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Psychiatric Care in the Hospital and the Home in Puebla, Mexico

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Psychiatric Care in the Hospital and the Home in Puebla, Mexico

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

by

Kathryn Law Hale

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ABSTRACT OF THE DISSERTATION

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Doctor of Philosophy in Anthropology

University of California, Los Angeles, 2017

Professor Thomas S. Weisner, Chair

Based on 15 months of fieldwork in the only public psychiatric hospital in the state, this dissertation uses extended participant-observation, interviews, questionnaires, and the analysis of audio-recorded clinical visits to examine the beliefs and practices surrounding psychiatric healthcare in Puebla, Mexico. Each chapter provides insight into how patients and practitioners negotiate medical care in a resource poor setting, using direct recordings of clinical discourse and interaction as supporting evidence. Chapter 1 characterizes the geographic and historical landscape of psychiatric healthcare in Mexico, and it juxtaposes the significant investment in infrastructure and tourism found in the globalizing context of Puebla with the uneven distribution of psychiatric care across the state. Chapter 2 discusses political and economic processes and characterizes the texture of multiparty interaction during psychiatric care in Mexico. It argues that although psychiatric training and psychotropic medications have ben largely developed outside of Mexico, psychiatric providers use local expectations regarding the co-presence and involvement of kinfolk to recruit kin as informal translators and medication administrators as well as providers of social support. Chapter 3 reviews audio-taped psychiatric consultations to demonstrate how professional understandings of the nature and course of mental illness are presented to psychiatric patients, and it challenges the notion that psychiatrists rely on medication management above psychotherapy or other treatment recommendations in areas faced with structural, organizational, and resource limitations. It also identifies a strong divergence between an American belief that psychiatric medication is taken "for life" and the grounded treatment timelines that recommend a medication be taken for nine to eighteen months before evaluating the tapering or cessation of the drug. Chapter 4 emphasizes the value of non-clinical language for the experientially-based amelioration of distress and presents the phrase "*estar más tranquilo*" as a way for patients to manage both their internal emotional volatility and the volatility of their immediate surroundings. Chapter 5 of the dissertation presents case studies of two patients, one of whom ended treatment early and another who successfully followed their treatment plan, in order to underscore different subjective experiences of clinical care and its results. The dissertation concludes by arguing that adaptation and *tranquilidad* may provide the potential for a shift in how we understand chronic mental illness, and calling for more research on the spectrum of experience with various mental illnesses.

The dissertation of Kathryn Law Hale is approved.

Elizabeth Ann Bromley

Steven R. López

Elinor Ochs

Thomas S. Weisner, Committee Chair

University of California, Los Angeles

2017

This dissertation is dedicated to my grandmother, the world traveler, Boo Law.

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Acknowledgements

A Ph.D. is a humbling experience. During the journey, you learn not only academic theory and methods, but that your successes are never merely your own – your advisers, peers, research participants, friends and family help you cross the finish line and achieve higher goals than you ever could have alone. Such individuals keep you sane, keep you focused, and they shape who you become. It is a pleasure to have the opportunity to look back over my past experiences and recognize those who have nurtured me to this point in my journey.

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During my time at UCLA, I am tremendously fortunate to have had the opportunity to study under the mentorship of Thomas Weisner, Elizabeth Bromley, Linda Garro, Steven López, and

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There is a surplus of stellar professors and staff at UCLA whom I have been lucky enough to get to know or from whom I have taken formative coursework. Even so, there were a few who have made an indelible mark on my graduate training and demonstrated human kindness inside and outside of the classroom, and I wish to recognize them here: Jessica Cattelino, Douglas Hollan, Anne Peplau, Daniel Siegel, and Suzanne Wertheim. I also owe a big thank you to Ann Walters and Tracy Humbert for guiding me through applications and expectations over the years and for embodying calm and kindness irrespective of the many other students and responsibilities they juggled. Each of these individuals significantly lightened the load during difficult moments of grad school, and that is a superpower worth celebrating.

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VITA

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2008	Rapaport, MH, Hale, KL, Koury, MA, Shubov A, & Bresee, CJ. "The role of oxytocin, vasopressin and cortisol in the beneficial effects of massage." Poster Presentation at the American Psychiatric Association Annual Conference.
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CHAPTER 1

The Landscape of Psychiatry in Mexico

Introduction

In 2000, Mental Disability Rights International published a critical report of mental healthcare and human rights in Mexico. The telling response of Dr. Manuel Urbina Fuentes, the sub-secretary of Sectoral Coordination in the Secretariat of Health, still holds true today: "Today, a Mexican model of mental health care should be analyzed and seen as a process of transition toward a renovated model in transition…. To arrive at a definitive version that shows before the eyes of millions of people in our country, and in other countries, the problems that we have, but also what we have accomplished and the plans that are in development to achieve better results" (Mental Disability Rights International 2000: 62). This provides us with a great starting point – Recognizing that Mexico is undergoing rapid institutional and social change, how can we characterize mental health in Mexico? What has changed? What problems remain?

Significant changes have been made to strengthen healthcare and mental healthcare in particular in Mexico. Public health insurance called *Seguro Popular* was enacted in 2003, including provisions for subsidized mental health care at affiliated government facilities, most often state-run facilities. Multiple regulations have been implemented to ensure healthcare services are provided to patients with mood disorders, psychosis, or epilepsy, and that specific medications are covered under CAUSES (Catálogo Universal de Servicios de Salud), the Universal Catalog of Health Services for Mexico (Comisión Nacional de Protección Social en Salud 2016). The country has begun to transition away from hospital-based care and toward community-based care under the *Modelo Hidalgo*, which will be further discussed in Chapter 2.

At the same time, a disconnect remains between the aims of the national government and the actual infrastructure and care provided on the ground. The greatest proportion of Mexico's mental health specialty services are concentrated in Mexico City, to the detriment of the rest of the country (World Health Organization, 2005). In the state of Puebla, there is a lack of mental health services across the interior of the state, and after other hospital closures, there remains only one public psychiatric hospital called *el Hospital Psiquiátrico Dr. Rafael Serrano* with multiple psychiatrists on staff. Mexico's General Law of Health (*la Ley General de Salud*) states that patients have the right to obtain information in their home language, and the Official Regulations for Psychiatric Attention (*Normas Oficiales para la Atención Psiquiátrica*) outlines the basic equipment and infrastructure needed to care for patients. However, no translators were provided for those patients speaking indigenous languages in Puebla's psychiatric hospital. In addition, the National Commission of Human Rights found that the hospital required infrastructural renovations (CNDH 2013: Anexo 1, Anexo 4) and was short staffed, such that it required more security, psychiatrists, psychotherapists, social workers, and a dentist (ibid: Anexo 2).

My purpose in mentioning this is not to paint a static picture of Mexico's challenges and shortcomings in the arena of mental health, but rather to underscore that Puebla is experiencing immense change in its regulation, infrastructure, and culture of mental health, and to recognize that these changes will not occur overnight. Legislation from international governance institutions like the World Health Organization, the United Nations, and the World Bank serve as globalizing forces that impinge upon local practice. At the same time, although local psychiatrists in Puebla recognize that globalization has brought new information in the form of research and practice guidelines, it has not necessarily provided high-tech computers, wireless internet, or the capacity to build pristine clinics. As a result, physicians operate to provide the best care possible in the face of limited resources.

For example, neither dementia nor Alzheimer's was a recognized diagnostic label under CAUSES coverage, and memory medications like Memantine were not seen as curative medications, so they were not covered by *Seguro Popular* insurance. Psychiatrists did not want patients to fall through the cracks, and they recognized that there is great strain on the system. One way to combat that issue was for some physicians to write down a diagnosis of 'psychotic disorder' for a patient suffering from dementia, as patients sometimes suffered from agitation, aggression, and hallucinations that are also present in psychotic disorders. This ensured that patients' visits would be covered by insurance, and that they could have the hospital pharmacy fill prescriptions for antipsychotics to decrease those psychological and behavioral problems in the short term, in line with practice guidelines developed by the American Psychiatric Association (Reus, et al., 2016). After a few visits, the psychiatrist might also start treatment with Memantine and give them Memantine samples they had stockpiled after recent visits from pharmaceutical representatives. In such instances, physicians do what they perceive to be medically necessary and morally right, and they navigate through institutional red tape when it is clinically significant to their patient's care.

Likewise, lay attitudes toward psychiatry are changing, where many individuals used to believe that psychiatry was for *los locos*, but now, they had either personally been helped by psychiatric or psychological care or they knew someone else who's life had been changed for the better by it. Many individuals found the ability to *desahogarse* (or get something off their chests) in therapy and to feel more calm/ balanced (*estar más tranquilo*) through psychiatric treatment. More than anything, patients who participated in my study reflected back on their time in treatment remarked on how they felt truly heard and understood in the psychiatric hospital in Puebla, and they felt that the doctors offered a valuable service that should be more widely used.

I lived in Puebla, Mexico, for a total of 18 months (3 months in 2011, 14 consecutive months in 2013-14, and 1 month in 2015) in order to empirically assess psychiatric care in family homes as well as in the outpatient clinic of the state psychiatric hospital. Between 2013 and 2014, I enrolled 34 patients, five psychiatrists and one psychologist in my study. I followed participants' outpatient visits, collected information on their demographics and family networks, and examined the everyday interpersonal dynamics of a selective sub-sample of three families outside of the clinic, audio-recording these interactions when permitted by study participants. In line with hospital regulations, study participants were not paid in cash, but rather were given a healthy meal in a reusable lunchbox each time they participated in study procedures. Participating clinicians were given a gift card to use at a common bookstore chain found across the city.

As the remainder of this chapter will show, Puebla is a city where great diversity coexists. During my fieldwork year, I lived on the western side of town, near the commercial zone of Angelópolis and its fancy mall, boasting stores like the Iron Palace (*Palacio de Hierro*), the MacStore, and Starbucks rather than counterintuitively named national chains like the Italian Coffee Company, which was reportedly founded by Venetian immigrants in the nearby Mexican village of Chipilo. Despite living within walking distance of a mall with high-end retail stores, I also lived on a street where sheep and goats would come to graze, and quickly learned that reality is always more complicated - and more wonderful – than you could expect.

Significance of Study

This dissertation advances a number of central arguments. First, it recognizes the dearth of interactional data surrounding the provision of psychiatric care in the United States and abroad, and it provides direct recordings of clinical discourse and interaction in order to document how patients and practitioners negotiate medical care in a resource poor setting. It challenges the assumed exportation of American biological psychiatry as synonymous with ‘medication management,’ in light of the fact that many treatment modalities (e.g., family psychotherapy, community integration) and research studies emphasize the aforementioned importance of the family to daily care as well as patient health or hospitalization (Hooley 2007). In its place, psychiatric providers in Mexico advanced a grounded, adaptationist framework for the pathophysiology and treatment of mental illness that incorporated notions of neural plasticity as well as behavioral and psychological adaptation. The dissertation also demonstrates cross-cultural differences in patient perspectives toward medication, mental illness, and what ‘counts’ as successful treatment.

Furthermore, my research addresses methodological limitations of experimental research on the treatment of psychiatric disorders. Typically, psychiatric research is conducted through cross-sectional studies or short-term (e.g., 10-week) randomized clinical trials with specific diagnoses and the exclusion of co-occurring ailments. By incorporating a longitudinal ethnographic approach of outpatients receiving treatment, this study enables us to track treatment progress across time, factoring in changes in diagnosis, medication, or life circumstances as well as changes in one’s personal perspective on mental illness.

The Globalizing Context of Puebla, Mexico

My research in Puebla began in the summer of 2011, when a NSF travel award enabled me to travel there and participate in the Minority Health and Health Disparities International Research Training (MHIRT) program led by Dr. Steven López from the University of Southern California (USC) and Dra. Carmen Lara Muñoz from *la Benemérita Universidad Autónoma de Puebla* (BUAP). The program team spent ten weeks in the capital city of the state of Puebla, also named Puebla, which is the fifth most populous city in Mexico and boasts a population of 1.58 million people (INEGI 2015a).

During that summer, I saw that Puebla is a place of deep history and strong contrasts. This was clearly demonstrated when I visited *la Iglesia de Nuestra Señora de los Remedios,* a 16th century church built on the outskirts of the nearby municipality of San Andrés Cholula. From a distance, it looks like the church is built on top of a natural hill and looks out onto the active volcano, *Popocatépetl*. Upon closer examination, you will find that the church sits on top of the Great Pyramid of Cholula, which was sequentially occupied by the Olmecs, Toltecs, and Spanish from the 3rd century BC onward. This city is locally known as the most ancient living city of America, and San Andrés Cholula still bustles with activity today. However, it has also become a residential center for many ex-pats and foreign employees working at the Volkswagen factory. Just as you will see restaurants offering a variety of foods ranging from *mole poblano* to *tacos árabes*, the culture, language, food, and architecture of present-day Puebla has been profoundly shaped by the mixture of indigenous, European, Middle Eastern, and African influences.

