Storms, Sustos, and Psychiatrists

The rain poured hard, dripping off the branches into puddles. The night was black save for the lightning, illuminating cloud cover when it struck. Flowers bowed under the weight of water. Rain, clouds, mountains, caves: so vital to stories of Oaxaca. The Mixtecos, *pueblo de la lluvia*, ñuu savi, people of the rain.¹ In some Mixtec pueblos caves are sites of worship, *el culto de la cueva*, and have names like yavi kee yuku, Cueva de la Curación, Healing Cave; or we’e dawi, Casa de la Lluvia, Rain House. The Zapotec, Cloud People, Bene Zaa, are named “owners”—*dueños*, or xaan—of the hills, water, and land. The Mixe are likely named for the Nahuatl word for rain, mixtii. Poj ʻEnee, Thunder Wind, is a Mixe protector god of rain and fertility. Where was Poj ʻEnee that night?

A Mixe family ran for cover, leaving on the mountainside branches they had gathered for firewood: no matter now. The cave was dry underfoot, a relief. The family watched the storm from the mouth of the cave, shivering. Slowly, though, the cave began to collapse; they covered their heads and screamed. Struck by a heavy stone, the mother fell to the ground.

I do not know if Antonia, Mauricio, and their other family members carried their mother’s body back to their home during the storm or whether they waited. I do not know what the funeral was like, or whether there was one. Mauricio fell ill first: “a mi se me estaba borrando la mente,” he said. My mind wasn’t working. “It was failing me, and I didn’t want to do anything. No work, no cutting firewood, no housework. I just walked around like a drunk.” Soon his sister Antonia became ill as well, began talking to herself, vomiting, having trouble sleeping. “She jumped, she danced, she stopped doing her housework,” her hospital file says. Mauricio explained, “When she gets sick her mind doesn’t work. She doesn’t want to do anything. She wants to go out alone.” I imagine Antonia walking the mountain, talking, her eyes cast downward, as they were when we met.

I have replayed the moment that Mauricio described many times, imbued it with the texture of a story although it was told to me in

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¹ Excerpt from Transforming Therapy: Mental Health Practice and Cultural Change in Mexico by Whitney L. Duncan (Vanderbilt University Press, 2018)
fragments. I have thought about what lay between the lines of transcript, what lay in Antonia’s silence when her brother spoke for her. I have wondered what the two whispered in Mixe, consulting, and I recall their soft tones. I have imagined the curandero (healer) patting Antonia down with basil, rosemary, passing the egg over her body to remove the fright, and I have wondered whether her soul ever returned to her, and whether it ever left.

We met in Oaxaca’s one public psychiatric hospital, Cruz del Sur, over a decade after the fateful storm. At the hospital, Antonia was prescribed psychiatric medications: clonazepam (a benzodiazepine for anxiety, trade name Klonopin), risperidone (an antipsychotic, trade name Risperdal), biperiden (controls side effects of antipsychotics), and valproic acid (an anticonvulsant and mood stabilizer, trade name Depakote). Mauricio pointed to the psychiatrist’s hastily written script. “Without medicine, the illness kills us,” he told me.

What was the illness, exactly? Espanto, as Mauricio put it. Fright, susto: that’s what Antonia’s curandero had said as well. But the spiritual cleanse the curandero provided “only helped a little,” Mauricio emphasized. Possibly, he considered, it was from too much thinking, “por tanto pensar.” Or maybe it was the neighbors’ envy, for despite their tragedy, they were surviving as campesinos (peasants) and “we spend our days well,” Mauricio said. The psychiatrist said Antonia’s diagnosis was retraso mental (mental retardation). As her brother spoke to me, Antonia sat stiffly in her dress, looking sideways, giggling and covering her mouth when I addressed her. She only spoke a little Spanish, so Mauricio spoke for her, not forcefully but rather tenderly, as an older brother who looks after his younger, ailing sister might.

Antonia’s story, told by Mauricio and relayed by me, is but one that could open this book. Perhaps like any story told in a psychiatric hospital, it begs many questions—questions about family and social life; about vulnerability to social and natural forces; about distress that stretches across the years and unfurls in various forms, some spiritual, some social, some psychiatric; about whose knowledge counts and encounters between ways of knowing. The stone that fell from the cave’s wall brought the rest of the cave with it.

Changing Landscapes of Mental Health

This book is an effort to understand the meanings of mental health in contemporary Mexico. In particular, I focus on the relatively recent growth of Euroamerican-style psychology, psychiatry, and other forms of emotional
therapeutics in Oaxaca, amidst a context of extraordinary sociocultural, ethnic, and linguistic diversity, medical pluralism, and social strife. What impacts are these newly popular “psy-services” having on the society, and how are they linked to larger historical and sociopolitical currents in Mexico? Are they interacting with, replacing, or merely operating alongside preexisting ideas and forms of care? For what types of issues are Oaxacans seeking such services, and how might they affect Oaxacans’ social interactions and self-understandings?

Transforming Therapy focuses squarely on psy’s dual role as an instrument of sociality, healing, and self-making, and as an instrument of biopolitical governance. I show how psy-globalization—the transnational spread of psychological and psychiatric ways of knowing and working upon the self—articulates with political economic projects, on the one hand, and simultaneously creates therapeutic sites of psy-sociality for commenting upon and contesting such projects and their failures, on the other (Duncan 2017a, 2017b). These sites range from the institutional to the informal, including the public psychiatric hospital, private clinical settings, support groups, and community settings in which people explicitly engage in self-work or mental health care. In these sites, Oaxacans grapple with and seek to recover from the emotional consequences of social problems and breakdowns, such as familial conflict and loss, poverty, violence, and migration, which themselves are often intimately tied to the broader political economy and cultural changes in the context of globalization and modernization.

Transforming Therapy is not a straightforward story of medicalization, psychologization, or subjectification. While psy-globalization and global mental health practice provide new imaginaries and means of self-understanding linked to modern forms of governance, they do not supplant ethnopsychological understandings of the self as socially and morally constituted. Nor do they necessarily displace “traditional” forms of therapy and medicine, although popular and professional discourse tend to pit “the traditional” against “the modern,” “culture” against “mental health.” Examining the reciprocal relationships between global trends, local political economy and cultural discourse, expert knowledge, and individual experience, I show how globalizing psy-ideas and therapies are transformative for and transformed by people seeking to transcend demoralization, comment upon and repair social relations, and experiment with new ways of knowing and acting upon the self.

In Oaxaca, the subject of mental health raises issues far beyond psychological wellness and suffering, and provides a lens through which to understand changing sociocultural formations as well as the ways individuals make
meaning within them. Indeed, the topic brings up deep ambivalences about what it means to be a person in contemporary Mexico, inspiring reflection on what tradition is or should be—and whether it is possible to be the type of person that the psy-disciplines seek to cultivate. This ambivalence contributes to a larger story about the uses and abuses of “culture” in Mexico’s practices of governance. Psy-ideas and psy-practices balance precariously on the taut thread of the social fabric, on the tension created by the longing for seemingly opposed forces: change and sameness, modernity and tradition, independence and interdependence. In the flux and interchange between the local and the global, any easy dichotomy between them collapses.

