for work, there's no work, so you can't stay.

Sofia said mothers in the area had been particularly sad lately because of rumors that American immigration authorities were cracking down on undocumented migrants—as well as their kids who were born in the United States. Her impression was that they were

all in danger of deportation as well as discrimination. “How can you not cry thinking about your kids there? It’s really sad, and people are talking a lot about it. I felt horrible thinking about it all.” In addition to worry about her undocumented sons, Sofia was preoccupied by concern for her U.S. citizen grandchildren, whom she has never met.

Making my way down the steep, rocky pavement to town from her house, I pass several other families I know: one with a teenage son, Timoteo, who was born in the U.S. and is planning on leaving San Miguel Tlacotepec as soon as he finishes high school; one consisting of an old woman living alone and suffering from various health problems. The hill also affords a view of houses belonging to still more families with whom I have become familiar over the years, all of whom have migration stories. Hermalinda’s husband left for the United States 17 years ago and she never heard from him again; it is well-known he has another family there. She lives with her teenage son Max who was born in the U.S. and who, like Timoteo, is planning on going to the U.S. as soon as his passport comes through. Max asked if I had any helpful English-language books that would help him prepare; meanwhile, Hermalinda contemplates the prospect of living alone once he goes. She was aware that Max could apply to bring her to the U.S. legally once he turned 21 in a few years, but she may cross with a *coyote* before then.

I offer these as just a few examples of non-migrants whose lives are nonetheless intimately tied to transnational processes over which they have very little control. Though this chapter focuses on children’s emigration, similar stories are common from Mixteca residents with spouses, siblings, aunts, uncles, cousins, and friends living with and without documents in the United States. Undoubtedly there are many factors influencing emotional experience in these cases, but migration is frequently the fulcrum around

which much affective experience and expression revolves. Thus, I argue that the concept of 'transnationally shaped sentiments' may be productively employed to understand some of migration's consequences for non-migrants' well-being in high emigration communities. To develop this concept I will present a case study from San Miguel Tlacotepec.

'YO SENTÍA QUE EL SOL ESTABA TRISTE'

Carolina and I sit on unsteady wooden chairs on her patio in San Miguel Tlacotepec, accompanied by the sounds of chickens and roosters circling the yard in search of stray feed. The patio is covered by a makeshift roof attached to trees, under which lie piles of wood, *petates* (mats woven of palm), shovels and other tools, old furniture, and hundreds of dried corn cobs, or *mazorca,* which Carolina and her husband have harvested and which she is now cleaning and preparing to thresh. I had approached Carolina's home to see if she would be interested in participating in the CCIS survey, but hours pass before I even remove the survey from my bag. Like most people living in San Miguel Tlacotepec, Carolina has much to say about migration and its impacts.

After she asks me to sit down and establishes where I am from, she immediately launches into the story of her son, Oscar, who is an undocumented migrant living in San Jose, California. Tearfully, though rarely pausing her work cleaning the *mazorca,* Carolina tells me that Oscar recently suffered a serious car accident in the United States and, in addition to a broken hip and an injured back, had lost a foot. The person who hit him apparently did not pay for the medical treatment, so Oscar sought help from community members in California who are giving him, along with his wife and child, a

place to live as he recuperates. Carolina tells me that after the accident she suffered debilitating sadness and worry which impeded her daily functioning and exacerbated her already severe health problems. Everything around her seemed to reflect her emotional state: "I felt like the sun was sad" [*Yo sentía que el sol estaba triste*], she says. She has begun to feel better since she visited Oscar in San Jose: with assistance from the ambassador, Carolina was granted permission to go for three months. Carolina expresses anger at the *gringo* ambassador and authorities who then "rejected" her and refused to allow her to remain with her ailing son. "They would only let me stay if I had money in the bank," she says bitterly, referring to the policy requiring those seeking tourist visas to prove they do not have incentive to remain in the United States.

While Carolina is telling the story of Oscar, his accident, and their family's struggle, her older cousin Amalia arrives, bearing a small plastic bucket of bull's blood from a slaughtering. Amalia (who I met and interviewed in 2007, as well) joins the conversation, sitting on another wooden chair, and the women begin reflecting on the subject of immigration—both their own and that of their children and husbands. Carolina had visited the United States to take care of her son, and lived for many years as an 'internal migrant' (as those who migrate for economic reasons within their home countries are often called) in Mexico City. Amalia had never been to the United States, but her husband had worked there for a time, as had her son, and she had several daughters currently in the San Diego area. For her own part, Amalia worked for years as a seasonal agricultural worker in Culiacán harvesting tomatoes, beans, and squash.

Although their histories of migration were quite different, Carolina and Amalia have similar opinions on the matter, and spoke eloquently about the ways in which

migration has impacted their lives. When I asked the women if they thought their children should come back to Mexico, they became animated, explaining that they would prefer their children to come home but they know there a few opportunities for them in the area:

> Carolina: We always tell our kids, we always say: 'Look, kids, if there isn't work [in the United States], better if you just come back here, even if we just have some beans and a little corn, that's what we'll eat.' And when there is a little work here they can work, and when there's not, well then no. There's no permanent work here…so we take it day by day, dealing with it. We don't eat like they do in the city, like in the United States, where you have your milk, your juice, your oranges, your *pan Bimbo* [brand-name white bread], your *Tortillinas* [brand-name flour tortillas], who knows what—your cheese…
>
> Whitney: You eat what you—
>
> C: —We don't have any of that here.
>
> Amalia: We're limited, because here there's no work.
>
> C: We don't eat well, that's why we say—
>
> A: —We have a few chickens, a few pigs—
>
> C: —I don't even have a refrigerator! [Laughs] I can't!
>
> A: Animals to sell and eat. [C: I can't. It's not possible.] We sell animals…I make tortillas to sell.
>
> C: She sells tortillas.
>
> A: Well, that's my work, because where else would we work?
>
> C: When we need tortillas, I buy 10 pesos worth, she sells some to someone else, like that. That's how we live.
>
> A: That's how we live!
>
> C: That's how we live. I grind corn to make my own tortillas so I don't have to buy them, because sometimes there's no money. And my husband—where's he going to make any money? Now he doesn't have a dime, and he's old. Who is going to give him work, you know?

A: And where am I going work? I'm old.

C: [Affirming] She's old, too!

W: But you keep making tortillas.

A: Well, just tortillas because I can't go out and work.

C: My spine is bad—I can't work like I did when I was young. When I had my kids, I worked a lot, but now I can't. I don't feel well. I have hypertension, high blood pressure; I can't see well in the sun; I'm not well.