When I returned in 2013, I was confronted by imposing growth and constant construction. Within weeks of my arrival in June, the *Estrella de Puebla* ferris wheel was inaugurated quite literally with a bang given its fanfare and fireworks. After several months of confusion as busses were rerouted to avoid construction, a new bridge named the *Viaducto Boulevard Carlos Camacho Espíritu* was built over the *Boulevard Héroes del 5 de Mayo* in order to reduce bottlenecks and benefit those individuals who travel downtown daily. Hydraulic concrete was installed across the city in order to create new jobs and decrease necessary repairs of cracks due to leakage during the rainy season. Billboards lined the streets announcing, "Today is better!" and listing various accomplishments of the local government, including street repairs and open-air gymnasiums (fieldnotes 2/7/2014). *Parque Lineal* and a bike trail opened along Boulevard Atlixcáyotl in my neighborhood, and new basketball courts and free mini golf were opened in *el Jardín del Arte*. Green spaces and cultural attractions were intended to "support family gatherings because in order to foster security, we must not only combat crime but its causes" (Cambio de Puebla 2015). The Governor of Puebla, Rafael Moreno Valle, spearheaded these projects, expecting the parks to encourage exercise and combat obesity among its citizenry and to generate income through tourism and foreign investment (Secretaría de Salud 2016: 88-108). It was well known that Governor Moreno Valle wanted to modernize Mexico and move it into the First World, using his position to demonstrate his ability to serve as the next President of Mexico – something that he had reportedly been groomed for since he was a little boy.[1] All of the above projects were completed during my 14 months of fieldwork between July 2013 and September 2014, reflecting the increasing urbanization and modernization of Puebla on a global scale.

However, some residents expressed frustration over the massive expenditure of public funds and the neoliberal commercialization of sites of cultural patrimony, believing it was done for the

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[1] Rafael Moreno Valle ended his 6-year term as governor on February 1, 2017, and has since announced his intention to run to be the PAN party candidate for the 2018 Presidency (http://www.eluniversal.com.mx/articulo/nacion/politica/2016/09/22/moreno-valle-se-destapa-rumbo-al-2018). His official website (http://www.morenovalle.org) displays a countdown "to retake the presidency" from the PRI party.

sake of his campaign image on the (inter)national stage. For example, Moreno Valle proposed the building of a theme park called the 'Park of Seven Cultures' or 'Intermunicipal Park' close to the Great Pyramid of Cholula in 2014. The announcement included the plan to buy or confiscate 8.5 hectares (85,000 m^2) of land that was protected under the National Institute of Anthropology and History (INAH). This project was met with protests and marches by local Choluteca families who said that their cultural patrimony was not for sale, and feared that such developments would lead to prohibitively high entrance fees and price locals out of participation. Others fretted that money is a limited resource and that improvements in infrastructure were not as quickly achieved in other areas, such as water sanitation, poverty, and lack of healthcare. Ultimately, the planned development was canceled (Muñiz Montero 2015).

Residents of Puebla (referred to as *poblanos*) have seen rapid changes to infrastructure and the deployment of their social capital in recent years as new bridges and museums are erected for local benefit and the public eye, a mural of the Statue of Liberty has popped up, and the *Paseo de los Gigantes* in *Parque de la Constancia* showcases replicas of the White House, Egyptian pyramids, and Rome's Colosseum sitting alongside Puebla's Cathedral.[2] *Poblanos* have seen the effects of global capitalism in the form of the privatization of water straining the vast inequality in the metropolitan area of Puebla, where the household disposable income per capita is more than twice that of people living outside of the metropolitan area (OECD 2015: 30). In early 2017, news outlets fretted over the creation of a Secretary of Tourism, Art, and Culture to replace the State Board for Arts & Culture (*el Consejo Estatal Para la Cultura y las Artes*), believing that it would foster exoticism and support "those who believe in a culture of spectacle that reduces the possibility of a diversified world" (Rivera Morales 2017). This frustration with supporting box-

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[2] Governor Rafael Moreno Valle inaugurated this park in January 2017, near the end of his term. Information on its opening ceremony and the park's contents are available online: http://www.capitalpuebla.com.mx/puebla/abre-sus-puertas-el-parque-paseo-de-los-gigantes-en-puebla.

office hits that benefit from local social capital without supporting local residents was affirmed when Moreno Valle inaugurated a sound and light show at the Cholula pyramid on the last day of his six-year term that would cost the average family of four 2,000 pesos at the ticket counter (Llaven Anzures 2017). Given that Mexico's average household income is 13,240 pesos per month (INEGI 2015b: 1) and a minimum wage job provided 63.77 pesos per day or 1275.40 pesos per month (Mexican Secretariat of Labor and Social Welfare 2014), such cultural events are out of reach for many local residents. The effects of globalization are palpable and the *poblano* people have voiced the tension and skepticism they feel toward their government bringing modernity to the pueblo. In the face of protests regarding the loss of cultural authenticity or identity, it is telling that the City Council of Cholula's slogan is "modernidad con identidad" (modernity with identity).

Governor Moreno Valle's actions speak to theoretical interests in globalization, and the community's response parallels Moore's (2011) work on how globalization impacts individuals' day-to-day lives, not only through the increased connectivity afforded by internet and travel, but also new relational connections to one another and to their world. She notes that, "It is one of the paradoxes of globalization that it is not global… Likewise, global capitalism is not a single, coherent entity or set of forces, but rather a dynamic set of processes establishing and disestablishing uneasy, shifting, often provisional connections that continually seek out new sources of profit (e.g., Harvey 1990; Bayart, 2001; Tsing, 2005)" (ibid: 3). Local citizens in Cholula fret over laying concrete on top of ancient farmland where flowers used to grow – as if the introduction of foreign materials likewise signals the introduction of foreign or 'external' values, or the destruction of ancient lifeways. The monetization of such spaces may limit accessibility and reinforce power inequalities that prohibit an individual's participation in a cultural group. On the other hand, these spaces may create emergent forms of sociality and emplacement, or they may engender resistance and a turn toward ‘traditional cultural values,’ however those values are locally defined and enacted. Rather than injecting notions of difference and subjectivity into theories of interconnection in order to underscore the production of change, Moore makes a strong argument to study practice and process from the ground up and consider identity not as something you are, but something you do (Bourdieu 1990; Ortner 2005; Schatzki 2010). I follow this call throughout my dissertation.

Uneven Distribution of Psychiatric Care in Puebla

Historically, there has been an unequal distribution of psychiatric care in Mexico, with most psychiatrists living in two or three of the country’s most important cities (de la Fuente et al. 1988). Mexico has a strong centralized government where many services - including most mental health specialty services - are concentrated in Mexico City, to the detriment of the rest of the country (World Health Organization, 2005). In the state of Puebla, there is only one public psychiatric hospital (*El Batán*) with multiple psychiatrists on staff. This highlights the lack of mental health services in the interior of the state and an increased likelihood of patient relapse and more severe illness presentation (Tenorio-Martínez et al. 2009: 382). Even so, the State Program of Mental Health in Puebla has reported that the number of mental health consultations provided has more than doubled in the past five years, growing from 34,418 consultations in 2011 to 67,921 in 2016 (Puebla Noticias 2016). The reported number of psychiatric consultations provided has likewise seen an exponential increase of 2 ½ times since 2001 (ibid).

Public health insurance called *Seguro Popular* was enacted in 2003, including provisions for subsidized mental health care at affiliated facilities. However, decreasing the monetary cost of psychiatric treatment for patients has not eliminated all problems or guaranteed treatment compliance in the long, triangular state of Puebla. After all, patients regularly travel as far as 4-8 hours each way to attend their psychiatric visits at El Batán, and treating psychiatrists ask the patient to have a family member accompany them to each visit until they can successfully manage their own symptoms.

La Ley General de Salud says that patients suffering from a mental illness have "The right to be treated and cared for in their community or the location closest to where family or friends live" (Article 74b, Section VII). Lara Muñoz et al. (2011: 534) cite this section of the law of health, noting that there are an estimated 38 psychiatrists within the state of Puebla that are registered members of the Mexican Psychiatric Association (*Asociación Psiquiátrica Mexicana*). In 1988, the ratio of psychiatrists for every 100,000 inhabitants was 1.5 (de la Fuente et al. 1988: 3) and, using a different methodological approach, Lara Muñoz et al. (2011) more recently found that in 22 of the states in Mexico, there is less than one psychiatrist per 100,000 inhabitants. De la Fuente et al. (1988: 4) noted that, "In the city of Puebla, you will find 26 established psychiatrists and only one in another city of that state." This number has grown over the years, such that during 2013-14, there were 25 psychiatric residents in training and many more practicing psychiatrists within the city limits. Even so, the distribution of psychiatrists clearly remains uneven between and within states. Lara Muñoz has spearheaded initiatives to combat this problem, including the assignment of a psychiatry liaison to health centers in Puebla and the attempt to train General Practitioners to recognize psychiatric symptoms and refer to psychiatric specialty care. Attempts have been made to integrate psychiatry specialists into general hospitals over the past 4-5 years, but a lack of beds and a lack of financial and political support to ensure implementation of such policies (Alarcón 2003: 55) have failed to make inpatient care a reality.

Instead, the provision of mental health services remains fragmented in facilities like *El Batán*, which suffer from medication and staff shortages and only recently (August 2013) began renovations to clinic infrastructure which had been direly needed for over a decade.

Current Landscape of Mental Health Services in Puebla

At the time of my fieldwork, there were 25 medical doctors enrolled in the psychiatric resident training program at la Benemérita Universidad Autónoma de Puebla (*la BUAP*), which is the oldest and largest university in the state. Each resident had completed four to five years of medical school, followed by a one-year internship (typically in a *centro de salud*), and one year of social service (where individuals give back to the community), before beginning the 4-year residency process to specialize as a psychiatrist. Psychiatric residents spend their first year of residency taking coursework. Their second year of residency is divided between six-month rotations in *El Batán* and *el Hospital del Niño Poblano*, although one third-year resident also works at *El Batán* all year, serving as chief resident in conjunction with one to three staff psychiatrists. The Hospital del Niño Poblano (opened in 1992) is a pediatric hospital that offers specialty services, such as cancer and leukemia treatment, open heart surgery, and congenital defects (e.g., cleft palate). It houses a 12-bed facility for infant and child burn victims[3] and does provide child psychiatry as well.

In addition to being home to a prominent psychiatric residency program at *la BUAP*, Puebla's capital city - also called Puebla – has various public and private care centers. *El Hospital Psiquiátrico Dr. Rafael Serrano* (better known as *El Batán*) is the only public psychiatric

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[3] A news article reports that Puebla has the second highest rate of child burn victims in the country, with an average of 650 per year (http://www.periodicodepuebla.com.mx/entidad/10419-el-gobierno-de-puebla-se-ha-olvidado-de-los-ninos-quemados-julieta-martinez-de-fundacion-qangeles-sin-quemadurasq-).

hospital in the state of Puebla, and it was the site of my dissertation research project. It was founded in December 1967 and has been in continual operation ever since.[4] 2017 marks its fiftieth year of service. It works closely in conjunction with the State Center of Mental Health (*Centro Estatal de Salud Mental* in Spanish, or CESM), which is located on the other side of the inpatient wards and offers child psychiatry and addiction detoxification/ rehabilitation within walking distance of the main outpatient clinic.

El Batán offers adult outpatient care to individuals between the ages of 18 and 65, as well as short-term and long-term inpatient care. Children under the age of 18 could be seen at the nearby area of Paídopsiquiatría in the State Center for Mental Health (CESM). Patients over the age of 65 are usually referred to Mexico City and hospitalized there in *el Hospital Psiquiátrico Fray Bernardino Alvarez,* reportedly so that they can receive more personal attention and closer supervision. *El Batán* also services prisoners from the Social Reintegration Center (*Centro de Reinserción Social* in Spanish, or CERESO) because the jail lacks psychological attention (Ramírez Paniagua 2017). Prisoner-patients are typically accompanied by two police officers in order to receive medication management once a month

Up until 2013, there was also a private psychiatric hospital in nearby Cholula, named Hospital Psiquiátrico San Juan de Dios. It had been open for 103 years before closing its doors and transferring patients to other care facilities (including *El Batán*) or, when possible, placing them with family members. Currently, there are plans to turn this hospital into a museum, but licenses and approvals have delayed the process.

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[4] Spanish-language information on the founding and purpose of the hospital, which was originally designed as a "granja" (literally meaning "farm") for long-term psychiatric patients, is available here: https://www.poblanerias.com/2014/10/el-batan-lleva-47-anos-brindando-servicio-hospitalario-para-enfermos-mentales/

There is one privately run psychiatric hospital called *Casa de Salud* which was also founded in 1967, and it boasts first rate facilities which it proclaims are "unique in its kind in the country."[5] It differentiates itself from other facilities, reporting it is guided by "A very different concept of hospitalization and psychiatric treatment, where the humane treatment and respect for the person is primary and our main policy" (http://www.casadesalud.com.mx). Their website lists offerings of group and family therapy, yoga and pilates, and an art workshop, and the hospital provides individual rooms to patients with the means to pay for one. One of the staff psychiatrists from *El Batán* moonlighted there to make extra money, but very few patients had heard of this facility, and those who had heard of it remarked that the prohibitive cost made it so that it was not an option.