Openings and Closings / Aperturas y Cierres
At the beginning of my study, people often asked me why I had chosen Oaxaca as my fieldsite if I wanted to understand mental health in Mexico. “Here,” the trope went, “people think you have to be crazy to go to a psychologist.” I was assured by Oaxacan mental health practitioners and members of the general community alike that there were many mental health problems in Oaxaca, but that they were too stigmatized to discuss openly. People frequently mentioned how “behind” Oaxaca was in matters of mental health and how wedded Oaxacans were to “tradition” and pensamiento mágico (magical thinking).

“The Mexican,” Octavio Paz famously wrote in The Labyrinth of Solitude, is a “person who shuts himself away to protect himself: his face is a mask and so is his smile. In his harsh solitude, which is both barbed and courteous, everything serves him as a defense: silence and words, politeness and disdain, irony and resignation. . . . The Mexican is always remote, from the world and from other people. And also from himself” (1985, 29). Although it’s now over a half-century old, Paz’s Freudian analysis of Mexican character—rooted in the loss and rejection of the Conquest and borne out as a kind of cultural melancholy and shared inscrutability—bears some resemblance to the way Oaxacans talk about themselves, or about other Oaxacans, at least when the subject of mental health comes up. Like Paz, many noted a need for ritual as a form of self-protection and a “predominance of the closed over the open.” As one Oaxacan psychologist put it, “People live with a lot of fear of being talked about, so they protect themselves too much. It’s a very closed, reserved society.” A Oaxacan doctor went so far as to report that “the further away you get, the smaller the village, the more conservative and distrusting it is.”

Many spoke to me about how Oaxacans tend to be emotionally repressed and resistant to deep exploration of the psyche. “Unlike other people,” Paz
wrote, “we believe that opening oneself up is a weakness or betrayal. The Mexican can bend, can bow humbly, can even stoop, but he cannot back down, that is, he cannot allow the outside world to penetrate his privacy. . . . He refuses to emerge from himself, to ‘let himself go?’” (1985, 30–32). A Oaxacan friend of mine echoed these descriptions when he said, “We limit our emotions. You cover those emotions up and don’t get them out for many reasons. For fear of rejection.” He concluded: “Expressing the emotional in Oaxaca . . . it’s very rare.” Some people opined that such repression was more notable among indigenous Oaxacans: “They are more closed,” one Oaxacan psychologist insisted. “It’s harder for them to talk—or, there’s much more embarrassment. The problem is, there’s still a lot of repression, mostly with women. . . . Therapy is not yet part of their culture.”

If such self-reflections are accurate, Oaxaca hardly seems the kind of place where mental health services and emotional therapeutics would thrive. After all, most forms of therapy require us to “emerge” from ourselves, take off our “masks,” and disclose our feelings. Psychology, psychiatry, and other forms of mental health practice and emotional care urge us to work on the self, act on the mind with psychopharmaceuticals, and aspire to particular forms of emotional management and self-expression. The psy-related disciplines do create certain types of “order, ritual, and tradition,” which Paz opined were so important to “the Mexican,” but they are usually deeply rooted in Euroamerican thought, philosophy, history, and politics (Good 1994; Illouz 2008; Luhrmann 2000; Rose 1998, 2007; Shorter 1998; Young 1995). The idea of mental disorders as “mental,” as well as the drive to mine the individual psyche, express inner feelings, and build self-esteem, reflects a particular view of the self as an independent entity in need of a particular type of work (Kirmayer 2007).

Indeed, mental health and emotion are intimately interwoven with and constituted through culture (Abu-Lughod 1986; Jenkins 1994, 2015; Kleinman 1988a; Lutz and Abu-Lughod 1990; Wikan 1990). Sociocultural life impacts what is considered pathological or deviant to begin with; how symptoms and sentiments are experienced, identified, and expressed; how illness and distress should be treated therapeutically; and even the outcomes of illnesses themselves (Hinton and Good 2009, 2016; Jenkins 1994; Jenkins and Barrett 2004; Kleinman 1980; Kleinman and Good 1985; Lewis-Fernández et al. 2014; O’Nell 1996). Notions of psychopathology are 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).
From this perspective, the cross-cultural validity of psychiatric diagnostic categories cannot be taken for granted. Such categories are provisional (Davis 2012): they shift along with shifting sociocultural values and economic interests (Braslow and Starks 2005; Healy 2002, 2006; Kirmayer 2006; Lakoff 2005; Luhrmann 2000; Metzl 2010; Myers 2015; Shorter 1998; Starks and Braslow 2005; Young 1995). What happens when those culturally based ideas are exported and implemented in new settings, where their validity has not been established? At least as far back as Ruth Benedict’s seminal paper “Anthropology and the Abnormal,” anthropologists have argued that “normal-abnormal” categories and notions of deviance are culturally determined and should not be judged according to Western local normalities (Benedict 1934).

Many forms of indigenous medicine in Oaxaca—and in Mexico and Latin America more generally—do not make a Cartesian distinction between body and mind, for example. Instead, the human body is understood to be “homeostatic and self-regulating,” and health is rooted in a delicate balance with nature (Rubel and Browner 1999, 86; see also Ocaranza 1934). Well-being begins not from the relationship of man to himself, but rather “the relationship of man to the earth and the elements, labor, heaven, and the environment” (Hernández 2001, 35). For many Oaxacans, “self” is not so much an independent, individual entity as a system of interlocking parts. Illness and health, life and death, spirituality and the cosmos, the mind and the body, sociofamilial relations, and the natural world are all forces intertwined in an intricate dance. Interdependency is central, as Oaxacan anthropologist Jaime Martínez Luna writes: “We are Communalidad, as opposed to individuality, we are communal land, not private property; we are about sharing, not competition; we are polytheism, not monotheism. We are exchange, not business; diversity, not equality, even though we are also oppressed in the name of equality. We are interdependent, not free” (2010, 17). Psy-ideas and psy-practices—with their focus on internal experience and expression, on the individual as the seat of consciousness and volition, and on personal suffering and liberation—tend to be based on quite a different worldview, and this worldview is rapidly spreading.

Despite the assurances I had received that a study of the meanings of mental health in Oaxaca would be impossible due to stigma and taboo, closed minds and masks, communality and magical thoughts, my curiosity was grounded in a simple observation: psy-services were becoming more visible and sought after in Oaxaca. Importantly, public psychiatric services for those with acute mental illness continue to be scant and insufficient. But walking through Oaxaca City, it is impossible not to notice the assortment
of psychological and alternative therapy clinics, private psychologists and psychiatrists, and self-help groups available, many of them quite new.