A: Now we can't work. [C: Not now, no!], her because of her illness and me because I'm old. Who's going to give me work? Nobody, and now I don't have the energy to work.

As their exchange indicates, not only are Carolina and Amalia intensely aware that their children have little by way of opportunities in the region, but also that as older women of about 55 (Carolina) and 70 (Amalia), neither do they. Throughout our several chats Carolina mentioned food frequently, always in relation to lack of work and lack of money and opportunity in the Mixteca and in Oaxaca more generally. 'We don't eat like they do in the city, in the United States,' she says, mentioning several of the food brands she imagined one might have the privilege of eating in those locales. As I have discussed elsewhere in the dissertation—and as has been well documented in the literature on rural Mexican communities—the condition of poverty in which many indigenous communities live is chronic, longstanding, and in the past thirty years has been intimately linked to economic reforms on the part of the Mexican government (in conjunction with the United States). For hundreds of thousands of rural, indigenous communities, migration to the United States and Mexico is quite literally the only option for putting food on the table—even if it's 'just some beans and a little corn.'

After Amalia tells me about her time working in the fields of Culiacán, the subject of Carolina's son comes up again, and Carolina begins crying. "I'm sad because my sons are over there [in the United States]," she said. "My son lost a foot, and before, he was the one who helped us, even if he only sent a little." This aspect of the tragic situation had not arisen in our earlier conversation: it became clear that Carolina was not only extremely worried about her son's well-being, but she was also quite concerned about the fact that he could no longer work and thus could no longer send remittances to help her and her husband get by. Though Carolina "never asked for anything and he only sent a little every once in a while," it seems to have helped a great deal. "There [in California], the rent is very expensive, so everything they [both her sons] make, or the little they make, they have to put toward rent." She went on:

> C: My sons…don't have papers. They can't rent an American house, they rent with Mexicans, because those *gringos* don't want to rent to Mexicans who don't have papers. They think they're not going to pay or something, they doubt them, and so they don't rent to them. I went with them to look for apartments and that's how it is! You have to apply, tell them what work you have, how much you make so they'll rent you an apartment—no way.

Amalia's daughters had experienced similar difficulties, as well as more general lack of mobility due to the fact that they are undocumented:

> A: And since they don't have their papers to look for a more or less regular job, well they can't go out—they can't go out to look for one. So they get paid whatever their bosses feel like paying, because they don't have any rights. There, they go around hiding themselves—that's how my daughters live. They're always hiding, because they don't have work, they don't have papers, they can't freely move around to find a good job where they're paid better…They go around hiding from the *migra.*

These accounts begin to underline the way in which emotions and anxieties may be shaped transnationally. Unsurprisingly, parents express intense worry for their children on the other side of the border, particularly when their children are undocumented. "They're always hiding"; "they don't have any rights"; "they can't freely move around"; "*gringos* don't want to rent to Mexicans," and so forth—Carolina and Amalia are painfully attuned to their children's vulnerable positionality in the United States. Such worry is perhaps similar to any parent's worry about children, particularly when children are living abroad or traveling internationally. But there are important differences: Carolina's worry is acute, unremitting, and tied explicitly to sociopolitical formations in the United States, in particular U.S. immigration policy and the criminalization of undocumented migration. Worry, anxiety, and fear clearly intensify in times of crisis, like Oscar's accident, and as someone 'without papers,' Oscar is particularly vulnerable. Whereas in other situations we might imagine him going back home to Mexico to recuperate or Carolina traveling freely to be with her son, here their mobility and ability to receive and give support is severely restricted. Carolina's affective evaluations and assessments make clear how closely such restrictions are felt:

C: With my son's problem, I've felt worse and worse. I've felt very bad.

W: Would you say it's caused a lot of anxiety?

C: Ayyyyy, yes, for my son, what happened to him. My God, What did he do [to deserve it?] What did I do? What do I owe God? Who did I harm?

W: Sometimes there are accidents, and they don't have to do with—

C: Then I tell my husband, 'I think you're bad and you should confess.' Ayyy, no, I fought with him. He has a strong character and then I told him, 'Look what happened to my son,' and 'What guilt I have'…I felt so badly, I felt like the sky had fallen. That's how it felt. Little by little I

> started recuperating, and [my son] is recuperating a bit, as well, so I feel like I have a little more energy. But I always have this doubt. I always have these doubts, like 'How will my son be?' It's not the same as if he were close, because I would go see him. No? But it's that he's far away and I can't cross, you know? It's not the same as if he were in Mexico City and I could hop on a bus and go see him.
>
> W: Yes, there's a barrier, a border.
>
> C: There, no—they put this hill, jump it if you can. How can we? You can't. So with all this, you say, 'My God, why?' If I could cross I would. I would go see my son and I would come back here. But you can't. Now I'm feeling a little better, though.
>
> W: Do you think you were suffering from depression after the accident? [2]
>
> A: Ayyyyy, yes, so much—I didn't sleep, I didn't eat, my head hurt, everything hurt. I was sad about what happened to my son, I didn't feel like doing anything. I didn't have worth. Everything bothered me. I didn't want people to talk to me or to say anything. I was really bad—but no matter. We have to suffer.

Again, Carolina's description of suffering and emotional distress may resemble that of any mother talking about a tragic accident her child suffered. Her suffering and distress are relational; her experience of her own body ('my head hurt, everything hurt') is tied directly to the imagination of the pain her son is suffering on the other side of the border. But Carolina's pain is deeply intensified by her helplessness: she cannot be with him, not because the distance is insurmountable, but because very specific laws and policies on the U.S. side of the border prevent her.[3] (Earlier in the discussion, Carolina

[2] Prior to this segment of our talk, Carolina had discussed her experience with psychologists in Mexico City and had mentioned depression as a reason one might seek help from a psychologist. Her description of depression was as follows: "When there is nothing left to do, when I don't even know what to do—that's all I feel. I do this, I do the other thing, should I go or should I not go, then I go over there and 'What do I do?' or 'What am I doing wrong?' And one gets very depressed [*se deprime mucho*]—it's like when one is very sad, it makes us want to cry—well, it's something you feel inside, no? Like you can't get rid of everything that's inside you. That's when we have depression. You feel like you're not worth anything, like you're alone, like you have no-one. That is so-called depression."