The city of Puebla is peppered with multiple public and private general hospitals, including *Hospital Ángeles, Hospital Puebla, Hospital General del Zona Norte, Hospital Universitario de Puebla BUAP*, and *Hospital General del Sur*. Although these hospitals service patients with various concerns, they are focused on general care and often house only one or two staff with psychiatric/ psychological training. Hospital staff told me that these psychiatric providers generally offer abbreviated consultation hours. During my time in Puebla, I repeatedly heard that at one hospital in particular, the two psychiatrists on staff only came in on Tuesday and Thursday afternoons. The rest of the time, patients were simply told upon arrival to go to *El Batán* instead.

Additionally, there are various private practices for child, adolescent, and adult psychiatry operating throughout Puebla. Although public data are not available, most psychiatric specialists with whom I spoke managed a private caseload in addition to being a professor or working in an institutional setting. Psychiatrists working at *El Batán* reported offering psychotherapy as well as

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[5] "Sin duda, Casa de Salud ofrece instalaciones de primer nivel, únicas en su tipo en el país" (see http://www.casadesalud.com.mx/instalaciones.php).

medication management in their private practice, but stated that the biggest difference between treatment in the hospital and in their private practice was the prescription of brand name medications and the flexibility offered for scheduling appointments. Specific providers would offer additional studies such as sleep studies, nutritional analyses, transcranial magnetic stimulation, and neurofeedback.

For patients requiring addiction treatment, options included the Addiction Unit at the CESM and one of 20 *anexos* in Puebla. *Anexos* are residential treatment centers for addiction that can vary from a mid-grade rehabilitation center with high quality resources called an *anexo clinical* to poorly staffed neighborhood *anexos* that are unregulated[6] and have gained a reputation for corporal punishment and patient neglect. Addiction treatment centers typically have treatment wings separated by gender and are modeled after the 12-step Alcoholics Anonymous program. Patients must pay for care, which can range from 100 pesos a day for the neighborhood *anexos* that have been described by Angela Garcia (2015) to 6,000-7,000 pesos per month[7] at the CESM to upward of 30,000 pesos per month at other private clinics in the area.

Non-institutional or web-based resources for psychiatric services are also common. The most prominent resource is the non-profit community organization Voz Pro Salud Mental, which advocates for human rights, offers educational resources, and hosts free psychoeducational programs through its *Familia a Familia* (Family to Family) support group. It received training from the National Alliance for Mental Illness (NAMI) in the United States regarding how to facilitate their support groups. Including Puebla, the non-profit organization's website (http://www.vozprosaludmental.org.mx/index.php/contacto#tm-middle) currently boasts

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[6] According to hospital psychiatrists, as of December 2013, these *anexos* are beginning to be more closely regulated by the government, and a referral list based on the available options has been created.

[7] If a patient has Seguro Popular, this price goes down to 2,000-3,000 pesos per month.

locations in 14 Mexican cities. Most patients had never heard of the organization, but a couple contacted them to attend family support groups after I printed out contact information for them.

Other area support groups include Neurotics Anonymous and Alcoholics Anonymous, both of which publicly post fliers around town inviting people to attend their meetings. Neurotics Anonymous (*Neuróticos Anónimos*, abbreviated as either N/A or NAIL) is a nonprofit organization for mental health issues that was started by Grover Boydston in Washington, D.C., and has since expanded to parts of Latin America, including Mexico.[8] I knew of at least four N/A centers during my fieldwork in Puebla. The group is closely modeled on 12-step programs like Alcoholics Anonymous, and it uses mutual peer support where peers who are deemed to have successfully recovered from similar experiences teach other members how to combat such strong emotions and emotional dependence on people or situations. N/A defines a neurotic person as someone "whose emotions interfere with your functioning in any way or to any extent, provided that he or she recognize it" (see http://www.neuroticos-anonimos.org.mx/preguntas-frecuentes/). Neurotics Anonymous support groups believe that strong emotions are harmful and that "a moment of emotional disturbances could destroy oneself or his/ her closest loved one" (ibid). Therefore, the group aims to help people recover from mental and emotional illness, decrease their egoism, and achieve tranquility.[9] In addition, there are multiple web-based resources for mental health, including an online self-help course from the National Institute of Psychiatry (ADep, http://www.inprf.gob.mx/), psychoeducational videos and resources provided by the Pan American Health Organization (PAHO-WHO), and Facebook pages for some branches of *Voz*

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[8] For a history of the organization, see Boydston (1974), Zweben and Ashbrook (2012), or the Spanish video embedded at the bottom of the organization's webpage (http://www.neuroticos-anonimos.org.mx/).

[9] An e-book published http://www.neuroticosanonimosbvoax.org.mx/docs/literatura/nuestro_libro.pdf states that "The only requirement in order to be a member of N/A is to have the desire to achieve tranquility." Beliefs surrounding the potential for strong emotions to cause illness will be discussed further in Chapter 4.

Pro Salud Mental. The increasing presence of the internet, social media, advocacy groups, and the transnational pharmaceutical industry can also have a strong influence on the exportation, recognition, or expansion of diagnoses among users and serve as vehicles for psychiatric globalization.[10]

Finally, although not specifically focused on mental illness, Puebla has multiple entities focused on the well-being and development of persons with disabilities. As of April 2017, the Secretary of Public Education and the Administrative Committee of Puebla for the Construction of Educational Spaces have worked together to refurbish the Center for the Service Center for Job Training and offer more educational services and job training to individuals with disabilities. In addition, CiNiA is a multi-purpose assembly factory located in the neighborhood of Angelópolis, Puebla, which is dedicated to hiring people with physical, auditory, or intellectual disabilities.[11] This enterprise is especially important given that official figures estimate over 700,000 of 2+ million disabled individuals have no employment. Founded in 2005 based on *Grupo Gureak's* model of labor inclusion in Spain, the facility provides wheel-chair accessible spaces and has an interpreter on staff. Similarly, the private *Asociación para la Capacitación del Minusválido* (ACAMI) offers employment training and industrial work to people with physical or intellectual disabilities. I have seen their paper goods and products used by Mexican pharmaceutical companies, Volkswagen, La Gran Bodega grocery chain, and at holiday events such as a *poblano* version of Oktoberfest. See Figure 1 for an illustration of a product I received which was assembled by ACAMI employees on behalf of Sun Pharma.

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[10] For example, for a discussion of many of these factors in relation to ADHD, see Conrad and Bergey (2014).

[11] The informational website Dis-capacidad.com took a tour of CiNiA's facility in 2011 and wrote up an online summary, along with audio clips from employees, which is publicly available: http://www.dis-capacidad.com/nota.php?id=1557#.Uwkf-Xm60RM. At that time, they estimated that 80% of CiNiA's 350 employees had some kind of disability.

Figure 1. Example of products manufactured and packaged by the Association for the Training of the Disabled (ACAMI) employees in partnership with Sun Pharma.

This image depicts a gift bag that was manufactured by ACAMI employees. The gift bag contained a plastic bag filled with candied dates and a flier on Sun Pharma's new SSRI and antipsychotic medications. The back of the pharmaceutical flier thanked ACAMI "for their valuable collaboration to assemble the gift that you hold in your hands."

Primary Field Site: El Hospital Psiquiátrico Dr. Rafael Serrano

The Hospital Psiquiátrico Dr. Rafael Serrano is located in the southeastern corner of the city, in a residential area with a surprising mix of shacks and homes in the gated community "Hills of Marble and Elegance" (*Lomas de Marmol y Elegancia)*. More commonly known as *El Batán*, meaning "nest of vipers" in reference to the surrounding fauna at the time it was built. The hospital opened during the summer of 1967, serving as one of nine "granja" (farm) style hospitals created in Mexico. In its original formulation, such hospitals were created to replace older facilities like the famous *La Castañeda* asylum in Mexico City. "Granja" hospitals typically had farm animals and crops on the property, and provided a space to isolate patients with serious mental illnesses from the bustle of city life. Part of each patient's treatment was working toward their rehabilitation through agricultural work and artisanal crafts (González-Salas, et al., 2014: 143; Sacristán 2003: 62). Today, the *granja* model has fallen out of favor in Mexico and been replaced by aspirations toward the *Modelo Hidalgo* (explained in **Chapter 2**).

When you arrive at either end of the complex, you are met by large, fenced-in gates that encase the area. Guards or auxiliary police stand watch to ensure that only patients and approved staff enter the hospital or its outpatient clinic. Visitors must stop at the front gate and sign in, leaving their voting credential or IFE with the attendant. As visitors walk down the gravel road to the hospital, they will pass the hospital parking lot, where many staff and some patients park (see Figure 2.1 on the following page). As the building comes into view, you will also pass by another fence and often see patients on the other side who wear blue or pink clothing and mill about the yard. These are some of the 215 male and female inpatients who live in the hospital and are wards of the state. One patient in particular was a fixture in the hospital, known by everyone for standing and waiting for those who pass by, calling out "*Una moneda… Una monedita por favor*" ("One coin…. A tiny bit of change, please"). I remembered him from my 2011 trip, and he was still there three years later, begging for money to buy a treat in the hospital store.

Figure 2.1. Walkway from parking lot to outpatient area of the hospital

Inside, the hospital complex covers 324,522 m^2 of land and contains 20 outpatient consultation rooms and 425 inpatient beds (Espinoza 2014).[12] The inpatient and outpatient areas are separated by a tall steel fence (see Figure 2.2), and at any given time, at least one police officer guards the gate, mostly to ensure that no inpatients under their care escape (as has happened from time to time).

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[12] This represents a significant proportion of the 580 total psychiatric beds reported across the state of Puebla (WHO AIMS 2011: 42).

Figure 2.2. External view of the inpatient area of the hospital

The inpatient area houses four *pabellones* (or hospital wings) that are divided by gender for both acute patients and chronic, long-term patients. Each *pabellón* has a nurse's station up front, and dormitory style beds. There is also a medic's station known as "the hospital of the hospital" (fieldnotes 8/2/2013) where long-term inpatients receive medical attention for respiratory infections or other ailments.

Depending on when you visit the inpatient area, you might see long lines of men and women heading toward the central plaza of the hospital to eat. The lunchroom serves three meals a day (at 9 am, 1 pm, and 6 pm) to all inpatients. Acute inpatients are served first, followed by chronic patients. Directly across from the lunchroom are administrative offices for the director and sub-director of the hospital, the payroll office, a supplies room with sign-out sheet, and facility management, as well as a small store where patients can buy sodas and snacks.

Most of my research time was spent in the outpatient ward on the other side of the fence. Directly inside the front door of the outpatient clinic is a large waiting room with 80-100 seats and signs reminding patients to keep quiet and remember that smoking was prohibited. On the other side of the room were service windows for patient registration and reception, medication pick-up, and a special pick-up window for controlled substances. The waiting room was filled with patients by 8 am each morning, some of whom came alone, and many of whom came accompanied by relatives and friends and quietly ate tamales they had purchased from the street vender outside the main gate. Over the course of the day, the room slowly emptied out. A TV silently played soccer matches, and from time to time, nursing students came and gave talks on physical and mental health (including self-care and nutrition) while patients waited.

In the outpatient area, there are three offices for psychotherapy, two for social work, one triage room for new patients, and six to seven rooms for psychiatric care, as well as offices for the pharmacist, psychology scheduling staff, and the teaching coordinators who supervise the training of the psychiatric residents. Although I spent time observing each of these entities, as well as the functioning of the inpatient wards, in order to document and understand how the hospital functioned from day to day, my research focused on interactions between practicing psychiatrists or psychiatric residents in training and patients receiving outpatient care.

Study Sample Characteristics

Patient Demographics

Study participants include 34 patients with various psychiatric diagnoses, two staff psychiatrists, three psychiatric residents, and one psychologist. All but one consented patient filled out the demographics questionnaire. Twenty-seven participating patients returned for scheduled visits at least once and twenty-four patients composed the bulk of my data corpus. In my overall study sample of 23 women and 11 men, ages ranged from 17-70. Two thirds of that sample (25 participants) had left school by the end of junior high (i.e., 9th grade). See Table 1 for the breakdown of educational attainment across my patient sample.

Table 1. Breakdown of educational attainment in patient study sample (N = 33)

Highest education level achieved	**Number of participants**
Partial primary school	2
Finished primary school	12
Partial secondary school	1
Finished secondary school	10
Finished high school	2
Complete *Carrera Técnica* (i.e., Technical Degree)	3
Partial college education	2
Finished college	1

Although my study sample was small, the gender and social class of patients was correlated with an individual's level of educational attainment. Both individuals who left before finishing primary school were women above the age of 50 who lived over 100 km from the hospital and reportedly left to help care for their younger siblings. The one man who had finished college had the highest income in my sample (7,000 pesos per month) and had spent time living and working in the United States. As a female patient named Renata explained, "In the ranch where I live, people have the idea that you'll get married and your husband will provide and take care of you. Or rather, you don't have to work for anybody, which is a totally incorrect idea" (research interview, 7/11/2014). In my patient sample, the highest grade completed by women was ninth grade, with the exception of one woman who had started studying Veterinary Medicine, but left college early in order to get married and give birth to her daughter. Beyond that, all seven individuals with a high school, college, or technical degree were men.

The overwhelming majority of women worked as stay-at-home mothers or housewives, although three women also worked part-time outside of the home as a street vendor or seasonal farm worker. Men reported a variety of occupational statuses, as reflected in Table 2 below.