Strolling up the hill into the historic Xochimilco neighborhood, you encounter a hand-painted sign on the outside wall of a convenience store advertising cheese, chocolate, chorizo, and, in larger type, a psicólogo who offers his services in the same building (Figure 1). Dodging traffic on one of the city’s main thoroughfares, Niños Heroes, you see a building painted gold and black with advertisements for psychological therapy, neurolinguistic programming, and adolescent emotional support groups. Making your way down Porfirio Díaz into the historic city center, you come across a poster for Neurotics Anonymous stapled to a light post. Turn right on Abasolo near the Santo Domingo cathedral, and you find signs for a Gestalt psychologist who also offers homeopathic remedies. Go deeper into the city,
near the sprawling 20 de Noviembre market, and you discover handwritten ads for therapy—10 pesos—hardly visible among the rows of produce, cheeses, artisan rugs, and mezcal.

As these signs suggest, the number of private psy-practitioners offering humanistic, Gestalt, psychoanalytic, and other forms of psychotherapy has exploded in Oaxaca City. Schools increasingly have psychologists on staff. Some churches host psychologist-led family events and include psychological services in their health dispensaries. Several Oaxacan universities offer degrees in psychology, and local clinics now offer certificates in various forms of therapy from neurolinguistic programming to hypnosis. Television and radio shows, some sponsored by the government, attempt to destigmatize 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 (psychoeducation) has also made its way into PROSPERA (formerly Oportunidades), Mexico’s notorious cash-transfer poverty alleviation program, for which participants in urban and rural areas are sometimes required to attend educational sessions about mental health, just as they must attend sessions on cancer, hygiene, and nutrition. Virtually unused twenty years ago, outpatient services at the public psychiatric hospital where I met Antonia and Mauricio are now routinely overwhelmed by the volume of help-seekers from all over the region. Oaxaca’s State Mental Health Program (Programa Estatal de Salud Mental) coordinates with civil organizations to provide educational workshops, courses, video debates, free consultations, conferences, cultural and artistic exhibitions, marches, and radio and TV programming throughout the state. In short, psy-services and emotional support options in Oaxaca are increasingly visible and are actively promoted by practitioners, organizations, churches, schools, and the government.

On a van ride from Oaxaca City to the Mixteca region, I saw a home-made 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 but cornfields in sight for miles.

A bit further up the road, the van hurtled by several centers for Neuróticos Anónimos (NA, Neurotics Anonymous), a self-help group for those self-diagnosed with emotional or mental illness. One of the more longstanding options for emotional care in the region, Neuróticos Anónimos was founded in Mexico City in 1977. In 1986, the first Oaxacan
NA center opened and the state is now home to over forty such centers—more than any other state in the country. Standing at the tribuna, as the podium is called, thousands of Oaxacans divulge their feelings in front of others, revealing painful details of their emotional lives. These are not the remote and barbed people Paz describes, but people who are making themselves almost painfully vulnerable.

When I reached the Mixteca, I visited friends in several mountain pueblos. In San Miguel Tlacotepec, the Centro de Salud (community health center) was being renovated to accommodate a psychologist. In Ixpantepec Nieves, a man I had just met in my friend Doña Celeste’s miscelánea (convenience store) started talking to me about how living as an undocumented migrant in California had been a “trauma” for him. A few minutes later, Doña Celeste told me about a school program in the village in which psychologists offered “self-esteem” workshops to children to help prevent them from experimenting with drugs.4

Two decades ago, I was assured, I would have been hard-pressed to find a mental health practitioner in the region at all. In the words of Mixtec medical doctor and psychologist Dr. Mariana Pérez,

During all these years I’ve been practicing, things have changed a lot; the panorama has opened up dramatically. Eighteen years ago, you were working yourself to the bone [estabas picando piedra] in this sense. There was a very small group of psychiatrists and psychologists. . . . It took a great deal of work to pave the way [poder abrir camino]. Whereas currently, there is high demand in all areas, there is a lot of demand, people are much more sensitized [sensibilizada], more needing of help and more accepting of it. . . . Back then, there was social prejudice—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. People are very open—for example, there has been an increase in psychological attention at schools. It’s very different than it was before—it’s a much more open attention. From a social point of view, as a society we are much more willing, much more open [mucho más dispuestos, mucho más abiertos].

As another psychologist and public health administrator put it to me, “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.” For each person who said Oaxacans were “much more willing,
much more open” to psy-ideas and psy-practices, though, several more said they were too “closed” and “traditional” to ever accept, let alone seek out, such services. For each story about the intransigence of traditional culture, I collected another about sociocultural transformation.

Some of these stories were hopeful, reaching toward a desired *apertura* (opening), a sense of longed-for modernity finally coming to pass. Others revealed a distinct sense of nostalgia for a past in which the social fabric was more tightly woven, a past—in part remembered, in part romantically imagined—of reciprocity rather than capitalist exploitation, of popular representation rather than political repression, of tightly bound family units rather than migration-related family separation. The social fabric: I think of it as a colorful textile, dyed in the crimson juice of the *cochinilla* bug and strung on the wooden looms you find throughout Oaxaca. To many, the social fabric is, as one person put it, “falling apart.” In clinical settings and beyond, Oaxacans are grappling with the effects of this unraveling using psy-vocabularies and psy-practices, which provide new material to begin to weave the social fabric together again.5

*Transforming Hearts: Psy in Historical Context*

After we had lunch at her store, Doña Celeste walked me up the pueblo’s steep hill to visit one of the local curanderos, Antolín, whose dirt-floored, cinder block house was filled with tools, animal figurines, herbs, and medicine boxes. A bird chirped from a cage somewhere within the house. “Doctors don’t even know where illnesses start,” Antolín opined in a deep nasal voice. “They have new technology, so they say, ‘no, do this, do that’ and they name the illness, then later they come up with another name—they have lots of names. But where all illnesses start, what I’ve analyzed during all my career and studies, is how every illness comes from bad air [mal aire] or fright [susto]” (see Méndez Hernández 2009 for another curandera’s account of susto).

Antolín’s practice is rooted in Oaxaca’s rich system of *medicina tradicional* (traditional medicine), which, along with religious leaders and family, has been a main source of support for problems that are now often taken up in clinical and self-help settings.6 To be sure, most pre-Columbian Mesoamerican groups possessed complex notions of emotional well-being as well as treatments to address what contemporary psy-disciplines might consider mental disorders. Most historical records of Mesoamerican medicine concern the Aztecs, who took the heart to be the center of emotional and psychological life. Some have suggested that what Aztecs called “losing the heart” may have resembled what is now often referred to as “losing
one’s mind” or “losing one’s head” (Padilla and Salgado de Snyder 1988, 62; Somolinos D’Ardois 1978, 27). Such disturbances were often interpreted as omens and led to threatening imbalances in both the individual and the community at large. Therefore, the community at large participated in the restoration of health for the patient (Somolinos D’Ardois 1978, 19). Diagnoses of this condition were “deeply imbedded in . . . mystical and supernatural concepts” and “treated by ‘techniques for transformations of hearts’” (Belsasso 1969, 32).