[3] Discussing the ways in which "illegality is both produced and experienced," Chavez points to the often arbitrary nature of policies which create 'illegal' immigration: "[i]llegality is a status resulting from political decisions made by governmental representatives who could just as well have decided to allow

recounted in painstaking detail the hoops she had to jump through to visit Oscar for a mere three weeks, and she voiced anger and disgust at the bureaucrats who denied a mother the chance to remain with her suffering son.) Thus paralyzed by both her own suffering around her son's pain and by U.S. immigration policy, Carolina begins to blame herself and her husband, as though she could only comprehend her family's misfortune by attributing it to her and her husband's own sins and wrongdoings: "What did I do? What do I owe God? Who did I harm?"

While Carolina's circumstance is extreme given her son's accident and injury, I was often struck by the frequency of similarly dire circumstances and by the intensity of worry that many families expressed about their (and their friends' and neighbors') relatives in the United States. Their perceptions and expectations around the risks, vulnerabilities, and suffering which migrants endure are shaped by stories the migrants tell, by stories the media tells, and by stories which circulate in towns like San Miguel Tlacotepec, where the 'culture of migration' is longstanding and pervasive. Often these stories evoke gruesome and disturbing imagery which reverberates in non-migrants' narratives about their family members on the other side. Carolina's account provides one powerful example:

> C: Those who go, they don't go for pleasure. It's necessity. It's because they have the necessity to do something—to build a house for their family to live in. That's why they go. They leave their families, they go to work, because not everyone can go. And how much will the *coyote* charge so that migrants will have to go through the mountains? How many die in the mountains, in the desert? You don't think there are many? And when they have to cross the river, how many die? I saw a

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migrants to enter under the sanction of law – as legal immigrants, legal workers, or legal guests of some type (Ngai 2004). The migrants themselves are the same people, whether deemed legal or illegal by their countries of destination." (Chavez 2007: 192).

> report, imagine, I think it was in a river…and since they [the border patrol] hunt [migrants] like rabbits, when this man fell, a stake thrust into his neck and the tip of the stake went down his back—the stick with its pointed end, and he fell. Really, can anyone survive that? [A: They're going there to make lives for themselves.] Those who go to live, they fall dead. They [the border patrol] put traps down as if [the migrants] were deer. That's what they do! So, I say that this isn't fair.

A: They go to work, not to rob or do things like that.

C: They go to look for a life, not to rob. They go to work. Like—for example, you all [referencing me and the other researchers in town] come here, you come house to house because this is your work. They send you, and that's how it is. We're not going to treat you badly, like 'Listen, you all from wherever, we're coming out with sticks and stones'—it's not your fault. [A: You all aren't going to pay for what you're doing here…] No, we shouldn't do this, so I tell my husband to speak nicely to you all, because thank God our children are there [in your country] and they haven't been treated *that* badly because they're hard workers, I tell you. They're treated well, they have their little work and everything is okay up until now since they haven't been treated badly. Where things are bad is at the border-crossing, that's where it's extremely dangerous, that's it.

Carolina's perception that the border patrol and immigration enforcement officers 'hunt migrants like rabbits' and 'put traps down as if the migrants were deer' is consistent with her more general impression that Mexican migrants, particularly the undocumented, are dehumanized, criminalized, discriminated against, and generally treated like animals in the United States.[4] Not all Tlacotepenses were as preoccupied by the dangers of migration, but such risks come up frequently in conversation. In Carolina's narration, the risks are juxtaposed to the worthiness and moral virtue of her children's endeavors: 'it's necessity,' and they are not criminals or robbers, but are going to work and thus should be treated with respect.

[4] The case of Bartólo detailed in Chapter 7 resonates with Carolina's account, as well: he describes being treated like an animal by employers and others while working as an undocumented migrant, and attributes his severe depression to the frightening and bewildering experiences he sustained.

Thus not only is the pain of longing and missing migrant relatives apparent in community members' narratives, but so too are transnationally shaped sentiments of anxiety, worry, and vigilance. These sentiments, I argue, are a central aspect of 'being-in-the-world' in migrant sending communities. Whether composed of acute anxiety, worry, and vigilance or the more diffuse sense of longing and insecurity that characterizes many community members' accounts, transnational migration shapes everyday experience and emotional expression among those with close family members in the United States. When migrant relatives lack legal documentation and so exist in a state of 'illegality'—and particularly when migrant relatives face crises, as did Oscar—transnational anxieties can intensify.

In this sense, transnationally shaped sentiments are also deeply relational and intersubjective. Medical anthropologist Sarah Horton makes a similar observation:

> 'illegality' does not structure individual experience alone, but sets in motion a concatenation of shared vulnerabilities and intimate interdependencies between family members. Mothers' very undocumented status within the United States not only produces their own embodied distress, but also produces a continuous feedback loop between their children's grief and their own (Horton 2009: 23).

This feedback loop of grief, 'shared vulnerabilities,' and 'intimate interdependencies' also operates when children emigrate and parents remain, as we see in Carolina's case. Both migration and 'illegality' are experienced intersubjectively and in relation to knowledge and/or imagination of the processes occurring on the other side of the border.

This is not to say, however, that all transnationally, intersubjectively shaped sentiments are negative, or that 'illegality' necessarily produces the types of anxieties and insecurities Carolina describes. Many people with migrant children and other relatives in

the United States express experiencing their absence in relatively positive terms, satisfied that the gains migration provides are worth the sacrifice of physical presence. As Willen points out, we must be careful not to fall "into the trap of assuming that all undocumented migrants' lives are necessarily ongoing tales of suffering and distress" (2009: 13). Indeed, at the end of her account Carolina seems to suggest she does not want to represent her situation and that of her son as one characterized solely by suffering. 'Thank God our children are there [in your country] and they haven't been treated *that* badly because they're hard workers,' she says. 'They're treated well, they have their little work and everything is okay up until now since they haven't been treated badly.' Of course, both Carolina and Amalia had already recounted the ways in which their children, like other undocumented migrants, *had* been treated *that* badly; the hedge seems to be more to avoid offending me by implying Americans have done wrong by her family. She tells her husband to 'speak nicely' to the American researchers in town, as though their treatment of us might somehow come back to positively impact her sons' lives on the other side.

Ethnographies of transnational migration are essential for understanding the various material, symbolic, ideological, cultural, and emotional configurations that migration creates in the lives of those who experience it. But while much scholarship examines "new transnational cultures, identities, and community sphere" migration creates, leading to "new emergent cultures and hybrid ways of life [which] resemble neither those in the place of origin nor in the place of destination" (Hondagneu-Sotelo1997: 549), few examine how sentiment itself is produced and experienced transnationally. My approach seeks to take into account conditions and processes in both origin and host countries, emphasizing the connections between them and yet the

disjunctures which produce specific forms of suffering on either side. Carolina's narrative and evaluations serve as a paradigmatic case for understanding these transnationally shaped sentiments.