Table 2. Occupational status of in patient study sample (N= 33)

Occupation	**Men**	**Women**
Stay-at-home parent/ Housework	0	20**
Full-time student	1	1
Unemployed/ seeking work	4	0
Part-time job	3	3**
Full-time job	2	0*
Retired	1	0

Note:
* Over the course of the study, one female patient began working a full-time job in addition to being a housewife.
** Some individuals reported more than one occupation, resulting in a total greater than 100%.

As mentioned above, *El Batán* is the only extant psychiatric hospital in the state of Puebla. In addition, however, the neighboring states of Guerrero, Morelos, or Tlaxcala do not have a psychiatric hospital (WHO-AIMS 2011a: 42), thereby making it so that *El Batán* may be the closest available hospital for individuals coming from those states. In my study sample, half of participating patients came from within Puebla's city limits, half traveled from another city in the state of Puebla, and one patient came from the state of Tlaxcala.[13] However, the geographical layout of the state of Puebla meant that someone might travel farther from within the state of Puebla than between Puebla and a neighboring state like Tlaxcala, which Puebla almost entirely wraps around (see Figure 4).

Figure 3. The geographic location of the state of Puebla (highlighted in red).
Image designed by TUBS. Accessed from
https://commons.wikimedia.org/wiki/File%3APuebla_in_Mexico_(location_map_scheme).svg
and used under the Creative Commons Attribution-Share Alike 3.0 Unported license.

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[13] Specifically, twelve patients came from within the city limits of Puebla, four patients came from the outlying areas around the city, fifteen patients came from another city in the state of Puebla, and one came from the state of Tlaxcala. The participant who traveled the farthest to reach the hospital (227 km) came from within the state of Puebla.

Participating patients traveled an average of 54 kilometers (approximately 1 hour by car, longer by bus) to attend their clinical visits, and some traveled as far as 227 km (approx. 4.5 hours) each way. As will be discussed further in **Chapter 4**, average household income (1,614 pesos or $116.62 USD every two weeks) was quite low among participating patients in comparison to national averages. Overall, my sample struggled to make ends meet and they stated that they attended this hospital rather than general clinics due to its provision of low-/ no-cost[14] medical visits, psychotherapy, lab tests, and psychotropic medication through *Seguro Popular* health insurance.

Participating Clinicians

Participating clinicians included five psychiatrists, including three psychiatric residents in training and two staff psychiatrists. One psychologist that worked primarily with long-term inpatients in the hospital taught the principal investigator about the chronic inpatient wards and was also interviewed, but the data discussed in Chapters 2-4 exclusively refer to clinical interactions between staff psychiatrists/ psychiatric residents in training and their respective patients. Although I did not collect demographics questionnaires from participating clinicians, the psychiatric residents were all second-year residents (or "R-2" residents) between the ages of 27 and 30, the psychologist was in her mid thirties, and the staff psychiatrists were in their early thirties and mid forties, respectively. The psychiatric residents hailed from all over Mexico[15], and often traveled home to be with family during school vacations. Both of the staff psychiatrists

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[14] Visits are charged on a sliding scale depending on family income, which is assessed through a socioeconomic study during triage.

[15] To name just a few, their hometowns included: Mexico City, Puebla, Morelia, Toluca, and Guadalajara.

were from Puebla, and the psychologist was originally from Mexico City, but had moved to Puebla to be closer to family.

During my interviews with participating psychiatric residents, I asked why they chose to study psychiatry, and why they chose to do so in Puebla specifically. All three stated that the federal district (el D. F.) in Mexico City was their first choice, as it was the most well renowned program, but two of them stated that Puebla came in second. A third psychiatric resident specified that although she did not view Puebla as the second best program, she considered it her second choice because she was from the area. She explained, "Mexico City comes in first, then there's a good program in Guadalajara, I believe there's also a strong program in San Luis Potosi, and then there might be another one ahead of Puebla." (interview with Dra. M, 8/8/2014). However, "Due to the national exam, they only accept like… I don't know…. In my year, they accepted like 130 people total, across the entire country" to enter into psychiatric residencies (ibid).[16] Moreover, the top schools have a very small number of openings – often only three to ten positions each year – so when she did not receive a post in either *el Hospital Psiquiátrico Frey Bernardino Álvarez* or *el Instituto Nacional de Psiquiatría – Ramón de la Fuente Muñiz* in Mexico City, she chose to study in her home state of Puebla despite the fact that, as she understood it, Puebla's program did not hold the second highest national rating. Although the residents with whom I spoke recognized that the hospital facilities were severely lacking and

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[16] This psychiatric resident emphasized the small number of residency positions by comparing it to gynecology, where the specialty might accept approximately 600 people in a given year. In contrast, during the 2014-15 academic year, the United States of America reportedly had 211 psychiatric residency training programs accredited by the Accreditation Council for Graduate Medical Education, which offered 1,353 positions (https://residency.wustl.edu/CHOOSING/SPECDESC/Pages/Psychiatry.aspx).

needing repair,[17] they felt that their placement in Puebla was a good position with supervisory support that would set them up for a successful career.[18]

There were also important differences within the group of psychiatrists to which I refer throughout this dissertation, as it studied staff psychiatrists as well as psychiatric residents in training who are still maturing in their profession and developing their own interactional style. Although both staff psychiatrists emphasized that they were lucky to have a government job with healthcare insurance and good pay, the two staff psychiatrists with whom I worked closely each managed a private practice and/ or moonlighted at private hospitals in addition to working at *El Batán*. One of the staff psychiatrists had been practicing for 10-15 years. The other finished residency within the past 5-7 years and remarked that even in that short time, significant changes had been made the the residency program. For example, there was no supervisory support or formal weekly meetings scheduled to discuss tough patients in his psychiatric residency program. This stands in stark contrast to the experience of the psychiatric residents that I observed, as they had weekly training meetings with teaching staff as well as the opportunity to drop by and informally consult with a staff psychiatrist on the unit when needed.

Given that my primary interest in clinicians was their way of interacting with patients, a few notes of comparison are merited regarding substantive educational, economic, and linguistic divides between these samples. All participating psychiatrists and psychiatric residents were born and raised in a big city, sometimes even the capital of their home state. Each of them had also at

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[17] This sentiment was supported in internet forums (see post http://www.foroenarm.org/t14676p10-r1-de-psiquiatria-en-donde#425188 by Resi_Puebla on 12/05/2011) and the 2000 report by Mental Disability Rights International.

[18] A further consideration when choosing a psychiatric residency is whether a student's home state has a psychiatric training program. Duncan's (2012: 299-300) dissertation, for example, noted that "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", although it is unknown whether those cities were chosen due to their ranking and/ or their proximity.

least finished college, if not medical/ graduate school as well, and each person knew how to read or speak English. Most owned a 'smart phone,' and a car, and at least half had a laptop or iPad as well.

The psychiatrists were extremely aware of the differences in educational attainment and social class between themselves and the patients to which they attended, and they would translate jargon as often as possible while recording the patient's medical history. Psychiatrists exchanged jargon like *menstruación* (menstration) for words like *regla* (literally, a monthly 'ruler,' referring to a woman's 'period') and clarified expressions like "dar la luz" (to give birth to) by asking the more informal expression, "*Cuándo se alivió?"* (When were you relieved of the pains of childbirth?"). They worked to talk patients through the names, drug classes, and doses of their medications, emphasizing that they might not receive this information anywhere else and that some patients' lower educational attainment meant that they would be unable to read the prescription sheet they were given. For the clinicians, it was not enough for the patient to know they must take 'the little blue pill' every morning. Rather, they explained the cause, course, and treatment of mental illness in detail (**see Chapter 3**) in order to help transform the unexplainable into the understandable and combat associated stigma. They sought to treat not only the individual's psychiatric symptoms, but the broader need for psychoeducation in the community as well.

Outline of the Dissertation

In the course of this dissertation, I provide an ethnographic account of the practice of psychiatric care in Puebla, Mexico, through my sustained engagement at the *Hospital Psiquiátrico Dr. Rafael Serrano*. I work to reflect micro-analytic and macro-level factors that influence its execution, and focus on the complex interactions and decision-making between the individuals that populate these institutions as a primary driver of current practice and possible social change.

In **Chapter 2,** entitled "Family Life and Social Medicine: Discourses and Discontents Surrounding Puebla's Psychiatric Care," I advance our understanding of globalization in relation to psychiatry. I challenge the construction of psychiatry as only treating the individual patient and provide grounded doctor-patient-family member interaction in a Mexican psychiatric clinic in order to review what happens when doctors cannot interact with patients as atomized individuals even though *in theory* they are trained to think of patients that way. Challenged by severe structural constraints and bolstered by lessons from other nations' efforts at deinstitutionalization, psychiatrists in Puebla push to keep patients out of the inpatient wards and in their respective communities. To this end, psychiatrists call upon co-present kin who are identified both as the customer and part of the caretaking system outside the clinic. This modification to the visit structure changes the dynamic and content of clinical visits while doctors seamlessly respond to unspoken beliefs and values that are central to local life, ultimately showing that efforts to define a "global psychiatry" informed by global policy will fail because it cannot exist in a uniform way – the ideologies of psychiatric practice are molded by the particular political, technological, and social arrangements of practitioners and patients who populate local clinics and negotiate clinical care.

Chapter 3, "Explanatory Models Have Some Explaining to Do," offers a rare glimpse into how explanatory models of illness are presented to patients with varying psychiatric diagnoses. This chapter analyzes 63 audio-recorded clinical visits and multiple interviews with four participating psychiatrists in Puebla, Mexico, in order to provide direct evidence of how psychiatrists explain the causes of and treatments for mental illness to new patients, and how they maintain therapeutic engagement across time. Mexican psychiatrists provided not only detailed pharmaceutical prescriptions, but also detailed descriptions of behavioral changes and referrals to psychotherapy, hoping the combination would serve as psychoeducational resources for patients and associated kin. Data excerpts reveal that the exact ‘recipe’ of recommendations made by physicians varied from person to person. In most cases, physicians made recommendations surrounding ‘lifestyle factors’ that are commonly cited in the health sciences to be correlated with mental and physical health (cf. Cassidy et al. 2004; Walsh 2011: 579-581, 584-586), including physical activity, alcohol consumption, smoking, and nutrition. However, in some cases, the physician’s behavioral recommendations also included confronting a spouse or child who was the primary source of the patient’s distress (especially if it had been previously recommended by the patient’s psychotherapist), or creating a plan to secure gainful employment or achieve academic milestones. Individual, relational, and socioeconomic variables were included in patient’s treatment plans, although only some of those variables were explained through explicit causal models.

Academic research has equated Explanatory Models primarily with disease causation and reproduced static dichotomies through the ‘nature vs. nurture’ debate. However, in this Mexican clinic, psychiatrists’ endorsement of a biopsychosocial treatment model demonstrates that biomedical psychiatrists did not simply focus on disease reduction and treating diseased organs, but rather attended to the treatment timeline and prognosis as well to mold patient expectations. In practice, psychiatrists used generic chemical imbalances as a proximate causal explanation for mental illness, regardless of whether the diagnosis in question was depression, schizophrenia, or obsessive-compulsive disorder. When turning to treatment, they advanced an adaptationist stance to both neural networks and human behavior, but left psychotherapy – another integral component of prescribed treatment - out of their Explanatory Model (EM). This EM supported the use of psychotropic medications but arguably short-circuited patient understandings of the value of psychosocial treatment arms in conjunction with medication.

In contrast to the Diagnostic and Statistical Manual's glossary codifying the distress of an individual patient, **Chapter 4**, "Ecologies of Care and the Desire to be '*Más Tranquilo'*," demonstrates the significance of informal, embodied experiences in affecting symptomatic change in clinical practice. Across 65 references to tranquility/ equanimity made by psychiatric patients inside Puebla's only public psychiatric hospital, treating psychiatrists, patients, and patients' relatives all used the phrase "*estar más tranquilo"* as an antonym and antidote to psychiatric distress. Just as idioms of distress like *nervios* can help broadly communicate suffering to others despite being associated with a wide range of possible symptoms (Jenkins 1988a: 313-315; Low 1985: 189), striving to be *más tranquilo* can manifest on multiple levels while indexing adaptation, recovery, and wellness. Aspiring to a state of tranquility was a call to practice calm in the face of precarity, and it helped patients manage their internal emotional volatility as well as the volatility of their immediate surroundings (cf. Jenkins 2015: 12-13). Analyzing this discourse around the experience-near amelioration of distress is an extremely powerful treatment strategy in a world of biomedical objectification and the frenetic social life experienced by many across the globe.

Chapters 2, 3, and 4 were each written as stand-alone articles intended for publication. A version of Chapter 2 is forthcoming in the journal *Culture, Medicine and Psychiatry* and was strengthened by helpful comments from external reviewers. It is reprinted here with permission.

In the **Conclusion,** I close the dissertation with a discussion of the connections between my chapters and the implications raised by my research.