How to transform hearts? For millennia, indigenous groups have had highly advanced ethnobotanical taxonomies and complex pharmaceutical knowledge systems, using different plants and combinations of plants to treat specific maladies. There were likely at least 2,500 plants utilized in Mesoamerican therapeutic circumstances that might now be labeled as psychiatric (Somolinos D’Ardois 1978, 32). Also important to Aztec healing was the tonalpouqui, who acted as a middleman between gods and the afflicted patient and who “made use of psychotherapeutic methods to reestablish the emotional equilibrium of the individual” (Padilla and Salgado de Snyder 1988, 63). Many of these practices were obliterated, abolished, or marginalized with the Conquest and colonization of Mexico, which left Mesoamerican medicine in a state of disarticulation. When the new economic and social order was established in Mexico under the Spanish crown, pre-Hispanic medical practices were often considered primitive, discriminated against, and associated with witchcraft and ignorance (Quijada 1991). What survived and is now called medicina tradicional or curanderismo is actually a blend of Mesoamerican, Spanish, Mediterranean, and African medicines brought to the New World with slavery. This blending largely took place according to the terms of the colonizer, though, and many aspects of pre-Hispanic medicine—and its treatments for ills of the spirit and heart—were lost (Sandstrom 2001).

And while pre-Columbian civilizations had elaborate ways of dealing with the ills of the heart that may overlap with contemporary psychiatric diagnoses, early Colonial medicine tended to marginalize and demonize madness as a punishment for sin (Belsasso 1969). Those deemed mad in the early Colonial era tended to be persecuted, sometimes even killed by Inquisition tribunals (Somolinos D’Ardois 1978, 94; Narváez 2002, 36). Some received care and charity from monastic institutions like the Hospital General de Convalecientes y Pobres Desamparados, often referred to as San Hipólito, established in present-day Mexico City in the 1560s. For many years it acted more as a halfway house than a hospital (Somolinos D’Ardois 1978), but as the first institution on the American continent dedicated to
caring for the mentally ill (De la Fuente and Heinze Martín 2014, 523), San Hipólito was likely also “the first instance of what would later be called ‘colonial psychiatry,’ and the first truly global expansion of institutional mental health care” (Cohen et al. 2013, 5).

The field of Mexican psychiatry did not truly emerge until the late nineteenth century, however, and its legitimacy was tied to Porfirián policies and processes of development and modernization, thus shaping the discipline’s role in a rapidly changing postcolonial society. In the late nineteenth and early twentieth centuries, more and more psychiatric institutions, academic psychiatric and neurological societies and journals, and universities with psychiatry degrees and departments began to emerge (Narváez 2002; Somolinos Palencia 1983; Somolinos D’Ardois 1978). Many of the common treatments for mental illness in this period, such as insulin shock, cardiac shock, and electroconvulsive shock, were developed in Europe, and many of Mexico’s first influential psychiatrists were Spanish (Gorbach 2014; Narváez 2002, 65; De La Fuente and Heinze Martín 2014).

European and American psychological and psychoanalytic approaches also contributed to the emergence of Mexican psychological disciplines during the first half of the twentieth century (De la Paz López 2011; Rivera-Garza 2001). In general, twentieth-century psychology in Mexico was marked by fragmentation and heady ideological disagreements between psychoanalysts aligned with Freud and Marx, psychoanalysts working from Erich Fromm’s sociocultural psychoanalytic tradition, and humanistic, behavioral, cognitive, psychometric, transcultural, and social psychological approaches (Sanchez-Sosa 2004, 100–101; see also Gómez 2010; Galindo and Vorwerg 1985; Sanchez-Sosa 2007). Latin America’s first psychological society was founded in Mexico in 1907 (Sanchez-Sosa 2004, 95), and the 1950s saw a proliferation of psychological and psychoanalytic associations and splinter groups. Primarily rooted in psychoanalysis and psychometrics in the early 1960s (Galindo and Vorwerg 1985), Mexican psychology soon shifted toward transcultural and behavioral approaches.

Mexico’s first public, institutional efforts to promote mental health services were developed in the late 1940s through the Department of Neuropsychiatry and Mental Hygiene (Departamento de Neuropsiquiatría e Higiene Mental; Ramírez Almanza and Méndez Calderón 2007, 5; Secretaría de Salud 2001, 26). By the 1960s and 1970s, Mexico’s public health efforts had begun emphasizing models of patient rehabilitation and reintegration. In this vein, nine of the eleven public psychiatric hospitals in
the country adopted the granja (farm) model of psychiatric care, in which patients tended to livestock and worked the land around the hospital to grow their own food as part of their treatment (De la Fuente and Heinze Martin 2014, 524; Secretaría de Salud 2001, 26). Additionally, some psychiatrists began incorporating a more socially based approach to psychiatric treatment that included patients’ family members (De la Fuente and Heinze Martin 2014, 525). However, the advent of pharmacological treatments for mental illness in the 1950s transformed psychiatry around the world, including in Mexico, where the neurobiological approach currently dominates institutional psychiatric care.

As this brief account reveals, the conflicts and contradictions that characterize psy-globalization in Mexico, and perhaps particularly in Oaxaca where medicina tradicional continues to thrive, are intimately connected to histories of conflict, conquest, colonialism, and postcolonial modernization. A rich medical system that addressed ills of the heart and various forms of madness in Mesoamerican Mexico was partially obliterated and largely marginalized with the Conquest, and it would take hundreds of years for official forms of Mexican psychiatry and psychology to seriously attempt to take on such problems again. Yet this history also shows that imported psy-practices and psy-ideas are not new to Mexico; as elsewhere, they have thrived in urban cosmopolitan centers in conjunction with and as an integral part of modernization. It could be said that psy-globalization in Mexico began in earnest in the early twentieth century, when European and American ideas and practices around mental health, self, and psyche began to flourish in Mexico’s academic, intellectual, and medical worlds.

Like Mexico’s overall economic and infrastructural development, though, its public health care has developed unevenly and has been concentrated in its wealthier states and urban centers. While Mexico’s first institutional program to promote mental health was developed in the late 1940s, Oaxaca’s was not fully established until 2001 (Ramírez Almanza and Méndez Calderón 2007). The state’s public psychiatric hospital, Cruz del Sur, was founded in 1963 in the granja model and continues to be the state’s only institution for public psychiatric care (Ramírez Almanza and Méndez Calderón 2007). Thus, it is not surprising that many Oaxacans looked at me incredulously when I said I was studying the “spread” of psy-services in the region. But even the numbers from Cruz del Sur tell a story of change, with consultations almost quintupling from just over 2,500 per year in the early nineties (Ramírez Almanza and Méndez Calderón 2007) to about 12,000 per year currently (Cruz del Sur Psychiatric Hospital records...
2015). And, while public psychiatric services are scarce and inadequate, “therapeutic culture” (Füredi 2004; Illouz 2008) is rapidly spreading and entering public consciousness.

Social Change, Social Suffering, and Psy
When I first visited Oaxaca City (metro population about three hundred thousand) as a college student in 2002, I was struck by the city’s beauty and vibrancy, its tree-lined cobblestone streets and imposing cathedrals, and its peacefulness. The tranquil cobblestoned capital in my memory was fictional to begin with, but this memory contrasted with my later impressions, when I returned as an anthropologist-in-training five years later. Then, I found what seemed to be a much larger city, congested, and somewhat on edge. It was still a lovely place, but I sensed it was strung more tightly.