TRANSNATIONALLY SHAPED SENTIMENTS AND OAXACA'S CULTURE OF MENTAL HEALTH

'Sacar lo que traemos adentro' [Getting out what's inside]

Although Carolina mentioned suffering debilitating depression and anxiety related to her son's condition, she did not seek any type of care or treatment. I initially thought this was the case because she did not see herself as ill or in need of intervention from a specialist, or because she had not heard of professionals specializing in emotional or mental health. However, as our conversation continued, she told me how, years before, she had received psychological care in Mexico City and how much it had helped her. In particular, she said it showed her she was too docile a person: "I woke up, I opened my eyes to the fact that I shouldn't be that way," she said. "I always blamed myself for everything." She recounted that the psychologist told her she was taking too much responsibility for her grown children's lives; when Carolina suffered a back injury and became depressed because she could not cook, clean, and iron for her 30 year-old son, the psychologist said she needed to put herself first and let her children care for themselves. She also learned how important forgiveness is, as well as talking about and "getting out what's inside [*sacar lo que traemos adentro*], to be calmer and healthier."

Carolina's enthusiasm for psychological care was quite fervent; her perception was that psychologists are extremely effective, almost miracle workers: "Psychologists

are very well-trained…They do many things, they do marvelous things, beautiful things, right? You see one and you say, 'Ayyy, this is great, how nice.' They even ask you what you see, what you're imagining, because imagination—that's where everything comes out." Given this positive perception, I asked Carolina why she had not sought out a psychologist when she felt so badly after her son's accident. She responded:

> Because finding a psychologist and getting treatment—well, it's pure money. For medicine, for everything, because even just to talk to someone you have to pay…If you were to ask me, 'Would you like [a psychologist]?' Well of course we'd like one, but we have to pay to see one. They come and they charge you; they're not going to come for free…I have no resources, so it's not like I can say 'Now I have a little money, so now I'm going to make an appointment.' No, I don't go because I can't pay.

Carolina was far from the only Tlacotepense with strong opinions about the need for psychologists in the area; in fact, the desire for accessible psychological services became somewhat of a refrain in our CCIS research. Community members frequently insisted depression and other emotional difficulties were major problems in the town and that there was a strong need for trained professionals to intervene and provide support. Perhaps unsurprisingly, migration-related isolation was invoked as a primary reason for these problems, and thus the need for increased access to care.

In 2010 the San Miguel Tlacotepec Centro de Salud was under construction to make room for both a dentist and a psychologist, so community members may soon have a low-cost option for therapy. In the absence of mental health professionals, however, general doctors provide de facto psychological and psychiatric care. In 2007 a staff member at the Centro de Salud told us that Tlacotepenses "come here with general complaints, like body aches. We diagnose them with depression, and patients tell us their

problems. We give them advice on how to beat depression, and if their condition doesn't improve we send them to a psychologist." One of the town's private physicians provided a similar account: "We talk with them, give them some guidance. We're general practitioners; we've studied psychology, but just a bit. Patients come to us and vent, and we give therapy. Older people sometimes don't come to us and go instead to the priest." While the Centro de Salud is not authorized to prescribe psychopharmaceuticals, some private doctors in the town do. As one told us, "People usually present with an anxiety crisis that eases up in a few days. Sometimes we give them antidepressants and about a fourth of Diazepam or Valium, but it's a very small dosage so they won't become dependent. The other drug we prescribe is Fluoxetine [Prozac], which they will keep taking, but also in very small dosages." Another doctor reported having prescribed antipsychotics and sending patients to Oaxaca City for more intensive psychiatric treatment.

More than medications, though, community members expressed desire to have the opportunity to '*desahogarse'* and '*sacar sentimientos*,' or 'get emotions out.' "With a psychologist it is possible, that's what it's all about, to extract everything one has inside," as Tlacotepense Donatio Luna said. Sofia, whose case I discussed earlier in the chapter, also provided an account of the importance of psychological care:

> I found out about psychologists on TV and the radio, the news—you start to learn about these things. They help a lot, and it's like I'm telling you. You go and talk about what you feel, what's wrong with you, or what you want to do. Psychologists orient you, tell you if what you're feeling is good or bad and that you don't have to be closed off in your own problems without being able to do anything about it…With a psychologist you can—and this is what it's about—get out everything you carry inside [*sacar todo lo que uno trae dentro*]. With girlfriends you can't, really, as women we often keep it all inside…It's not the same as with a psychologist.

These accounts begin to illustrate how the psy-imaginaries discussed in prior chapters have spread beyond the clinical context and metropolitan centers. Exposed to psychological discourse through the media, local Centro de Salud *pláticas*, private doctors, and schools, community members in the Mixteca seem to be embracing the possibility of having the space in which to express painful emotions—many of which are migration-related—and cultivate the self. To conclude, I will provide a brief case study which illustrates in more detail how transnationally shaped sentiments contribute to Oaxaca's growing field of mental health services.

'Una desesperación muy fuerte'

María Luisa is a 55 year-old mother of six who first experienced what she described as a crippling depression when her daughters migrated to Southern California in 2004. At that point, María Luisa began suffering intense fears, *nervios*, anger, sadness, loss of appetite and "a strong sense of despair" [*una desesperación muy fuerte*] which led her to close herself in her home, crying for hours on end. "It's very difficult," María Luisa said, choking back tears. "I suffered a great deal, and I did not think I'd be able to recover. I isolated myself and had no desire to do anything." She said the only reason she did not commit suicide was because she had young children to take care of, as well as a granddaughter whose mother had just left for the United States:

> Maria Luisa: I was so afraid [when my children left]. I was so, so afraid. I don't know how to explain it, but I felt so much fear. So much despair. A compadre of mine understood because he, his wife, and her comadres had felt similarly. [He told me] 'You've gone through so much, and it's good you did not end your life. I also suffered [like that].'

Whitney: You were thinking about [suicide]?

ML: Yes, because of the despair I felt. Maybe I got it under control because I had the little girl, my granddaughter. I was so afraid that if something happened to me, how would she eat? This was my worry. Who would take care of her?