CHAPTER 2

Family Life and Social Medicine: Discourses and Discontents Surrounding Puebla's Psychiatric Care

Introduction

A large body of research is concerned with the global exportation of Euro-American psychiatry (Littlewood 1990; Summerfield 2004; Watters 2010) and pharmaceuticals (Biehl 2005; Good 2010; Jenkins 2011b; Lakoff 2005; Petryna, et al., 2006) to address many forms of suffering. Much of this literature critiques the production of a blameless biology (Lurhmann 2000:8; Singh 2004; see also Garro and Yarris 2009) and the hyper-individualism that is internationally exported through the explanatory logics of both American psychology and psychiatry (Kirmayer 2007). Currently, Euro-American psychiatric treatment is often viewed as synonymous with medication management (Biehl 2005: 22, 49, etc.; Carpenter-Song 2015:292-3; Seale, et al., 2005: 2865, 2870). At the same time, when speaking of psychiatric globalization and trying to assess its penetration in a given location, the literature is very fragmented, much like public psychiatric care is fragmented in many cities (Myers, et al., 2016: 419). This fact makes the literature extremely confusing to follow, and may leave us wondering what exactly we are referring to when speaking of the World Health Organization's (WHO's) plans to achieve "global mental health."

For some researchers, the issue being targeted is the global presence of Western psychiatric diagnostic labels as outlined in the Diagnostic and Statistical Manual of Mental Disorders and assigned by professionals (Alarcón 2009; Kirmayer and Minas 2000) and the pervasiveness of

Western ways of seeing the world (Summerfield 2012). For others, talk of psychiatric globalization instead refers to a 'global' psychiatry that recognizes a diversity of actors can contribute to national feedback influencing the production of global recommendations (Heaton 2013:21). From yet another analytic direction, we might variably examine the desire for and prevalence of seeking psychiatric treatment among the general population, the uptake of biomedical explanatory models by the general populace, or the presence and acceptance of associated interventions, medications, and/or technologies by both practitioners and patients alike in a given locale. Even if we argue that multinational corporations have made psychiatric (i.e., psychotropic) medications a global phenomenon, the active substance is repackaged in various branded and generic formulations that muddy the waters when assessing its "global reach." In general, when something is labeled global, it can mean being all-encompassing [of all times and places] in terms of its distribution and prevalence or its scope (but not location per se), or it can alternatively refer to something being unmoored from contextual factors that allow it to circulate and be recontextualized within the limits of a new cultural setting (Collier and Ong 2005: 10).

This claim that the West is exporting a global biomedicine is part of a larger problem discussed by Applbaum, where "[t]he history of psychiatry has been told mainly from the point of view of North America and Western Europe, from whence the biological paradigm and the major engines of its dissemination – the DSM (Diagnostic and Statistical Manual of Mental Disorders) and psychopharmaceuticals – originate" (Applbaum 2012:593). However, researchers have found significant cultural variation in the symptomatic presentation of psychiatric disorders as well as the terminology used to describe mood disorders.[19] Moreover, research on acculturation and psychiatric globalization often leans on old notions of cultural consensus or a homogenous set of beliefs that are applied to the appearance of a specific disorder in a non-Western and/ or "non-modern" context (Lester 2004). Hence, such talk elides the frequent equation of forms of globalization, in this case psychiatric, with unidirectional change stemming from a Euro-American, neo-liberal hub (Conversi 2010:40), as opposed to emphasizing the interdependence of entities and multidirectional flow of transmission. By looking for evidence of globalization trending toward Western medicine, and then bolstering research with ideas from Western theoreticians that focus on individual neurochemical selves and governmentality (e.g., Rose 1996, 2007:63) in settings like Mexico that might not solely subscribe to those models, one risks misrepresenting local understandings of self and other as well as conceptions of health and well-being, which could be individual and/ or relational in nature (Garro 2010; Markus and Kitayama 1991). Furthermore, one might misread cultural change and assume direct causal force where there is no such influence behind it. In reality, psychiatric categories are "inextricably bound up with cultural values about (for example) independence, autonomy, and appropriate gendered experience, and so must always be subject to questioning and critique" (Lester 2004: 611; see also Marsella and White 1982). Ultimately, basic scalar terms such as 'local' and 'global' do not reflect multiple directional, historically structured processes (Pigg 2012: 322) that are unstable and can change both what interventions are possible and what meanings will be attributed to such experiences. Therefore, after reviewing the extant literature on globalizing

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[19] A vast literature is relevant here (Hinton and Lewis-Fernandez 2010; Kirmayer and Young 1998; Kleinman 1988; Nichter 2010; and others) in order to demonstrate how the core values, norms, and health concerns shared by a given group influence the culturally authorized ways of responding to pathological situations, which Nichter (1981) has termed idioms of distress. In addition, Janis Jenkins (2015) recent book details how culture shapes each stage of mental illness from onset to recovery, while also reminding us of universal human projects of struggle, selfhood, and meaning-making.

psychiatry in Mexico, this chapter will reveal that there is no monolithic global experience even when using the same diagnostic manual and similar medication formulations on arguably universal underlying disease processes. Rather than assessing if an ideological model of biomedical psychiatry is at odds with Mexican family life and therefore dissuading entry into treatment, in the second half of this chapter, I turn to patients and practitioners that populate the Mexican health system and demonstrate how local families carry their everyday standard of accompaniment (acompañamiento) and social support - or lack thereof - over to the psychiatric outpatient clinic. Even in the face of uneven healthcare infrastructure and unpredictable "access" to medications, psychiatrists in Puebla work within this local ecology of social, structural, and economic forces to provide care that goes far beyond mere medication management that is said to be typical of Western psychiatry. Together, clinicians, patients, and caregivers mobilize family values and notions of agency in order to cobble together therapeutic efficacy – focused much more on relapse prevention and mental health than on diagnostic labels or psychopharmaceuticals, which are likely to change over the course of treatment anyway.

The Project of Defining Psychiatric Globalization

As Koplan and colleagues (2009: 1993) note while making the case for advancing a shared definition of the term, global health "…can be thought of as a notion (the current state of global health), an objective (a world of healthy people, a condition of global health), or a mix of scholarship, research, and practice (with many questions, issues, skills and competencies)." With roots in public health or international health, the term 'global health' implies "starkly different understandings of the most salient threats facing global populations… and of the appropriate justification for health interventions that transgress national sovereignty" in locations with poor public health infrastructure (Lakoff 2010: 59).

In the case of mental health specifically, relatively little work has been published. Therefore, the extent studies (Duncan 2012; Finkler 1991; Lester 2007) are especially relevant to the topic of psychiatric globalization in Mexico despite the length of time between them. Kaja Finkler (1991) conducted a seminal study of biomedical practice within an Internal Medicine Clinic in Mexico City. In it, however, she dismissed psychiatry as a form of biomedicine that had "not taken root in Mexico for many reasons" (1991: 67), including the discipline's supposed notion of the autonomous individual instead of the power of the family (ibid: 126). Her rough sketch of Euro-American psychiatry as distinctly dyadic and focused on the autonomous individual constructed adult psychiatric patients as an agentive client who should manage their own care[20], as opposed to Mexican psychiatry where scarce resources and familistic values would undermine the relevance of self-directed care. However, I use the word 'constructed' here in relation to Euro-American psychiatry because very little ethnographic data exists in the United States of America to corroborate this characterization of psychiatric medication management visits. Many studies have documented medical communication in general (for example, Mishler 1984; Robinson and Heritage 2005; Good and Good 2003) and some have followed psychotherapeutic visits with U.S. psychologists (see Kirmayer 2000; Lakes, et al., 2006; Lester 2017), psychiatric intake interviews (Bergmann 1992), or multidisciplinary treatment teams for pediatric chronic pain (Buchbinder 2011). Others (Alarcón 2001) have critiqued that we even speak of a unitary U.S.-based or 'American psychiatry' rather than recognizing the subspecialties and internal disputes that separate biological, behavioral, and psychodynamic psychiatry.

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[20] The work of McCabe et al. (2002) and Seale et al. (2005), both of which were conducted in the UK, respectively offer fine-grained analysis of psychiatric consultations and interview accounts of when and how psychiatrists strive for patient-centered care.

In contrast, Rebecca Lester's (2007) research found that despite sharing diagnostic clinical language across U.S. and Mexican eating disorder clinics, Western notions of individuation and independence did not map onto the underlying disease. Instead, therapists emphasized family closeness and interdependence as primary in psychiatric practice in Mexico. Mexican clinicians were dissatisfied with American or European approaches and as a clinician named Monica told Lester, "We need to develop a Mexican model for treating eating disorders" (ibid: 377). Indeed, a grounded analysis of psychotherapeutic practice and psychiatric treatment in Mexico is direly needed to see if or how global diagnostic categories and health policies map onto local social realities. Rather than devising a Mexican model of psychiatric treatment, however, I aim to examine the multidirectional flows or "assemblages" (cf. Ong and Collier 2005) composing its practice, as enacted by people on the ground - whether that be members of the steering committees for the DSM or ICD, or the reconfiguration and uptake of such ideas by local psychiatrists, social workers, hospital staff, patients, and unaffected laypersons.

Subsequently, Whitney Duncan (2012) sought to develop a definition of mental health globalization using her own data in Mexico. Her nuanced dissertation on Oaxacan psychology and psychiatry found that various psy-practices and conceptions of mental health (such as notions of trauma, self-esteem, and the pharmaceutical imaginary[21]) were expanding to new spaces through clinician psychoeducation, increasing treatment availability, and the effect of international commodities, technologies, and health policy on help-seeking for psychological and psychiatric problems. At the same time, psychiatric globalization, which she defined as the transnational spread of mental pathology as outlined in the DSM and ICD, was found to be less pervasive than psychological globalization, defined by her to encompass the cultivation of self

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[21] See Jenkins (2010: 21) for her definition and analysis of the notion of the "pharmaceutical imaginary."

and emotions as components of mental health (cf. Anderson-Fye 2003; Rose 1996). Ultimately, the adoption of terminology for mental pathology as outlined in the DSM and ICD was not common parlance among the lay population in Oaxaca, and even among psychiatric patients, its usage did not supplant folk etiological understandings of the self or how to treat emotional problems.

While formulating her terminology and evaluating its effects, Duncan keenly pinpointed the ICD and DSM. These are the two dominant diagnostic manuals in circulation, and both are used in Mexican psychiatric practice. Even so, this definition was focused on diagnostic criteria as products of globalization – or top-down global health policy regarding mental illness and the administration of psychopharmaceutical medications as the primary treatment for such disorders. In line with Kirmayer and Pedersen's (2014) concerns when framing global mental health, her definition falls prey to privileging professional diagnostic language that is unlikely to be heard among laypersons and which might simultaneously obscure attention to social and structural determinants of health. A stronger call would recognize the need to move beyond simplistic global/ local (cf. Ecks 2006), developed/ developing (cf. Cohen 1992), or institutional/ subjective (cf. Jenkins 2015) binaries of social change. Instead, Duncan's definition could build in the possibilities for fluid notions of power (cf. Rhodes 1992) and nonlinear social change on the ground – a dynamism which she achieves in her discussion of data but is missing from her definition of psychiatric globalization - as well as acknowledge how such changes on the ground can move back up the hierarchy to inform global policy.

Without doubt, there is mounting evidence that cultural beliefs about psychiatry may be reconfigured in a rapidly globalizing – and not necessarily homogenizing – world (Anderson-Fye 2003; Appadurai 1996:11; Duncan 2012; Giddens 1990, 2006), such that "unsettling the assumptions of Western practice… enables us to investigate how mental health care is supplied across cultures" (Myers, et al., 2016: 423). Globalization rarely results in wholesale ideological or institutional transfer, and even if it does, there is no single monolithic 'Western' or 'American' biomedicine to export (Hahn 1995; Kleinman 1977, 1980: 24, 1987; Rhodes 1996: 166-170; Taylor 2003). Both psychiatric policies and practices undergo incomplete globalization across symbolic, spatial, communicative, and socio-political planes (cf. Ecks 2011) that make unpredictable heterogeneity and diffusion in all directions the norm (Appadurai 1996: 81; Christen 2006; Hodgson 1999). After all, studies of cultural production should not be evaluated like Mendelian genetics, where the outcome will necessarily have a recognizable mixture of discrete traits from the two or more 'cultures' and fall along a spectrum from homogenous to heterogeneous.

Both Duncan (2016: 202-3) and Lester (2007: 371-2) have noted the relatively short chronological timeline surrounding the public awareness of psychiatric disorders in Mexico, as well as the influence of insurance infrastructure and broader public health initiatives and policies, such as those spearheaded by international governance institutions like the WHO, the UN, the World Bank, and the IMF. By focusing more explicitly on the emerging expression and construction of psychiatric care in Puebla, rather than the cultural products which result, this chapter moves beyond discrete notions of hybridity and allows for evolving forms of emergent practice that are unique to the various actors and institutions involved at a given field site. In my field site, the concrete experience of actual persons interacting in the local clinical community do not support the hegemony of increasing globalization as purposively driven toward a Euro-American biomedical model, and it repurposes or challenges some of the implicit values assigned to Euro-American psychiatry.

The Task at Hand

The extant literature in Mexico does not provide published grounded interactional data regarding mood disorders or describe the family's relation to these treatment encounters, as has been done in other international field sites (Chua 2012; Nunley 1998; Pinto 2011). More broadly, the perspectives of practitioners, patients, and laypersons are rarely evaluated together in such studies of globalizing psychiatry. Therefore, a gap remains in the ability to characterize the reality on the ground in Mexico or theorize about what those data might mean.