In this Oaxaca, the zócalo is as much the site of perpetual plantones (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 impressive as much for their historical and architectural 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, which many told me was 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 commentaries the situation provoked spoke to the frustration many Oaxacans feel toward their government, which is frequently characterized as irrevocably corrupt.

Some of this anger can be attributed to Oaxaca’s 2006 conflicts, in which 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 (the Popular Assembly of the People of Oaxaca, or APPO), 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 thirty people were killed with many more injured over the course of the seven-month conflict. As of 2011, dozens of people were receiving psychological and medical care for the effects of torture they suffered during the conflict, and there were 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 and impunity that characterizes state politics. Roadblocks, strikes, and demonstrations have been constant in recent years, and in 2016 confrontations between the teachers’ union and authorities again became violent during a protest of national educational reforms.

Another part of the anger and anxiety people expressed revolved around Oaxaca’s status as one of Mexico’s most economically marginalized states. Thirty percent of the state’s population (thirty-nine million) lacks running water, plumbing, and reliable access to education (INEGI 2012; CONEVAL 2012), and one-fourth of the state’s residents have limited health care access. Those fifteen years or older have an average of only 6.9 years of schooling and about 16 percent of the population cannot read or write (INEGI 2015). Oaxaca’s maternal mortality rate (98.3 per 100,000) and rate of illiteracy (16.7 percent) are among the highest in Mexico (ONU Mujeres 2011). Oaxaca City has a sizeable population of middle-class and wealthy residents, but overall only a little over 10 percent of the state’s population is not categorized as “poor or vulnerable,” and nearly 62 percent live in either extreme or moderate poverty (CONEVAL 2012).

Moving through the Valle Central and its fields of corn and maguey, up into the green mountains of the Sierra Madre, on to the lush and humid coastal region, and circling northwest to the dusty hills of the Mixteca Baja, you encounter hundreds of villages in the midst of various forms of upheaval. Social and economic inequality have characterized the region for nearly the duration of its several-millennia history (Gay 2006; Murphy and Stepick 1991; Williams 1979), and this inequality roughly maps on to ethnicity, such that Oaxaca’s stunning diversity—it is home to sixteen indigenous groups, each of which is quite internally varied—exists alongside deep-seated patterns of marginalization. Thirty-four percent of the state’s population speaks an indigenous language, which is a higher proportion than any other state in the nation, and over half the population of Oaxaca resides in rural communities with fewer than 2,500 residents (INEGI 2012). Because indigenous populations bear the brunt of poverty and lack
access to health and educational services, they are disproportionately likely to emigrate to the United States and other areas of Mexico.

Oaxaca has a long history of emigration, but various economic reforms from the 1980s through the present have accelerated the forces that drive people out of the state in search of work. Mexico renegotiated its foreign debt in the 1980s and 1990s and began instituting neoliberal economic policies: deregulation, cuts in the public sector, privatization, export-centered industrial growth, foreign investment, and free trade (Haber et al. 2008; Schmalzbauer 2010, 1861). The country’s focus on industrial expansion through maquiladoras (export manufacturing plants) has not provided viable alternatives for agricultural communities—like those in rural Oaxaca—that have been unable to compete in the global market (Stephen 2007, 124). In 1994, the passage of NAFTA solidified economic integration between the United States, Mexico, and Canada, and required Mexico to lower its price supports for farmers and reduce import restrictions. The prices of Mexican crops fell, prices of feed and fertilizers rose, and by 2001, corn farmers and their families were living on less than one-third of what they had earned six years before (Stephen 2007, 127).

Oaxaca’s rural and indigenous communities were already extremely marginalized before these modern economic developments, but their vulnerability has arguably intensified in the past twenty years. Structurally positioned at the bottom of the ethnic, class, and occupational hierarchy and without local labor opportunities, members of such communities often have few options but to emigrate (Holmes 2013). In the 1990s and early 2000s, approximately 150 thousand Oaxacans were leaving to seek work in northern Mexico or the United States each year, and between 1990 and 2005, the number of Oaxacans residing in the United States tripled. In 2009, about 1,203,680 people—34 percent of the state’s total population—lived outside of the state (Ruiz Quiróz and Cruz Vasquez 2009, 33), most of these in the United States. In some pueblos, so many people have left that only a fraction of the population remains. The majority of Oaxacan migrants residing in the United States are undocumented and living in conditions of extreme structural vulnerability (Duncan 2015; see also Quesada et al. 2011; Holmes 2013).

To be sure, social suffering, that is, “human problems that have their origins and consequences in the devastating injuries that social force can inflict on human experience” (Kleinman et al. 1997, ix), was painfully present no matter where I went in the region. One of the central themes from my interviews and casual interactions in the city and Oaxaca’s rural areas was that life in Oaxaca has become more dangerous and unstable.
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.” This is the Oaxaca where mental health services have begun to thrive.

Amapola of La Loma

The cobblestone facelift in the historic downtown was particularly infuriating to residents of the neighborhood where I lived for a year during my main fieldwork stay, colonia Lopez Mateos, where so many streets remained unpaved and hardly passable. Colonia Lopez Mateos is on the top of a large hill, known as La Loma, or The Knoll, overlooking the city stretched out to the east, Monte Albán off to the west, and the green mountains of the Sierra Madre off to the north. From the front patio of the house I lived in, I could see the road snaking past an impressive conglomeration of houses built precariously up and down the hill—multilevel concrete mansions alongside corrugated tin shacks and ramshackle wooden structures. There was a smattering of trees on the hill and unpaved roads bending off the main street, which dozens of cars, motorcycles, buses, and trucks, few of which had mufflers, would thunderously pass. All day every day, the near-constant din of jingles, whistles, bells, and loudspeakers announced the arrival of independent vendors selling everything from tortillas and fried plantains to water and propane.

The house on the hill was owned by an American most people called Pedro, whom I knew through a series of family connections, and who had very generously offered the apartment beneath his main house—a concrete addition with a bedroom, living room, kitchen, and bathroom all adjoined by an outdoor patio teeming with pink geraniums, vines, cacti, and bougainvillea—for me to live in during my fieldwork. One morning a few days after I moved in, I dragged a table out to the patio to take in the view and work on my fieldnotes. As I mused on some of my initial interviews and observations, one of the groundskeepers came over to sweep, water the plants, and pick up after the house dogs, Oscar and Güera. This was Amapola. Amapola and her husband, Mario, were good friends of Pedro, having worked for him in various capacities for over twenty years, and Pedro had already suggested he thought Amapola and I would get along well. I
estimated that she was in her fifties; she had long, dark hair with streaks of grey and wore a gauzy ankle-length skirt with an intricately embroidered blouse. She was quick to smile and easy to talk to, but when she first asked me what I was working on, I felt a tinge of nervousness; I didn’t want to be told that my project would be doomed due to Oaxacans’ resistance to matters of mental health.