María Luisa had never heard of depression and initially did not seek help for her condition. Finally her sister-in-law, who found María Luisa crying at home every time she visited, insisted she seek treatment. María Luisa found a general physician in Juxtlahuaca who diagnosed her with depression and prescribed anti-depressants and vitamins, which María Luisa said helped a great deal. However, she has continued to experience unwanted feelings as well as somatic issues such as lung pain, diabetes complications, and hemorrhaging due to menopause-related problems. When I met María Luisa in 2011, her four eldest children lived as undocumented migrants in Southern California and she lived in Tlacotepec with her two youngest children and her granddaughter. Her husband had also just returned from the U.S. due to alcohol-related deportation charges—she said he had a severe drinking problem, and never managed to send back enough money to help with household costs. With the economic downturn her other children are unable to send much, either:

> My husband sent very little money and my daughters are married, so my husband sent a little and my son sent a little…but now there's no work there [in the United States] so my son doesn't send anything. He can't because there's very little employment…My husband doesn't worry about a thing and this depresses me, because I want to fight to provide for my kids but I can't do it all alone.[5]

[5] Some of María Luisa's quotations also appear in our forthcoming chapter, "Migration and Mental Health in a Binational Mixteco Community" (Calvario et al. forthcoming).

To support herself, her husband, and the three children—and especially to ensure the kids could continue their schooling—María Luisa was selling tacos in town. She expressed feeling overworked and constantly preoccupied with the question of how to scrape by both financially and emotionally. “I’m sad,” she said, “because I have no support…It’s so much responsibility, sometimes I get sick, and since I’m older—well, I go out to work, but sometimes I just can’t endure it all.” On top of her own worries, María Luisa worried for her children in the United States, particularly given the current difficulty of finding work. She was also preoccupied about the well-being of her eight year-old granddaughter who could not remember her mother since she emigrated when the girl was still a baby.

María Luisa thus attributes her illness to various interrelated factors, particularly separation from her children due to migration and the poverty prompting their migration in the first place. She spoke about how, because they were so far away, her children and husband could not understand her illness—it was impossible to convey at such a distance. Rather than supporting her from afar, her husband was angry she spent remittance money on treatment and medications. María Luisa wants her children to come home, but knows there is no work for them in Tlacotepec. She also mentioned the benefits of raising their own children—who are U.S. citizens—in the United States, particularly with regard to free public schooling. She knows firsthand how much suffering is possible in the context of San Miguel Tlacotepec; though she would prefer her family be together, María Luisa wants her children to be spared the struggles she has endured.

The isolation, financial troubles, and experiences of illness and emotion María Luisa describes are shaped by various transnational forces, particularly immigration

policies limiting cross-border mobility and communication, economic processes impacting employment opportunities and remittance amounts, and the lack of potential for flourishing among Mixteca residents more generally. In María Luisa's case, these forces translate to emotional suffering and contribute to a strong desire for psychological services, to which she has never had access. Although she received pharmaceutical treatment from a doctor, she said she had no one with whom to '*desahogarse*,' or unburden herself. She had heard of psychologists from other women suffering from depression—as well as from her daughter, who had attended *pláticas* given by psychologists in school—but had never had the opportunity to utilize one. María Luisa bemoaned the scarcity of psychological care and therapy and opined that they would help many other community members, as well:

> There's nothing here, not even psychologists. There's nothing. There are a lot of people who need treatment, lots of people who have problems here, so we need services. If there were [psychologists], I think it would help us a lot. I suffered so much, and I wanted someone with whom I could unburden myself [*yo sí deseaba alguien con quien desahogarme*].

CONCLUSION

Carolina and María Luisa's experiences provide illustrations of this chapter's two central claims: first, that emotional experience among non-migrants in high-emigration communities may be usefully conceptualized as transnational, and second, that transnationally-shaped sentiments and forms of distress contribute to desire for psychological services and thus to Oaxaca's growing culture of mental health. I couch my analysis within the framework of the critical phenomenology of migration and 'illegality' (Willen 2005, 2007; Horton 2009), which I argue may be productively applied to non-

migrating family members of U.S.-based migrants. Focusing on distress produced in situations of migration-induced family separation, I have shown how sentiments in the Mixtec community of San Miguel Tlacotepec can be shaped by and through transnational forces: economic policies contributing to rural poverty in Mexico and prompting emigration; immigration laws inhibiting circular migration and creating the category of 'illegal immigrant' (Chavez 2007; Cornelius 2004, 2006; De Genova and Peutz 2010); and the position of structural vulnerability which many undocumented migrants occupy (Quesada, Hart, & Bourgois 2011), which in turn contributes to anxiety, worry, and concern for non-migrating relatives remaining in Mexico. My account emphasizes the ways in which transnational socio-legal structures and the symbolic violence perpetuated by them have implications for social relations and emotional experiences across borders.

Additionally, I theorize that distress engendered by migration-induced family separation contributes to Oaxaca's growing field of mental health services: community members express wanting a therapeutic space in which to *desahogarse* and 'get out what's inside,' as they put it. As I discussed in the prior chapter, mental health practitioners are well aware of this increasing 'demand' for services in rural migrant-sending communities—a demand they hope to satisfy by providing increased access to care where feasible.[6] I am not suggesting that all experiences of family separation are negative; on the contrary, some community members emphasize the positive aspects of migration for their families, particularly with regard to the opportunities remittances can

[6] Migration is not the only factor contributing to increased desire for psychological care in the Mixteca—Tlacotepenses invoked marital problems, difficulties at school, domestic violence, economic difficulties, and more general social decline as important factors, as well—but migration-related emotional complaints were extremely common, and were frequently accompanied by discussions of the need for additional treatment options.

provide and an increased sense of independence and community involvement for women.[7] However, migration is a central aspect of everyday lived experience for members of this and other high-emigration communities, and has profound implications for how people understand themselves and each other. In this context, emotion is at once constrained and produced by transnational processes contributing to economic inequality and migration flows; policies governing immigration and creating 'illegality'; and structural vulnerability on either side of the border. The spread of Euroamerican mental health practice to this region adds an additional layer of globalization, which ties into the ways in which residents of the Mixteca experience, express, and manage transnationally shaped sentiments.

[7] For a more in-depth discussion of the impact of migration on the lives of non-migrating women in San Miguel Tlacotepec, see Andrews forthcoming.

CONCLUSION

This dissertation has examined a number of interrelated processes and has advanced several central arguments. Most broadly, I have argued that Oaxaca is experiencing changes in its culture of mental health—changes in which globalizing mental health conceptions and practices are gaining traction and impacting understandings of illness, self, and social relations in the region. I have shown how social crises such as migration and domestic violence are frequently dealt with in the clinical setting as matters of mental health, and how concepts like trauma, stress, and the importance of self-care and self-expression—integral aspects of the 'regime of the self' spreading through psychological globalization—are being promoted by practitioners and taken up by community members. The dissertation has also explored the link between these processes and broader forces of globalization, particularly the circulation of mental health discourse and ideology through public health campaigns and initiatives, which are themselves tied to recommendations and requirements of international governance institutions like the WHO, the UN, the World Bank, and the IMF. Additionally I have shown how, in the processes of psychological and psychiatric globalization, Oaxacan mental health practitioners act as 'conduits of the global' who attempt to mold the 'local,' primarily by dispelling so-called 'cultural' notions and practices which they view as incommensurable with mental health. This project goes well beyond the provision of treatment: I have argued that practitioners are explicitly attempting to foment culture change and promote modern forms of subjectivity.