The rationale for including the perspectives of various stakeholders in one's analytic scope is even stronger in the case of Mexico, where local understandings of self and other, as well as conceptions of health and well-being, have historically been more relational in nature (Finkler 1991; Garro 2010; Markus and Kitayama 1991). Several authors (Duncan 2012:283, 288-290; Finkler 2008: 167-169; Murphy and Stepick 1991:138) have echoed the central importance of the family in Mexico in particular, as well as the importance of family among the international Latino population more generally (Garro 2010; Han 2013; Jenkins 1988b:306; López, et al., 2004). Among Latin Americans, researchers estimate family closeness and commitment to caretaking of one another – glossed as "familismo" – to be quite strong (for more information, see Keefe, et al., 1979; Luna, et al., 1996; Phillips, et al., 2000). Notions of familism predict that the goals and well-being of the family can supersede those of a given individual, changing the dynamic of family interaction for better or for worse.[22] As an analytic unit, the family and familism are integral to the present study.

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[22] In no way do I intend to romanticize family involvement, as treating psychiatrists did voice that not all families were ideal social support networks, and that they were sometimes part of the problem. Ecks (2011: 27-28) has similarly shown that medications can have sociotopic/ pathogenic effects on family, and that prescribing doctors are cognizant of the fact that psychiatric medications transform not only the bodies and moods of individuals, but social relations as well (Das and Das 2006; Ecks 2006, 2011; Jenkins 2011a: e.g., p. 9-10; Whyte, et al., 2002).

On another level, although globalization is known to produce increasing economic interconnectedness and interdependence, it privileges capitalist institutions over other forms of labor, such as farming, and influences the local enactment of familism, social mobility, and household arrangements. Stiglitz (2002) and others argue that despite promoting economic growth at both the national and individual level, the global neoliberal economy fostered by the North American Free Trade Agreement (NAFTA) and policies from the World Bank and International Monetary Fund is fueling the level of income inequality within and between countries (Uchitelle 2007; World Bank 2001, 2016). If correct, these concerns about globalization increasing the divide between the rich and the poor would directly influence class divisions and access to healthcare resources, thereby tying into the ever-expanding literature on social inequality and physical or mental health disparities (Baer, et al., 2003; G. Duncan, et al., 2007; Lewis and Araya 2002; Link and Phelan 1995; Miranda, et al., 2008; National Center for Health Statistics [NCHS] 2010; Sapolsky 2004; Shonkoff, et al., 2009; Vega, et al., 2009).

The present study lets us begin to tease apart the otherwise difficult challenge of dissociating the assumed positive associations of 'Western acculturation,' 'globalization,' or 'modernization' from the indexes and material benefits of neoliberal trade between nations, institutional divisions between inpatient and outpatient psychiatric care (Varma 2016), or even specific commodities like psychopharmaceuticals (Skultans 2007:9). It reminds us that globalization does not necessarily yield easier access to health information technologies among health professionals – let alone patients – so that they can deliver better care at a quicker pace because the cost of such technologies can trump the portability of those technologies (Mastrogianni and Bhugra 2003: 164). In Puebla's only public psychiatric hospital, *el Hospital Psiquiátrico Dr. Rafael Serrano*, which is more commonly known as 'El Batán,' practicing residents and psychiatrists agreed that

"Due to globalization, our knowledge is on par with that of First World countries, and we can all study the same things. But the cultural context … varies a lot. It's not the same to arrive to a hospital in the U.S. and have a *tomografía*[23] right away, versus here, where they might wait six months for a scan" (interview with Dr. G, Aug. 5, 2014). In *El Batán*, psychiatrists identified as much more 'clinical' than Euro-American psychiatrists who could "scan first and ask questions later," and we will review examples of interpersonal psychiatric practice in Puebla in order to characterize what tools they rely upon instead.

This piece also reveals how notions of selfhood are imbricated in psychiatric care and broader healthcare infrastructure. It recognizes that although Mexico is engaged in a project to create universal healthcare and achieve well-being for its citizenry, structural and socioeconomic concerns are superimposed on such beliefs. International organizations and interests influence Mexico's healthcare system and, thus, its citizenry's beliefs about psychiatric illness. Again and again, we see that international healthcare reforms seeking global mental health strive for more cost effective solutions, and although calculations of market value are ideally freed from any social or cultural considerations, in reality, other values get added to the equation (Collier and Ong 2005: 13). Some values, such as the presence of family support, can be pragmatically employed by psychiatric providers, and other values, such as implicit notions of 'autonomy' and 'community' get problematized in ways that matter to global health debates.

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[23] *Tomografía* uses X-rays to take cross-sectional images of structures inside your body and includes specialized forms such as Computerized Axial Tomography (CAT) scans. Local physicians ordered CAT scans and MRIs in order to image the body and brain and check for organic causes of presenting psychiatric symptomatology, and electroencephalograms (EEGs) in order to diagnose epilepsy.

Ethnographic Context

Puebla is the capital of the state of Puebla, Mexico. Located about two hours south of Mexico City, psychiatrists from other states characterize Puebla's residents as forming a culturally 'closed' [*cerrado*] group (field notes, May 22, 2014) that is fiercely protective of their social networks and slow to share family matters or invite someone new into the group.[24] A city of 1.5 million people (INEGI 2010), Puebla is well known as the historical site of the battle of Cinco de Mayo and the current site of the largest Volkswagen plant outside of Germany. The city of Puebla is home to the *Benemérita Universidad Autónoma de Puebla*, a public university that serves as one of Mexico's main training hubs for psychiatric residents. As mentioned above, Puebla also houses the state's only public psychiatric hospital: *el Hospital Psiquiátrico Dr. Rafael Serrano* (henceforth referred to as '*El Batán*'). This was the setting for 15 months of fieldwork.

El Batán is located on the southern outskirts of town, close to the city jail, and it serves a wide spectrum of psychiatric disorders. The hospital is composed of three primary areas: an outpatient clinic, an acute inpatient ward (with hospital wings separated by gender), and a long-term section dedicated to approximately 215 patients who live in the hospital as wards of the state after being abandoned by their family members. According to the WHO AIMS (2011a: 46) report, Puebla's inpatient population includes a staggering 62.3% with a length of hospital stay of over 10 years, proportionally placing it in the third highest position across all 32 state facilities in Mexico that were evaluated. There are no halfway houses in Puebla[25], so with these remnants of the older asylum system of mental healthcare in the area, the specter of deinstitutionalization

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[24] For example, a very popular blog in Puebla (http://www.puebla-mexico.com/expats-in-puebla-mexico/) writes that Puebla is a city "where the locals have a reputation for being exceedingly kind to strangers yet glacially slow to add anyone new to their social circles."

[25] Of further note, there are only 3 halfway houses in all of Mexico (WHO 2011a: 15).

without effective treatment options or the potential for family reintegration looms large. In contrast, the patients who receive outpatient care and were the focus of this research study were completely separate from those statistics and were often still living with and supported by their relatives.

The outpatient clinic sees an average of between 75 and 110 patients each day, seven days a week, with an additional influx of five to ten new patients daily. Given this facility's role as the sole psychiatric hospital in the state, it was not uncommon for patients and their family members to travel as far as four to six hours *each way*[26] to receive outpatient treatment here, often waking at 3:00 am in order to arrive on time for their outpatient appointments. Almost all returning patients are enrolled in *Seguro Popular,* which is a form of national public healthcare implemented in 2004 in order to provide universal preventative healthcare coverage across multiple insurers as well as ensure treatment of physical and mental health problems (Frenk 2006; see also Laurell 2007 and Urbina Fuentes 2008 for assessments of *Seguro Popular*). In relation to mental health in particular, *Seguro Popular* provides no-cost medical visits, generic medication, lab testing, and psychotherapy to enrolled members at approved facilities, such as *El Batán*.

Unfortunately, most of Mexico's mental health specialty services are concentrated in Mexico City, to the detriment to the rest of the country (Souza y Machorro and Cruz Moreno 2010: 20; World Health Organization 2005: 315). After the 2013 closure of the *Hospital Psiquiátrico Nuestra Señora de Guadalupe* in nearby Cholula, reportedly spurred by high operational costs caring for the chronically mentally ill, this study's field site became the only public psychiatric

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[26] In my study sample, the average distance traveled was 54 km. This would take approximately one hour by car and more time by bus, and the majority of patients reported to travel using the latter form of transportation. The greatest travel distance reported by a study participant was 227 km. However, other patients treated at the clinic came from as far away as Chiapas.

hospital in the state of Puebla. *El Batán* aims to manage all inpatient care as well as a group of outpatient clients coming from various parts of the state, as well as neighboring states like Tlaxcala that do not have psychiatric care facilities like *El Batán*. Documents like the 1990 Caracas Declaration and the 2001 World Mental Health Report have called for the integration of mental health into primary care with a strong emphasis on community care and health promotion/ prevention of psychiatric ailments, only for researchers to later find poor training and knowledge among primary care doctors and nurses (Caldas de Almeida and Horvitz-Lennon 2010:220; WHO AIMS 2011a: 53) - when it is assessed at all (cf. WHO 2011b country report on Mexico, p. 2).

Even among the general population, much like knowledge regarding city bus routes to use or sketchy neighborhoods to avoid, knowledge about psychiatry was passed by word of mouth.[27] Patients almost always sought psychiatric treatment after receiving a clinical referral or speaking with a neighbor or family member who had been through treatment and recommended that they visit the hospital, as found elsewhere in Mexico (cf. Duncan 2012: 72, 308, 313-14). Given the specialization of psychiatric care at the tertiary level within the broader system and the inability of many to fact check through WebMD or another internet site[28] - let alone significant issues of low educational achievement and illiteracy among some cross-sections of the population[29] - most

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[27] During my time in the hospital, I saw many patients refer friends, spouses, and neighbors to seek psychiatric care – and sometimes, they physically brought them to El Batán and asked if a psychiatrist could speak with them. In one case, over the course of two weeks I watched an entire family come in, one by one, for treatment after suffering the sudden loss of a relative. Each of them mentioned their past relative feeling well cared for as their reason for coming into the hospital.

[28] A recent survey estimated that only 37.2% of Puebla's population used the internet (INEGI 2013:25). Three of the seven younger participants in my study used the internet to research their diagnosis and visit self-help blogs, but most individuals over the age of 50 did not use the internet at all to seek information.

[29] Staff physicians reported that this hospital served a lower income bracket and a higher proportion of illiterate clients than the general/ primary care hospitals in this area. Forty-two percent of participating patients (14/33) had finished part or all of primary school and one-third of my sample (11/33) had completed part or all of secondary

people initially assumed psychiatric treatment was only for the most severe cases (*los locos*). Inside of this category, patients clumped together images of alcoholics or schizophrenic patients without the capacity for autonomous decision-making – in other words, patients who were not in conscious control of their behavior. This was reinforced by human rights reports (cf. Rosenthal, et al., 2010) and local news stories such as "*Familiares olvidan a pacientes del Batán*" ["Relatives forget about patients in El Batán"] in *El Sol de Puebla* (Marcial 2010), which reports that 90% of chronic inpatients - estimated at the time to be between 225 and 250 individuals - are "abandoned by their relatives."[30] Knowing the strong emphasis placed on family cohesion and support, stories of patient abandonment served as an indicator of the stigma surrounding mental illness by suggesting that families would grow tired of caring for ill relatives, even though most of those patients were remnants from an older asylum model of care. Compounded by poor integration of psychiatry into general care (Lara Muñoz, et al., 2011), and staffing shortages of psychiatrists (Ocampo 2008; Heinze, et al., 2016), psychiatry as a discipline has struggled to integrate itself into day-to-day life or public consciousness in Mexico in a positive way.

It should therefore come as no surprise that mental health is a current and pressing concern in Mexico, where a large percentage of the populace is affected, and until recently, the majority of people paid exorbitant out-of-pocket costs for healthcare. In 2001 and 2002, it was estimated that the 12-month prevalence of any psychiatric disorder was 12.1%, or a ratio of 1:10 individuals among the general Mexican population (Medina-Mora, et al., 2005). Within the urban areas

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school. Two individuals had completed high school, three completed a technical career, two left college early, and only one finished college and earned their degree.

[30] This emphasis on "familial abandonment" and social isolation is a recurrent theme in Latin American reporting on long-term inpatient psychiatric care. The Mental Disability Rights International group (2000: x) reports that the National Commission of Human Rights (CNDH) estimate 70% of people placed in long-term Mexican psychiatric hospital care to be *abandonados.* To offer only a couple additional examples, see articles such as: http://larepublica.pe/19-03-2014/abandono-olvido-y-prision-en-pabellon-de-pacientes-psiquiatricos or http://www.lagaceta.com.ar/nota/538756/sociedad/psiquiatricos-nucleo-abandono-personas.html.

sampled in that study, anxiety disorders were the most common class of disorders, followed by specific phobia, major depressive disorder, and alcohol abuse/ dependence (ibid). Unfortunately, those with a severe mental illness in Mexico endure increased stigma from lack of psychoeducation, which is compounded by barriers to treatment access that lead to remarkably long delays – 14 years for lifetime mood disorders – between symptom onset in Mexican patients and their initiation of treatment (Borges, et al., 2007). As a result, only 24% of more severely affected patients in Mexico use any psychiatric services at all (Medina-Mora, et al., 2005). These statistics argue for psychiatric disorders generating a significant burden of disease.