Instead, when I explained my research, Amapola’s face brightened and she put her broom down and walked over to talk more directly. It turned out she had been in individual therapy and an emotional support group for nearly a decade, and that, according to her, these forms of treatment had “saved her life.” Without hesitation, Amapola launched into the story of how Mario had fallen ill ten years before. He had been a hard drinker, and Amapola suspected he was sleeping with other women when he was out. All of a sudden, she said, he came down with what seemed like dozens of health problems. None of the doctors’ tests revealed anything, until finally they thought to test him for HIV. Amapola described taking the test results out of the lab; how she breathlessly tore open the stapled pages and was stunned to learn that he had tested positive for the virus. “They told me I had to take a test, too,” she 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.’”

When she found out she, too, was positive, she couldn’t imagine sharing the information with anyone she knew—not her neighbors, her fellow Jehovah’s Witnesses, even her family. What has helped Amapola the most in the years since she received her test results, she said, is the psychological therapy she receives at the state-run HIV clinic. Amapola 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 needed to come to terms with her situation and the confidence to face it, accept it, not be afraid of talking about it, and learn to ignore those who judged and rejected her.

As Amapola 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, Cruz del Sur, the HIV clinic seemed luxurious, quiet, and high-tech with its computers and wireless Internet. As I sat in the courtyard waiting for Amapola’s
appointment to finish, I noted the offices and meeting rooms where patients and their health providers could interact privately, compared to the temporary (and far from soundproof) room dividers set up at the psychiatric hospital, where the clacking of typewriters ensured almost constant noise. The next day, 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 and Carpenter-Song 2005) in Oaxaca: unanimous agreement that mental health was taboo and mental health services underfunded, on the one hand, and the newfound popularity of mental health care and ideas around mental and emotional well-being, on the other. The visible growth of psy-services in Oaxaca City seemed only to underline the discrepancy between what most people thought the prevailing views were and what was actually happening on the ground.

Amapola’s stories and experiences spoke to many important cultural conundrums in contemporary Oaxaca as she poled back and forth between different explanations for—and reactions to—her life circumstances and health problems. I saw her nearly daily during the course of my 2010–2011 fieldwork, sometimes only in passing as she came over to tend to the dogs and the plants, and other times for long afternoons of tamale-making, chatting on the patio, walking around La Loma, or driving around in “Carly,” the name I gave to Pedro’s ancient Toyota station wagon that I had fixed up for my trips to the psychiatric hospital. One day, Amapola and I decided to take Carly out to pick up some special shampoo for Güera the dog, who had developed a nasty rash and had been scratching herself raw. As Amapola and I made our way down from La Loma and into another, more well-off colonia of the city, we passed a billboard painted with the slogan “A Life Without Violence Toward Women,” advertising a 1-800 violence help line, and Amapola began to marvel at the changes she had seen in Oaxaca’s recent history.

Speaking loudly over the din of traffic coming in through our open windows, she explained that although physical violence toward women had at least been acknowledged in Oaxaca for some time, campaigns drawing attention to the matter were quite new, as were many of the services and organizations that had cropped up to help women confront it. But it wasn’t just new services; Amapola also emphasized how new ideas about what even
counts as violence had become more widespread. Until recently, she said, “‘psychological violence’ was something that was very—that was not well understood,” she said. Now, though, “it’s been given more importance. Now yes—now they’re showing people that no one is better off being beaten or being spoken to with hurtful words. No! They’re going to feel even worse. It doesn’t help them. It damages them, and this damage can even happen later on.”

Although Amapola was making a general observation, her perceptions of gender inequality and violence were rooted in her personal history going back to her own conception: her mother became pregnant with Amapola after being raped while her husband was in jail on false murder charges. Since Amapola was illegitimate, her mother did not insist that she have the same rights as her siblings, and her father never saw her as his own. She did not enter school until age ten, and once she made it to the sixth grade, her parents told her they could no longer afford her education. At sixteen, they insisted she marry Mario, a friend of hers with whom they thought she had a romantic relationship. By eighteen, she had her first daughter, and Amapola assumed full responsibility for the home and family while Mario continued going out drinking and pursuing other women.

“I started to see that I had a responsibility to take care of both my husband and my daughter,” she explained to me on a different afternoon, weeks prior, over coffee and pan dulce in her kitchen. “I never thought that—that I could live, or that I could leave and fight in my life for *me* [luchar en mi vida para mí], since it was always like someone was telling me, ‘This is what you have to do: live like this, raise a family.’”

The billboard amazed Amapola because “a life without violence toward women” was simply unimaginable to her as recently as two decades before—let alone public campaigns and services to address its physical, emotional, and psychological impacts.

As we slowly made our way over large speed bumps and as I narrowly avoided collisions with buses and honking cars, Amapola explained that only recently had she begun to see that her own life was characterized by violence, and that the impacts of such violence had been, as she put it, “traumatic.”

“I’m coming up on sixty—I think,” Amapola laughed in the breezy way she often did, even when discussing serious topics. “It was only about fifteen years ago, though—that was when I started to understand and to hear terms like those. Before—no. Thinking back on my personal life and circumstances, I never realized that I—I was living that—that violence, you know? [nunca me di cuenta que yo, estaba viviendo esa, esa violencia ¿no?]”
“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.’ Híjole!” Amapola exclaimed.

“These things traumatize you [te trauman] 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.”

As her account suggests, Amapola’s understanding of violence has shifted over the years, just as statewide and global efforts to recognize and prevent gender violence have flourished. Over the past two decades, numerous asociaciones civiles (nonprofits), human rights campaigns and organizations, outreach efforts, and clinics have emerged, many of which focus explicitly on violence’s emotional and mental health impacts (see Duncan 2016 for additional discussion). 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 Amapola, 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 those traumas [esos traumas los debemos trabajar],” Amapola explained. “For example, there are exercises, there are therapies to get them out [sacarlas], get all of them out, talk about them.” This was important because “a lot of the time we unconsciously carry this problem and therefore we don’t overcome it, and then you just stay in the same situation, the same situation.”

Amapola had come to see such exercises as indispensable for cleansing herself of the destructive effects of trauma, which, left untreated, she said, could create emotional scars with pathological effects. And she had come to see herself as responsible for working on these issues in a long therapeutic process that included individual and group sessions as well as more diffuse forms of self-care and improvement. “The thing is working to overcome it [the violence],” Amapola went on, “to erase it so we can be healthy, have a better quality of life, and to consider ourselves important . . . to build some self-esteem [lograrse a tener una autoestima]. 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. You know?"

Amapola’s changing attitudes and her enthusiasm for therapy and the various forms of self-work it entailed were by no means limited to her, or even to Oaxacans living in the urban capital. Of course, unfortunately, nor were the broader sources of distress that led Amapola to therapy in the first place. What struck me about social suffering in Oaxaca, in addition to its sheer prevalence, was how it was being taken up both in and outside of clinical settings and framed as a matter of mental and emotional health, as in Amapola’s case. Although myriad factors shape Amapola’s views and experience of self and emotion, I suggest that the transnational spread of psychological and psychiatric ways of knowing and working upon the self—psy-globalization—has had an important subjective impact for her and many other Oaxacans. Practices of mental and emotional health have, for many, become means of grappling with contemporary life and its moral dilemmas, vicissitudes, and contradictions.