But to what degree has this project been successful? What types of selves and subjectivities have been produced, and to what extent have mental health discourses, ideologies, and practices actually penetrated ways of apprehending and experiencing the world in Oaxaca? I believe a longitudinal ethnopsychological study of self and emotion in Oaxaca would provide the most satisfactory answers to these questions, and that is the shape I see my future work in Oaxaca taking. The present study provides a comprehensive overview of Oaxaca's culture of mental health—an examination of how and why mental health services have grown so dramatically; what they consist of and what discourses and ideologies they promote; who is providing them; for what problems they are being utilized; and what impacts they are having on broader understandings of health and illness in the region. The next step is to examine in more depth how the 'work of culture' articulates with the 'work of self' as people navigate their personal and social worlds (Obeyesekere 1990; Parish 2008; Csordas 1994a, 1994b).

That being said, I begin to answer questions around subjectivity, self, and experience of emotion in Chapters 6 ("Gendered Trauma and its Effects"), 7 ("Narrating Illness at the Psychiatric Hospital"), and 9 ("Transnationally Shaped Sentiments"). In each of these chapters I show how particular globalizing concepts—trauma, expressing emotions, self-esteem, the pharmaceutical imaginary (Jenkins 2010)—have been taken up and made meaningful by community members, however provisionally. To provide additional preliminary analysis of how this is occurring, I would like to return to the story of Carmen I began in Chapter 6. Carmen and her husband Mario have had powerful experiences with psychologists and have begun to adopt important aspects of the 'regime of the self'; these in turn inform their experiences of self and orientations toward social

life. Their case shows how the spread of Euroamerican mental health services can impact subjectivity—particularly with regard to gendered expectations and an increased focus on individual experience, authenticity, and expression. However, Carmen and Mario's case also shows how globalizing mental health concepts are locally reconfigured to resonate with actors' everyday lives.

Concluding Case Study: Carmen & Mario

Carmen and Mario have lived in Oaxaca City for most of their forty-year marriage. Carmen was born in a small rural town in the Central Valley region, while Mario was born hours away in Tuxtepec; however, they were family friends growing up so have known each other almost their entire lives. Both in their late fifties, the couple have two married daughters and one younger son they adopted from Carmen's sister. The family was close with the owner of the house I lived in, Pedro, and had taken on the responsibility of looking after the property since Pedro lived full-time in Veracruz. I saw both Carmen and Mario nearly daily and certainly weekly throughout the course of my fieldwork; soon they became close friends of mine, especially Carmen. There were few activities I enjoyed more than our long chats, in her house or mine. Her charisma, openness, and easy laughter are irresistible, and it seemed every time I thought I had gotten a sense of her life she would recount an event or tell me something about herself which confounded my impressions. There was never a dull moment with Carmen, whether we were making tamales, sitting on the patio, or driving around in "Carly," the ancient Toyota I had had fixed up for my trips to the psychiatric hospital. Mario and I did

not share long afternoons or evenings together like Carmen and I did, but he was often working on the house and we had an ongoing banter—he liked to tease me about my various mishaps (e.g. a particularly terrifying encounter with a tarantula in my kitchen, problems with "Carly," near-constant issues getting running water to work in the house). I think he began to see me as an accident-prone comic character, and our interactions would frequently begin with him knocking on my door and jokingly yelling "*Guera! Guera! Are you there? What's the problem today?*"

One morning only five days into my fieldwork, Carmen was sweeping the garden patio as I was finishing breakfast. We started chatting casually, and she asked what I had come to Oaxaca to study. I told her my project was centered on mental health services in the state and she immediately brightened, saying her psychologist had "saved her life." "You have a psychologist?" I asked, and Carmen launched into her story—how Mario had suddenly fallen ill ten years before and was diagnosed with HIV; how she knew virtually nothing about the disease then and had not imagined she, too, could be infected; the devastating test results; the couple's ongoing struggles with both the disease and its stigma—and the anger Carmen continues to feel toward Mario for contracting it through infidelity in the first place. What has helped Carmen most in the ten years since she got her test results, she said, is psychology. Carmen receives both private and group therapy at the state-run HIV clinic, and she spoke passionately about how her psychologist has helped with her "way of thinking," her "self-esteem," her "acceptance" of her condition, and her ability to forgive Mario. She said that the support group, composed of all HIV-positive women, has provided the community she's needed to come to terms with her

situation and the confidence to face it, accept it, not be afraid of talking about it, and to learn to ignore those who judge and reject her.

As Carmen and I got to know each other better I learned more about her life, met her other family members, and took her to several of her appointments at the HIV clinic, which was a new and very nice facility. Clean, airy, and decorated with plants and paintings, the clinic also had a lovely courtyard with wrought-iron tables, umbrellas, and an outdoor café. After weeks of working in the hot and loud psychiatric hospital, the HIV clinic seemed luxurious, quiet, and high-tech with its computers and wireless internet. I noted in particular the offices and meeting rooms where patients and doctors/therapists could interact privately, compared to the temporary (and far from soundproof) room dividers set up at Cruz del Sur, where the clacking of typewriters ensures almost constant noise. When I mentioned to one of the Cruz del Sur psychiatrists how impressed I was with the HIV clinic, he complained bitterly that it just went to show how little the government cared about mental health. "There's all this attention to other diseases, like 'Look how great we are putting money into HIV,' and meanwhile the mental health facilities get nothing..."

But the HIV clinic *was* providing patients psychological services free of charge, a fact which seemed to underline the "cultural conundrum" of mental health stigma (Jenkins & Carpenter-Song 2005) in Oaxaca: on the one hand, nearly everyone with whom I spoke both casually and in interview settings, both professionals and laypeople, said that mental health was ignored and/or stigmatized on an institutional level and in the community at large. Conversation after conversation I heard the refrain, "Here, people think psychologists are for *locos*." Some people even warned me I would never finish my

study because I would be unable to find enough people willing to broach the subject of mental health. Yet on the other hand, the government *was* taking steps—however small—to provide more access to services, and no-one actually claimed to hold the opinion that these services were for *locos.* As I have discussed throughout the dissertation, though there were plenty of people who said they *used* to think psychologists were for *locos* or that people they *knew* held that opinion, far from resisting mental health services people expressed overwhelming desire for more access to them. This seeming paradox could be the result of sampling bias or a function of what people thought I wanted to hear as an American researcher interested in such subjects. However, Carmen was only the first of many people I met who not only approved of mental health services but who felt they had been life-changing and life-saving—and who fervently expressed that more of them were needed statewide.