Methodology

In portraying and analyzing local psychiatric practice in Puebla, I draw upon a total 18 months of fieldwork between 2011 and 2015. An initial visit to Puebla was made between June and August 2011 in order to assess feasibility, followed by 14 consecutive months of research between July 2013 and September 2014 and a subsequent follow-up visit between July and August 2015. The data analyzed in this chapter include a corpus of 63 audio-recorded clinical visits between 27 patients who regularly attended their follow-up visits with five of the hospital's psychiatrists (often with co-present kin), totaling 24 hours of audio data, 29.5 hours of one-on-one interview data with participating patients and providers, and 424 pages of field notes generated through informal conversations among general community members living in Puebla, as well as conversations with patients, psychiatrists, psychologists, social workers, and scheduling staff working in the hospital. The gender breakdown of these participating patients was: 19 females (70%) and 8 males (30%). The gender breakdown of participating treatment providers included three male psychiatrists and two female psychiatrists, as well as one female psychologist.

The larger study includes qualitative and quantitative data with 34 patients, as well as the five psychiatrists and the one psychologist mentioned above. All patients were recruited through rolling enrollment during their first triage visit to this hospital, so as to account as much as possible for differences in exposure to psychiatric treatment. Seven consented patients either discontinued treatment early or never returned to the clinic to initiate care. Among those patients who discontinued study participation, one was lost to follow-up, one did so after learning she had a more pressing medical issue requiring immediate treatment (cancer), two turned to private providers to refill their prescriptions, and three cited personal finances or familial obligations as more pressing than their own care.

The remaining 27 consented patients filled out a demographic questionnaire after enrollment which requested their age, sex, education, household arrangement, religious identification, household biweekly income (which was the most common monetary metric used in Puebla), and an open-ended section on previous help-seeking efforts. Each clinical visit was audio-recorded with the verbal consent of all parties present in the room, and informal discussion with the treating psychiatrist regarding each patient followed whenever possible. In addition, each patient was interviewed near the beginning and end of his or her study participation, often during their second visit to the hospital and again near the end of August/ September 2014 – anywhere between their second and seventh visit - as the investigator neared the end of her fieldwork year and returned to the United States. Both research interviews incorporated the Strauss-Carpenter

Levels of Functioning (1972, 1977)[31] instrument as a guide to assess changes in duration of hospitalization, symptoms, social relations/ integration, and work function. Rather than assigning a unitary outcome of impairment or improvement, this multidimensional scale evaluates the four areas listed above, and it has been adapted and validated in Spanish (Ahuir, et al., 2009). The final interview included the option for patients to draw and discuss their family network as it was relevant to their daily lives. Finally, interviews included an open-ended section that allowed patients to discuss any additional questions or topics they felt were significant to them personally. Whenever possible, the principal investigator also observed the outpatient and inpatient wards of the hospital.

The protocol was approved by the Institutional Review Boards (IRB) at both the University of California, Los Angeles and *el Hospital Psiquiátrico Dr. Rafael Serrano* prior to start of data collection. Patients were introduced to the research study after their eligibility was confirmed during an initial triage visit at the hospital.[32] Then they were given time to review the consent form with their family or spouse and consider participation. Most participants signed consent and initiated study procedures at their second visit, where their clinical history was taken. The five psychiatrists and one psychologist who participated were introduced to the study during a group staff meeting and given the opportunity to speak with me regarding any questions they might have and selectively enroll themselves at a later date. All study procedures were carried out in

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[31] In the authors' (1977) paper comparing two-year and five-year outcomes for patients with severe and persistent mental illness, the authors speak of this as a "prognostic scale" (ibid: 160) but do not coin a specific name for it. Subsequent publications typically refer to this as the Strauss-Carpenter Level of Function scale (e.g., Altshuler, et al., 2002; Cramer, et al., 2000) or the Strauss-Carpenter Levels of Functioning scale (e.g., Burns and Patrick 2007; Macfadden, et al., 2011), and it has been variably abbreviated as LOF or LOFS.

[32] Treating psychiatrists evaluated outpatients for eligibility and excluded anyone who did not meet criteria for a current psychiatric disorder requiring follow-up at the participating research site, as well as anyone who could not read and write and anyone who displayed current suicidal ideation or required hospitalization. Patients under the age of 18 were referred to child psychiatry [*paidopsiquiatría*] at the State Facility for Mental Health. Given that youth and adolescents were not treated at this facility, they were not included in this study.

Spanish, with the exception of one patient who had worked abroad in hotel hospitality and chose to code-switch back and forth between English and Spanish during his research interviews.

Data Analysis

‘Off-label’ Treatment and Scaffolding Stigma

Beck and Beck Gernsheim (2002: 22) advance Parsons’ notion of institutionalized individualism as “the process through which individuals are compelled to view the atomized individual self, abstracted from context, relationships or social group, as sole possible unit of analysis, action, and understanding.” They identify globalization and neoliberal capitalism as driving social change such that individuals must view themselves as independent and autonomous creators of their lives, which parallels Gaines’ (1982) discussion of the bounded self in Western psychiatry[33]. Despite the high number of people seeking psychiatric care and the availability of psychotropic medications through general practitioners as well as psychiatrists, dramatic uptake of pharmaceutical or biochemical conceptions of the self (Jenkins 2011b; cf. Jenkins 2011a: 6 for definition of these terms) did not occur among my study participants. Likewise, patients did not adopt neoliberal frames and speak of themselves as consumers or agents with human rights. Instead, physicians always provided a diagnosis for each patient and then used simplified shorthand to suggest that mental illnesses were similar to other chronic illnesses, such as diabetes or high blood pressure, with regard to the fact that they could be managed through appropriate medication and lifestyle changes. With the exception of patients with schizophrenia, psychiatric patients were encouraged to view their illness and its treatment as

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[33] Gaines explicitly contrasts this with the “indexical,” relational self that is particular to Mediterranean groups such as “Latin European groups” (1982: 182).

transitory, provided that they were compliant with the doctor's orders. Due to arguable clinician success in conveying their explanatory model and achieving treatment uptake, once symptoms abated, patients demonstrated no psychological dependence to the medication and stopped maintenance treatment unless symptoms presented again.

Psychopharmaceuticals were used as intended to treat individual symptomatology, but they were also used 'off label' to finesse the family's emotional and economic dynamics, which were affected by the patient's symptoms and suffering.[34] Authors such as Chua (2012: 222), Duncan (2012), and Ecks (2011) have shown that the airing and sorting of grievances among kin is part of diagnosis and the treatment process. Patients use both psychology and psychiatry to grapple with and repair social, familial, political, and economic crises. Patients and co-present kin regularly drew from multiple explanatory models at the same time in order to connect globalizing psychiatric notions with ethnopsychological understandings of subjectivity and emotional distress as well as its treatment (Duncan 2012: 290-91). This 'off label' treatment of social issues was the case for one patient with schizophrenia who began visiting *El Batán* approximately once a week (rather than the more standard monthly scheduled visits) after he was recently denied care at both *Seguro Social* and the IMSS centers. His mother brought him in without a scheduled appointment, and she consistently asked for a change in his expansive medication regimen every four to seven days as new behavioral issues developed. During these visits, the patient often complained of feeling sleepy, but the psychiatrist would respond that he looked calmer, noting that taking the medication was the best way for him to be able to continue living at home. On May 26th, the mother-son pair arrived again, as usual without an appointment,

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[34] In contrast, Christakis (2004) provides a critique of Western medical care and randomized clinical trials for failing to evaluate not only the medication's direct effect on the patient, but also "collateral [positive/ negative] outcomes" among social contacts and kin when assessing health outcomes or the comprehensive cost effectiveness of medical interventions.

but this time, the mother's hands were shaking and she looked scared. She described her son as extremely agitated and seeking sexual contact with her, asking if the doctor could hospitalize him because she did not know what to do for – or with - him. She fretted that her son would not have all of the comforts and care of home, but she recognized that his medical condition needed to be reassessed and that she needed a break. The psychiatrist approved the hospitalization, as much for the patient's social conditions as for his medical ones. The subsequent observation period and removal of most of his medications led to the identification of an effective regimen that controlled his symptoms. It also led to the end to their predictably unexpected visits.

Numerous patients arrive at *El Batán* only after seeing a general physician, DIF representative (standing for *Desarrollo Integral de la Familia* or the national social assistance program for Comprehensive Family Development), or community healthcare worker in a *Casa de Salud*, often years after their symptoms first began.[35] General practitioners (GPs) and counselors often took on the role of psychologists and psychiatrists in the absence of mental health professionals, as found in other settings (Duncan, et al., 2009; Varma 2012). When I spoke with new patients, they commonly stated that these GP doctors gave them one box of medication (typically a blister pack of 10 pills) and told them to take it "until it runs out" *[hasta se acabe]*. Two psychiatrists confirmed that they had also heard cases of circulating misinformation and incorrect prescription practices among GPs, fretting that general physicians could reinforce rather than restructure the patients' assumptions. In these situations, patients followed medical advice and stopped taking the medication after the one blister pack ran out – which was long before having achieved the 4-

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[35] Given the historical relevance of indigenous healing to help-seeking behavior, it should be noted that help-seeking behavior rarely incorporated *curanderismo*, with only 2/27 patients undertaking such care. Both of these patients did so at the encouragement of their parents. They traveled long distances to attend their visits, and neither had access to psychiatric care in their *pueblo*. Casual conversations with psychiatric patients and kin at *El Batán* also reported that such practices were more common in small *pueblitos* and that the practices had fallen out of favor in more 'modern,' urban cities.

6 weeks needed to reach therapeutic levels and finish an adequate trial. Without any instruction to return for a follow-up visit or to receive more medication, the medications did not produce the desired effects – or perhaps any effect at all – and likely bred distrust of the doctors prescribing such medications, if not doctors in general, at patients' subsequent visits.

As a result, psychiatrists and psychiatric patients reported that other physicians, like patients, had "a lack of culture" *[una falta de cultura]* or specialized knowledge[36] that fostered the spread of inaccurate ideas about the dangers of psychotropics. As mentioned above, my methodology included interviews asking each study participant about their expectations and fears after their first visit to the hospital. The single most common fear which arose during these interviews - and in all but two cases, during at least one of each patient's outpatient visits with the doctor as well - was that they would become addicted to the medications. Below are four excerpts underscoring the stigma surrounding psychiatric medications. These data were originally recorded in Spanish, but the excerpts below are provided in English (see the appendix for all original Spanish transcriptions). In the following data, we see practicing physicians, psychologists, patients, and their relatives each address the fact that most psychiatric medications are viewed as drugs that generate dependency and pose the risk of addiction. However, as the psychologist emphasizes in Excerpt #2, antidepressants and even antipsychotics are not "controlled substances" which are intended only for the severely ill and they should not harm people if taken under a doctor's supervision.

Excerpt #1
Investigator: My next question is: Can you describe some questions or beliefs that patients have when they arrive here for the first time?

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[36] Two psychiatric residents said that general doctors are not required to take a course in psychiatry in order to receive their medical license. This was corroborated by articles such as de la Fuente and Heinze Martin (2014: 526-27). The same is true of social workers, nursing staff, and police who work in mental health settings like *El Batán*.

Doctor: Um, I think that the most frequent, like, question or stigma that they bring is first, that they're going to get addicted. I think that's the single most common thing.

Interview with Dra. M, August 9, 2014

Excerpt #2

And another factor that hinders them – or that they have to get right but they don't- in order to go to psychiatry is because they are afraid of the drug. They still believe, many of them – or even the majority – that all psychiatric medication, number one, is for the crazies, and number two, that it generates dependency. That they're going to be addicted. No? When you turn to statistics, you'll see that only twenty percent of medication generates an addiction. Only twenty percent. And… um, obviously under the supervision of the doctor, you can remove and revise it [one's medication regimen] when necessary. *If* it even generates an addiction.

Interview with psychologist, Sept. 1, 2014

Excerpt #3

Doctor: You didn't also think – or have you heard that they are controlled substances or …?
Patient: Uh huh. Like drugs, more or less.

Doctor: And now, after all this time, do you think they're like that?

Patient: No. So, I believe that they're NOT. I think they've helped me a lot with my mood.

Clinical visit with María del Roccio, June 3, 2014

Excerpt #4

Investigator: You can also read more about the medications.
Patient: Uh huh. I'm going to do that too. Read, view. I like to look in the computers for everything I take. And I'm going to read about those medications, the ones that are highly controlled. Have you seen that there are many that are controlled substances?
Investigator: There are some, and there are others that aren't.
Patient: Uh huh.

Investigator: And that's important to know,
Husband: Yes.
Investigator: Because some patients believe, "Nooo, the medication is controlled. It's going to hurt me."

Patient: Yes, everything doesn't hurt you.

Investigator: There are some. It's not all of them.
Husband: Yes, the doctor told us that – okay, the first time we came, he said he was going to give us medication that doesn't…. that won't make you addicted to the medication. In order for you to get better, he says. Nothing will happen to you.
Patient: Uh huh.