Researching and Theorizing Psy-Globalization

*Psy-Imaginaries in Psychological and Psychiatric Globalization*

Analyzing psy-globalization provides a window into culture because psy has “crossed and blurred the compartmentalized spheres of modernity and has come to constitute one of the major codes with which to express, shape, and guide selfhood” (Illouz 2008, 5–6; Füredi 2004; Ong 2003; Richard and Rudnyckyj 2009; Yang 2015; Zhang 2017). However, in many contexts of late modernity and neoliberal reform, psy-concepts and practices are primarily diffused among educated middle classes (Behrouzan 2016; Chua 2014; Illouz 2008, 222; Leykin 2015; Matza 2012; Tran 2015, 2017; see Edmonds 2010 for a notable exception). In contrast, psy-globalization in Oaxaca is taking place in a context where, far from trusting it to ensure their well-being, citizens regularly question the very legitimacy of the state, where education is often difficult to access, and where poverty is widespread.

What are the implications of attempting to cultivate liberated, empowered selves through psy in contexts where agency is often severely constrained by a range of destructive forces largely out of people’s control? Why have psy-services and ideas emphasizing personal responsibility and

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self-help thrived while basic medical services and psychiatric care for the severely mentally ill continue to be scarce and poorly distributed?

One of the ironies of psy-globalization in Oaxaca is that it suggests particular ways of being, but does not necessarily produce the conditions under which such ways are attainable for most people. Psy-globalization produces particular *psy-imaginaries* that facilitate desire for mental and emotional health care in Oaxaca, but, due to uneven access to experts and medications—as well as to more general forms of inequality—they can also create a gulf between the selves people imagine and their ability to actualize them, between the selves that could be and the selves that are.

I use the term *psy-imaginaries* throughout the book to reference the possibilities for self-making that the psy-disciplines suggest (Jenkins 2010). My use of *imaginary* emphasizes imagination, potential, and creative capacity just as it emphasizes “how these capacities . . . are always shaped through politically inflected structures of signification that extend our conscious awareness of self, stimulating our imagination yet operating at more subdued levels of life” (Gammeltoft 2014, 159). Analyzing psy-imaginaries brings into focus how people engage ideas that circulate through institutions, media, and the state, which individuals may (but do not necessarily) draw upon as they imagine and actualize “possible selves” (Parish 2008).

Attempting to write about psy-globalization as one large process generative of particular psy-imaginaries, though, I was initially unsure how to encompass psychiatric services, on the one hand, and psychological services and the various forms of informal care that draw on pop-psychological ideas, on the other. Formal psychiatry, I found, promoted universalizing, biomedical notions of mental pathology to be treated with psychopharmaceuticals, while many of the psychological services I encountered preached more general and mundane forms of self-care and self-expression, applicable to the sick and the well. After dozens of interviews with psychiatrists, psychologists, alternative therapists, patients, and general community members, I began to consider psy-globalization as two distinct but interpenetrating processes characterized by their own psy-imaginaries: psychological globalization and psychiatric globalization (Duncan 2012).

*Psychological globalization* is, broadly speaking, composed of a “regime of the self” (Rose 1998) and its accompanying “technologies of the self” (Foucault 1988) meant to promote and cultivate self-knowledge, self-expression, responsibility, and empowerment. The “regime” refers to what it means to be human in the contemporary world, or “the technologies and techniques that hold personhood—identity, selfhood, autonomy,
and individuality—in place” (Rose 1998, 2). I suggest that the concept of psychological globalization encompasses not only the professional psychological disciplines but also imported pop-psychological, complementary and alternative medical (CAM), and New Age practices that explicitly promote the regime of the self in various ways. These services, too, spread ideas about the self and provide support for problems identified as psychological, psychiatric, or emotional. Based on a view of the self as fundamentally vulnerable to imbalance and disorder yet capable of self-transformation and psychological liberation, the regime of the self is spreading through a number of means in Oaxaca and is becoming part of many Oaxacans’ ways of being in and understanding the world.

Psychiatric globalization, on the other hand, refers to the transnational spread of universalizing notions of mental pathology as codified in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the World Health Organization’s *International Classification of Diseases* (*ICD*), as well as the psychiatric treatments and many psychopharmaceutical medications developed to treat those pathologies. International pharmaceutical markets, media, professional conferences, and exhortations on the part of the World Health Organization (WHO) and other international health governance bodies to prioritize mental health are central to the rise of both forms of globalization. So, too, is the field of global mental health, which has, in recent years, gained public attention and recognition by global health governance bodies, commanded more research dollars, and taken steps toward improving mental health infrastructure and capacity-building in various sites around the world.

Yet we have relatively little ethnographic research on global mental health providers and policy makers, the experts and practitioners who set local mental health agendas, allocate and administer funds, shape public discourse about mental health, and actually deliver the therapies and treatments in question (Kohrt and Mendenhall 2015, 44). After all, these are the professionals whose boots are on the ground and who determine the trajectory of global mental health care in local settings. My examination of Oaxaca’s expanding field of psy sheds light on this understudied area of global mental health practice.

**Researching Psy-Globalization**

To explore psy-globalization in Oaxaca, I used a mixed-methods, multisited approach. I spent the summers of 2007 and 2008 in Oaxaca, lived there for a year from January 2010 to February 2011, and made two follow-up field
visits in summer 2013 and summer 2015. During those periods, I lived in Oaxaca City but made regular trips to the Mixteca region. All told, I conducted 164 ethnographic interviews: 56 with patients and their family members at Oaxaca’s public psychiatric hospital, which I refer to as the “clinical sample”; 64 with mental health practitioners and healers, which I refer to as the “professional sample”; and 44 with laypeople—meaning nonpatient and nonhealth professionals—in the general community, which I refer to as the “community sample.” I conducted all interviews myself with the exception of a handful of community sample interviews conducted by research assistants. I did have a great deal of help conducting a large-scale (N=995) survey on understandings and perceptions of mental health services in 2013.

In winter 2007 and winter 2011, I also went to the Mixteca region as part of UCSD’s Center for Comparative Immigration Studies’ Mexican Migration Field Research and Training Program. As a group, we conducted 921 surveys in 2007 and 910 surveys in 2011 with residents of a small Mixtec town and with migrants from that town residing in the San Diego area (Cornelius et al. 2009; Fitzgerald et al. 2013).

In addition to interviews, I conducted four focus groups with community members and one with mental health professionals, as well as discourse analysis of public institutional documents, advertisements, pamphlets, and media coverage. The more structured interview, survey, and focus group settings revealed a great deal, and I draw on all these sources of data throughout the book. However, participant observation—from shopping at the market to seeking out medical care, from attempting to procure water for my home to attending emotional support groups and hanging out at the psychiatric hospital, from making mole with friends to sitting at a friend’s muertos altar, waiting for the spirits of the dead to visit—was the richest aspect of my fieldwork experience.