Patients at the public psychiatric hospital whose stories I tell in Chapter 7 frequently travel many hours to access such services, and some families discussed saving up money or using remittances sent from the United States for treatment and medication—not unlike how many families save for quinceañeras, patron saint festivals, and funerals. For every account of families treating mentally ill relatives poorly and chaining them up in back rooms, there were accounts of families making great sacrifices to pay for medications and traveling long distances to unburden themselves [*desahogar*] with a therapist. And although my research design did not allow me to interview families who had had negative treatment experiences, the positive reports of those I met at the hospital were quite powerful and convincing—particularly with regard to pharmaceuticals, but in both the clinical and non-clinical sample many people described

undergoing important and positive self-changes in the course of individual and group therapy, as well.

'Gracias a mis Psicólogos' [Thanks to my Psychologists]

Perhaps the most dramatic account of psychology's transformative power in people's lives came from Mario, who seemed an unlikely recipient of therapy. A short man with mischievous, sparkling eyes, a mustache, and a wide grin, Mario could be characterized as a 'typical' *machista* male—the kind I heard so much about from mental health practitioners, particularly those working in the anti-domestic violence sector (see Chapter 6). Before becoming ill, Mario had been a heavy drinker and would disappear for weeks on end, leaving Carmen with no idea of where he was. By the time they were about twenty years old, the couple had two baby daughters and Mario was, for all intents and purposes, absent. Carmen recounted how once she went looking for him and found him drinking with friends at a neighbor's house.

> I remember he said to me, 'Why are you looking for me?' and I said I was afraid something would happen to him. He told me, 'Don't look for me, don't worry about me—you only care because you want my money. You're worried about what I'm making because you want me to give it to you.' I'll never forget that day because I began to understand so many things…I said, 'You know, you're right, I need to work.' So I started to work and earn my own money.

Carmen began providing informal cleaning and washing services to make ends meet, and to this day she refuses to depend on Mario financially. She continues to work and save her own money, although now Mario hardly drinks and does not carouse in the ways it seems he used to. After the HIV diagnosis, he and Carmen both became Jehovah's

Witnesses and joined therapy groups at the HIV clinic, two changes which have profoundly shaped their lives over the past decade.

Although Carmen and I had discussed her experience of therapy many times, an event toward the end of my fieldwork clarified for me how important it had been for Mario, as well. It was an evening in November, and I was at Carmen and Mario's house chatting with Carmen over coffee and *pan dulce.* When Mario joined us at the kitchen table, Carmen was talking about their son, Leonel, who was finishing high school. The couple's usual humorous banter was interrupted when Mario suddenly became serious and started sharing the story of when he and Carmen decided to tell Leonel about their HIV diagnoses. Mario choked up and struggled getting the words out, but finally forged on and recounted how difficult it had been to confront Leonel about something that felt so shameful. Although Mario and Carmen were intensely devoted to their religion, they did not discuss such matters there—and Carmen mentioned numerous times how grateful she was to her therapy group for a space in which she could talk about her diagnosis openly, without fear of stigma. Mario agreed, saying that it was his psychologist, his support group, and God which together gave him the strength to finally speak to Leonel.

"I wrote a story about it for my support group," Mario said, and jumped up to fetch it. He came back with two pages stapled together. "Read it. Read the whole thing—it won an award in my therapy group. My spelling isn't good so I don't know if you'll understand it, but read it now." He watched intently as I read silently:

> Three long years of struggle passed as I underwent treatment. My two daughters, who are married, knew my diagnosis.
>
> Owing to my situation I had become a bitter person, aggressive, and everything bothered me. For example: coffee was always too hot, soup was too cold, there

were too many vegetables in my meal, my clothes weren't clean when I needed them.

I was too demanding with my son in every way.

More than anything I always felt like people, including my neighbors, were watching me. I felt that everything was black and bitter in life and I thought, 'Why me?'

I asked my God Jehovah to help me and I found the strength to confess to my son my truth. I did it fearing his reaction would be to reject me or that it would affect how he felt psychologically toward me.

These are the words I said.

'Son, we love you very much, and don't want you to think it is our intention to hurt you. But in life we have to learn to confront obstacles and today I'm going to confront something that I couldn't face up to. Now I want to find peace and do it whether your response is good or bad.

Your mother and I are undergoing medical treatment because we are people who live with a virus that maybe you have heard of, since it's often mentioned in the media. The virus is called HIV and in its final phase it's called AIDS.'

His response was.

'I imagined as much, I wondered why you both took so much medicine at the same time.' He understood and began to cry, hugging us tightly. He kept speaking:

'I often wanted to investigate or ask why you had all those medications, but I respect your privacy and so I didn't.

'In terms of my opinion, know that it doesn't bother me that you have HIV. For me, you are wonderful parents and I love you very much.

'And as you say, Dad, we need to face up to obstacles and now it's not just the two of you but three of us who can win the battle and we're going to do it happily, confidently, learning lessons for our future. Lessons for my future, lessons I have to learn in life.'

Living with this illness is a reality.

Thanks to the help of my doctors and, above all, my psychologists, I overcame the situation with my son, and continue to successfully face it today.

My health has improved as well as my character, and most importantly I have the unconditional support of my son.

> I fully trust in the hope that one day medicine will be developed to eradicate this disease.
>
> But even if that is not the case, I fully trust the word of God will be done
>
> > Prophecies of Isaiah 33:24
> > "No resident will say 'I'm sick.'"

"What do you think?" Mario asked me when I finished reading. Now it was my turn to have difficulty speaking—I was very moved by the story. I told him it was wonderful and very well-written. "No, no, the spelling's bad," Mario said modestly. I protested, saying "There are hardly any mistakes!" Then Carmen looked at the story and said, "Yes, there are errors," jokingly undermining some of Mario's beaming pride, but then exclaimed, "Mario wants to be a famous author!" and the two started laughing together.

Along with other things he spoke about and behaviors he manifested, Mario's story indicated he had experienced a genuine shift in how we regarded himself and others, as well as a newfound desire and propensity to confess and express his feelings. While he describes himself as formerly 'demanding' [*exigente*], bitter [*amargo*], and aggressive, as a *macho* male with difficulty showing affection and talking about intimate topics, in the story and in our conversations he said his "character has improved," as well as his treatment of Carmen and Leonel. Engaged in a project of working on himself to become more honest and expressive, to 'confront obstacles' and 'take responsibility,' Mario presents himself as an ideal psychological subject aware of both his own and others' vulnerability.

Of course we cannot attribute all these changes to Mario's experience of psychological treatment, especially given that during this time he had also become religious and given that we might expect major character changes after a life-altering

diagnosis of HIV. Additionally, Mario's newfound sensitivity and self-expression could have plausibly occurred without therapy and thus without the increasingly visible mental health sector. However, his own account indicates that what he has learned and experienced in psychological therapy have been central to his changing understandings. Viewed in light of many other, similar accounts from both the patient and community sample, I maintain that Oaxaca's changing culture of mental health has contributed to these subjective transformations.

Mario's story reminded me of something Carmen had said months before about therapy and about coming to terms with violence in one's life. "People here don't want to face up to things," she told me sadly. "They distance themselves and want to avoid the truth, avoid reality. They don't want to confront how things are." Through therapy and through religion, both Carmen and Mario had, in their words, 'faced up to things.' They had encountered a truth, a language in which to express it, and a space where they felt safe enough to do so.

'Like you're a Prisoner of Someone or Something'

Carmen has undergone her own transformations, as well. I discussed in Chapter 6 how she has recently come to see herself as indelibly marked by the violence she has suffered in her life. As she put it, "These things traumatize you even if you think—you say everything is fine. You think things are fine, but throughout your life it marks you, and when you finally manage to understand the emotional damage it's caused, lives are completely destroyed." Carmen never mentioned having suffered physical violence, but had come to understand many events in her life as types of emotional and psychological

violence which were important to "identify" and "work on." Over the past decade she had learned that talking about such violence was important "because a lot of the time we unconsciously carry this problem and therefore we don't overcome it." To build "self-esteem," it was important to "get it out, to clean the mind." Carmen went on:

> It's a long [therapeutic] process, because even as you're doing it you still act—you still let people overshadow you, treat you badly, hurt you. And when you feel that pain it means that we're still victims of violence, and it has a strong impact because—you don't, you still don't feel free but rather like you're a prisoner of someone or something…The impact is intense—it takes you in its web, this prisoner role, being dependent on something or someone, and it's there that problems begin that people can't free themselves from. But it's a huge amount of work, making people aware of all this [*concientizar a la gente*].

Like Carolina, whose story I recounted in Chapter 9, Carmen has taken explicit steps to "get out what's inside," to care for and "free" herself, and to become less submissive. Carmen expressed wanting autonomy and breaking the mold she felt society demanded: "Women have to attend to the husband, to the kids, to the house, and men no," she insisted. "Men make women do all this work, and that's violence."

What Carmen wanted, what was most "at stake" for her in the stories she told (Kleinman 1988b), was to be independent and judged based on her own behaviors and qualities rather than those of her family members. In the first six months I was in Oaxaca, Carmen was saving up money for her own coffin and funeral because she wanted peace of mind that even after death she would not become a burden to anyone. "I've always been a fighter," she said, and it seemed her therapeutic experience had further solidified that fighting spirit by cultivating a drive to explore and understand herself, establish her needs and responsibilities, express herself, and become fully self-sufficient. In the

process, she said she had strengthened her ‘self-esteem’ and her ability to put words to her desires, to resist being ‘overshadowed’ or placed in the role of a ‘prisoner.’

At the same time, Carmen very clearly struggles with these desires. She has integrated many aspects of the psy-imaginary and consciously seeks to adopt technologies of the self such as self-exploration, ‘taking responsibility,’ and self-expression; however, they do not necessarily seem to have become part of her taken-for-granted way of being in the world. Rather, Carmen struggles with how ‘free’ she really is. She knows her “possible self” (Parish 2008) is ‘empowered,’ strong, and self-esteeming, but she is also keenly aware that her agency is limited—by her precarious economic situation, by her lack of education, by her chronic illnesses, and by competing desires to be ‘free,’ on the one hand, and tied to the ebbs and flows of familial life, on the other. Throughout our time together she spoke about wanting to sell the house she and Mario owned so she could move into her own apartment and be ‘independent,’ for example, but she also knew that if she were to sicken and become unable to work in that scenario, she would be in serious trouble—not to mention the impact Carmen and Mario’s separation would have on their family or the fact that Carmen seemed in many ways to genuinely appreciate Mario’s companionship and the mutual understanding they had developed over the years. Carmen could not quite forgive Mario and wanted independence from him, but her ability and desire to leave were tempered by severe material constraints as well as the primacy of family in Carmen’s experience of selfhood.

When Kaja Finkler made the observation that “psychiatry failed to gain a foothold in Mexico arguably because of its prevailing notion of the autonomous individual,” which “goes against the dominant cultural understandings in all sectors of Mexican

society" (Finkler 2001: 72), it seems she did not consider that individuals and societies can hold multiple 'prevailing notions' simultaneously. Carmen, Mario, and other Oaxacans with whom I spoke did not view psychiatric or psychological conceptualizations as "counter to traditional cultural etiological notions of emotions that emanate from social interaction and the life world" (ibid). Rather, therapy and treatment helped provide *another* means of negotiating 'social interaction and the life world' in the context of globalization—indeed, this seems to have been at the crux of psychology and psychiatry's appeal for most study participants. Psychological and psychiatric globalization create encounters between multiple apprehensions of the world which may stand in tension, but which are not mutually exclusive on an experiential level.

We can see here how the psy-imaginary has come to hold powerful appeal and sway in people's lives, and how it has impacted important aspects of subjective experience. This imaginary encourages particular ways of understanding, exploring, and expressing oneself and one's emotions, and is predicated upon a view of the self as both inherently vulnerable and subject to psychological damage *and* as inherently capable of transformation, agency, and freedom. These views can produce dissonance, perhaps particularly in contexts where people's freedom is so very limited by structural factors such as endemic poverty and inequality. But they are not fully hegemonic or homogenizing; rather, actors modify psy-imaginaries and juxtapose them to other ways of knowing and being in the world. Practitioners' project of culture change and 'emotional modernization' may be producing subjects and selves who are more apt to work upon and express themselves, to become independent, to take their medications, and to agentively

seek liberation; however, such globalizing ideologies, discourses, and practices are always constrained and reconfigured by local realities and everyday experiences.

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