It is important to note that there is no monolithic “psy” that is globalizing and taking over “local” forms of care and ways of understanding the self. The psy-disciplines are extremely diverse and cannot be encapsulated in a neat analytical device. The ways the psy-disciplines are practiced in various locales are rooted in particular histories, cultures, professional practices, and political economies (Béhague 2008; Behrouzan 2015, 2016; Brodwin 2013; Cohen 1998; Davis 2012; DelVecchio Good 2001, 2007; Giordano 2014; Kitanaka 2012; Kleinman 1988a; Kleinman and Good 1985; Lakoff 2005; Myers 2015; Pandolfo 1997; Pinto 2014; Skultans 2007; Yang 2013; Zhang 2014). By analytically dividing psychological and psychiatric globalization,
I am attempting to identify the most prevalent sets of psy-related ideas, practices, and discourses circulating in the ethnographic context of Oaxaca. Like all forms of globalization, psy-globalization is a dynamic, multidirectional process in which transnationally spreading ideas are appropriated and transformed based on local meanings (Appadurai 1996; Friedman 2000; Giddens 1990; Inda and Rosaldo 2008).

Psy-Sociality

To ethnographically analyze the subjective side of psy-globalization, which is reciprocally related to structural and institutional processes, I develop the concept of *psy-sociality* (see also Duncan 2017b). Psy-sociality provides a lens through which to understand how psychological and psychiatric services, self-help groups, and support groups in Oaxaca not only stimulate the psy-imaginary and provide new material for subject formation but also how they create sites in which Oaxacans jointly grapple with the consequences of everyday violence (Schep–Hughes 1992), social injustice, and personal and familial turmoil. The concept of psy-sociality, in other words, emphasizes how psy is at once a powerful force of governmentality and a powerful source of healing.20

Here I am extending Rabinow's (1996) concept of “biosociality” to psy-settings in particular. Rabinow defines biosociality as “new group and individual identities and practices” (Rabinow 1996, 102) arising out of genomic technology, such as groups centered around particular chromosomes, loci, and alleles. He predicted that these groups would “have medical specialists, laboratories, narratives, traditions, and a heavy panoply of pastoral keepers to help them experience, share, intervene, and ‘understand’ their fate” (Rabinow 1996, 102). Biosocial communities—for example, online forums, support groups, and advocacy groups composed of those diagnosed with or at risk for certain diseases—are based upon a “biological conception of a shared identity” and a sense of shared risk (Rose 2007, 134; Gibbon and Novas 2007). Members of biosocial communities might organize to raise research dollars for a particular disease; support each other through difficult ethical decisions around genetic testing or whether to have children; or share experiences, knowledge, and resources.

Similarly, psy-sociality can produce “new group and individual identities and practices,” in this case facilitated by trained “experts of the soul,” as social theorist Nikolas Rose refers to psy-practitioners (1996, 17). However, psy-sociality emerges not on the basis of shared genes or molecular self-understandings, but from a sense of shared emotional, psychological, and social suffering; from shared psychiatric diagnoses; and/or from a more
general desire to engage in practices of self-work, healing, and emotional cultivation. In psy-sociality, the focus is not body, biology, or genetic code, but rather psyche, emotion, self, and mental disorder. I use psy-sociality not only to refer to explicitly delineated collectivities, such as support groups or online forums for those diagnosed with particular disorders, but also to the more diffuse ways in which people explore, learn about, and experiment with psy-imaginaries, meanwhile receiving support, insight, and kinship. In sites of psy-sociality, people gain new means of understanding themselves, their experiences, and each other; a new emotional language; and, in some cases, a new social group.

Sites of psy-sociality as I conceive them can be social in three possible ways. First, as sites in which people actually socialize and cultivate particular forms of social connections, such as support groups and online forums; second, as sites in which people are socialized into particular ways of knowing the self and orienting the self toward social life, such as emotional intelligence seminars and psicoeducación sessions; and third, as sites in which people actively grapple with the social, often with suffering rooted in socioeconomic, familial, and political conflict (Kleinman et al. 1997) that is linked to uneven development, inequality, and/or cultural change in the context of globalization and modernization—such as patients at the psychiatric hospital who attribute their disorders to the trauma of migration (Duncan 2015). While the vectors of psy-globalization seem to urge an inexorable shift inward, with a focus on the individual self, its potentialities, and its pathologies, this third component of psy-sociality points to the centrality of the social in Oaxacans’ conceptions of self, suffering, and disorder. As the following chapters show, mental health and well-being in this context are intimately tied to the health and well-being of the social world and familial unit, both of which are widely understood to be imperiled.

Plan of the Book
Mental health—as practice, concept, and experience—necessarily implicates broader political economic structures, as well as the ways humans creatively make meaning within them (DelVecchio Good et al. 2008; Ortner 2006). Therefore, in the pages of this book I move between analytical levels and zoom in and out between practices of emotional and psychological care, cultural discourses on mental health, and broader structural forces at work.

Chapters 1 and 2 focus on psy as a force of governmentality and biopower, or the means by which human biology becomes entwined with politics (Foucault 2009, 1). Illustrating how institutions and experts help
define a particular “range of possibilities for iterable speech and disciplined acting—and by extension thinking and emoting” (Zigon 2011, 15), these chapters explore how therapeutic practices and ideologies generate cultural conflicts as they define the ways that modern citizens should know and act upon themselves.

Yet while the frameworks of governmentality, medicalization, and biopower are powerful tools for analyzing contemporary psychiatry, they are insufficient for understanding the reciprocal relations between structure and subjectivity, constraint and agency, and coercion and consent central to psy-practice, clinical interactions, and the experience of suffering (Béhague 2008; Biehl 2005; Davis 2010; Pinto 2014; Raikhel 2016). Biopolitical projects and medicalization processes are not hegemonic or totalizing; rather, they are negotiated on the ground by actors in particular socio-cultural and economic contexts (Béhague 2009; Chua 2014; Davis 2010; Giordano 2014; Kitanaka 2012; Stevenson 2014; Zhang 2014, 2017).

In Oaxaca, psy provides a register for grappling with socioeconomic, political, and familial struggles, not necessarily for invisibilizing them, as critiques of medicalization and biopower might suggest. Indeed, the Oaxacans with whom I spoke did not emphasize the disciplinary aspects of psy, but rather its therapeutic and generative potential (Behrouzan 2016; Borovoy 2017). Mauricio put it powerfully as he explained why he and Antonia were at the psychiatric hospital for their susto: “Without medicine the illness kills us.” Many people reported immense relief as a result of such support—relief that should not be dismissed.

To illustrate these points, Chapters 3, 4, and 5 focus on the lived experience of psy-sociality both inside and outside of clinical settings. Put together, these chapters show how, in therapeutic sites of psy-sociality, actors reconfigure globalizing psy-ideas to be more experience-near. In so doing, they seek to transcend demoralization, comment upon and repair “social relations gone sour” (Finkler 2001, 5), and experiment with particular forms of self-work. In the elastic interaction between putatively “global” and “local” notions of mental health, new imaginaries emerge: new ways of apprehending self and other, new forms of sociality, and new forms of hope in the face of intractable dilemmas.