Interview #1 with Guadalupe, April 29, 2014

Fear of addiction to psychiatric medications was mentioned over 40 times in my data, reaching broad consensus on the salience of psychiatric medications being only for "*los locos*." When probed on the reason for this fear, patients stated that they knew psychotropics were strong medicines, and that their primary care doctors had emphasized that they could only take these medications for a short period of time. These fears are echoed in other ethnographic research (e.g., Das and Das 2006: 172-73) and such statements could plausibly stem from evidence of addiction to some benzodiazepines (cf. Tan, et al., 2009) such as Xanax and Valium, which individuals had then inappropriately generalized to all classes of psychiatric medication. Despite this cautionary tale, it was surprising to still find that many patients arrived with a dependence on benzodiazepines, presumably prescribed by those primary care treatment providers. Recognizing this shared fear of psychotropics and frequent over-prescription of benzodiazepines, psychiatrists had a challenging road ahead of them to gain their patients' trust. They viewed part of their task as transitioning patients to non-addictive substances and educating them on the evaluated safety of different classes of medication, given that very few patients researched their medications on the internet or read their package insert – if one was even provided. Clinical interactions were replete with advice, rather than leaving the patient to seek out ways to educate themselves.

Despite the support of clinical staff, patients in the present study struggled against transportation costs, competing demands at home, and conflicting information about how long to remain on psychiatric medications, such that by July 2015, more than half (59%, or 16 out of 27) of these patients had stopped attending visits without being formally discharged from treatment or titrated off of their medications at their treating physician's request. Those who cited monetary or familial obligations did not view psychiatric care in the same way that they viewed psychological well-being: as something that could be maintained through life changes and preventative self-care. Rather than more generally constructing themselves as pharmaceutical consumers that could optimize their health, they often returned to the clinic at a later time to reinitiate the otherwise cost-prohibitive pharmaceutical treatment for their illness. As discussed above, structural and experiential issues guide individuals to *El Batán* with misinformation about psychotropic medications along with an underlying distrust of psychiatric care that likely influences patients' treatment-seeking efforts. These data are complementary to longstanding concerns voiced by many (Vega 2001; Vega, et al., 2004; Wells, et al., 1989) of health disparities across the border among Mexican-Americans who chronically underuse mental health services and are more likely to use general practitioners (Vega, et al., 1999).

Interpersonal Psychiatric Practice in Puebla

Although the section above sketches some of the stigmatizing discourses circulating in Puebla around psychiatry, it does not address how professionals intervene on their patients' illness and illness beliefs. Therefore, we now turn to concrete clinical observations to fill in not only what is said regarding psychiatry, but also what is done in practice. First of all, at *El Batán*, visits are rarely one-on-one consultations between a psychiatrist and patient.[37] My field notes document

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[37] The same was found to be true at the Cruz del Sur Psychiatric Hospital in the nearby state of Oaxaca (Duncan 2012: 283), and among the lower-class patients treated at Salud Hospital in Mexico (Finkler 2008: 168). However,

that approximately half (14 of 27) of new patients consistently arrived for their visits with anywhere between one and five people from their family, which included their natal family or in-laws. According to Dr. G, the family is “basic” to the therapeutic encounter, as it was extremely rare to see a new patient arrive of their own accord. Rather, patients typically first sought care only as a result of a relative who was living with them noticing something was wrong and bringing them in. Physicians spoke of this as a demonstrated value for *acompañamiento*, where patients were accompanied and supported by co-present family, friends, or even co-workers who might even come alone to refill medications or speak with the psychiatrist when the patient was too ill to come (field notes for Feb. 18, 2014; interviews on Aug. 5 and Aug. 25, 2014). During general clinical observations in the hospital, I saw as many as ten individuals from a local community accompany patients to their first visit. Physicians take this multi-person consultation arrangement at face value, working with the family members in order to help this patient’s brain function better, as they put it.

During their clinical history-taking visit, which lasts between one and one and a half hours, the psychiatrist types away on their typewriters[38], sending telegraphic questions over the din of their typing. He or she takes down information on the patient’s education, socioeconomic status, living situation, access to running water and light, work history, sexual development and their presenting problem in order to fill out their clinical history in the chart. If the patient is older or struggles to speak coherent sentences, the psychiatrist will ask for him or her to interpret various cultural sayings (or *dichos)* as part of the administration of a Mini Mental Status Exam (cf.

Finkler (ibid) found that middle-class clientele were more likely to be organized around a nuclear family, and they were less likely to assume responsibilities that would relieve the physicians.

[38] Note: Internet is unavailable in *El Batán*, leading to the use of typed medical charts although digital records would facilitate continuity of care between different providers and levels of the healthcare system, in line with the charges of the WHO Mental Health Action Plan for 2013-2020 (2013: 14).

Folstein, et al., 1975) to screen for dementia. The only moment where they ask family members to step outside of the room for patient privacy reasons is when asking about sexual history. During the remainder of the visit, the psychiatrists regularly turn to the other people in the room – often a parent, romantic partner, and/ or sibling – and ask for their input: "When did this illness start? How did you notice it? What do they do when they are ill or get out of line?" Parents sometimes use this space to express frustration toward their adult children for failing to help around the house or, as the illness progresses, for disobeying them and frequently refusing to take their medication. If a patient attends a visit alone, the physicians regularly ask whether their family members or other people living with them have mentioned any changes since the start of psychiatric treatment. Psychiatrists recognize that co-residence is frequent and use the people accompanying patients as both an objective check on the patient's functioning and health, and as socially distributed remembering and reporting (Garro 2000; C. Goodwin 2004; Sutton, et al., 2010) that collectively describes illness and its constitutive symptoms at the same time that it distributes care in this quest for health.

For example, Providencia[39] was a 26-year-old patient suffering from panic attacks who was accompanied by both her mother and father at most of her visits. Although she had dropped out of college in order to get married, both Providencia and her son had recently moved back on to her parents' plot of land after discovering that her spouse had been unfaithful to her. She cited her spouse's infidelity as a trigger for the onset of her illness. Providencia spent her days at home with her mother and her son while her father worked long hours in agricultural work. In order to attend her visits, she and her parents traveled 60 kilometers by bus each way.

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[39] All names have been changed to protect the confidentiality of research participants.

During Providencia's second clinical visit at *El Batán*, the psychiatrist stated that although he recognizes that she is legally a responsible adult, he would still like for one of her parents to help her ensure that she takes her medication appropriately – at the right time, in the right dosage (field notes, April 30, 2014). Later, after four months of psychiatric treatment, the psychiatrist identified low iron levels in recent lab results as a related clinical issue to address. He asked Providencia to evaluate her own progress in treatment and then, as was regularly the case, he turned to her mother and father, asking for their perspective on her improvement.

Excerpt #5

Doctor: And this thing that just happened to you, we are going to try to evaluate it and see if it decreases at some point. I believe that your mood has improved. I think you have changed a lot, so, um, now we must discuss these [new] issues that are arising.

Patient: Yes, doctor.

Doctor: Okay? (looking toward her father) And how has she seemed to you?

Dad: Well, I'm almost never with her but now that I am going with her [to these visits], better. She looks happier, she looks better to me.

Doctor: Great. Well, that is what our work is all about.

During this most recent visit, the psychiatrist reviewed lab results that he had previously ordered and off-handedly asked whether she was on her period when the blood was taken, to which she responded "no." He mentioned that her iron levels were low and that given her answer, this indicated a new problem to address: anemia. In conjunction with this finding, she admitted to craving and eating *bloque suavecito* (clay bricks used in home design), and her father recalled that when she was pregnant, he would see her grab a hunk of adobe and eat it. The psychiatrist learned that she had never mentioned this to her psychologist, and he explained that this (called *pica*[40]*)* can be tied to anemia and anxiety. The psychiatrist noted that it is a dangerous activity that can hurt her teeth and digestion, so she should slowly work to stop the behavior, although he would also prescribe vitamins to help her system adjust. He assured her he would continue to check in on it as her treatment progressed, and hoped that the medication would help her decrease this habit.

This visit highlights both the social emphasis on patients being accompanied to their visits, especially on long distance trips, and the effort to corroborate clinical findings with the patient's working memory and family members' views of day-to-day behavior, as was repeatedly emphasized by the residents in clinical classes and one-on-one interviews with me. These multiparty interactions reveal how this patient's speakership is not limited to her body or to her individual abilities (or deficits) (cf. C. Goodwin 2004), and how treating psychiatrists combatted issues with a patient underestimating or overstating their progress by calling upon the perspectives of all co-present individuals. Likewise, even when a family member was speaking, the patient would nod in agreement or disagreement with what was being said, making consequential contributions by adding another perspective to the seemingly two-party dialogue. Here, Providencia's father provided a better picture of what the problem was by interpreting his daughter's behavior in context. Likewise, physicians turn to co-present kin to assess how pharmacological treatment was influencing interpersonal treatment in the household. This was true in the case of Rosa, a patient who suffered from a compulsion to repeatedly wash her hands and reported she had not improved after one month of medication usage. In response, the

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[40] According to the DSM, pica is an eating disorder where individuals consume non-food items/ substances with no significant nutritional value (e.g., paper, clay, soil, glass). It is more commonly found in women – especially pregnant women (Simpson, et al., 2000) - and children in areas of low socioeconomic status, and can be dangerous due to ingestion of poisonous substances or parasites as well as increased risk of gastro-intestinal obstruction or tearing of the stomach. During fieldwork, the researcher saw three women with this disorder receive psychiatric treatment, and all of them reported that the behavior started during pregnancy.

psychiatrist turned to her parents to assess “how she’s seemed” (clinical visit, June 4, 2014). Their descriptive reply was that “Something has improved because before, she would serve us our meal and remain mute during the meal, while now, she asks ‘Dad, would you like a little more?’” By describing finite social interactions across situations, they were able to track the process of progress until the patient herself could also see those changes.

These multi-party interactions sometimes proceeded smoothly, and at other times, they did not. Providencia deeply respected and cared for her parents, so she rarely disputed what they said. However, in some cases, patients arrived at the clinic violently thrashing and were determined to have florid psychosis, and they were not responsive to the doctor’s questioning. In these instances, the patient’s behavior spoke louder than their words and psychiatrists then turned to the relatives accompanying them (or, in rare cases, unrelated community members who were present) to fill out his/ her personal information, characterize their recent behavior, and evaluate hospitalization. On a more fundamental level, this family visit structure moves away from characterizations of Mexico as following the visit structure of Euro-American psychiatry which relies on individual, assumedly rational self-report to diagnose not only their disorder but their social functioning and competency (see also Luhrmann 2000:138-140).

Similar to Providencia, Guadalupe and her husband had moved in with his parents after she fell ill. During her clinical history-taking visit in April 2014, the psychiatrist was concerned with 27-year-old Guadalupe’s accelerated speech and intrusive thoughts. Given that she had initiated treatment only two weeks prior, the psychiatrist turned to her husband and emphasized:

Excerpt #6

Doctor: What’s important is that she takes her medications every day and that you watch her take them.

Husband: Yes. No – yes, she is taking them.

Patient: It's that sometimes, I tell my husband, ["See if I took them,"
Husband (interrupting): [Yes, she is taking them.

Patient: Because sometimes I feel like I didn't take them and…

Husband: It's that sometimes she doesn't pay attention – she just grabs it and goes.

Patient: I'm distracted.

Husband: Absent-minded. I tell her, "NO. Focus on your medicine so that (momentary pause) you don't think about other things."

Doctor: I know that you are an adult and a responsible person but at this time, I need for someone to help you with your medications.

Husband: Yes – that she's taking the medication. Yes.

Guadalupe suffered from racing thoughts and frequent fears that her husband would leave her if her mental health did not improve, and this terrified her given that her own family did not believe psychiatric care could cure her. Her social support network was small, and such fears made it hard for her to focus on mundane tasks like taking her medicine. Moreover, this excerpt reminds us that patients are viewed as having decreased competency, such that they might forget to take their medicine or, alternatively, take it twice and accidentally overdose. Therefore, her husband was asked to not only provide broad social support but medication management as well.

In the cases of both Providencia and Guadalupe above, the psychiatrist asked for co-present kin to monitor and assist with medication administration. In contrast to U.S. psychiatric visits, where the adult patient is constructed as an agentive client who should manage their own care – and who, as a consumer, also has the explicit legal option to refuse treatment – patients in Puebla were viewed as having diminished capacity for autonomy or independent decision-making, constructing a sick role (cf. Parsons 1951) that encouraged family members to help with their medication administration for at least the first few months of treatment initiation, and much longer than that if the patient was diagnosed with schizophrenia. Likewise, I never saw a voluntary hospitalization occur during my fifteen months at *El Batán*. Instead, psychiatrists would ask for whoever was accompanying them to sign off as "morally responsible" for the decision to initiate inpatient care (field notes, January 31, 2014), thereby empowering the family rather than the individual to consent in line with Article 51 B2 of the General Law of Health (*Gobierno de México* 2017: 20).

Akin to Lester's (2007:378) identification of the enduring cultural capital of familism in Mexico, psychiatrists at *El Batán* encouraged family members to learn about the patient's illness and to help patients be socially embedded at home, in line with research that health and health care transcend the individual patient (cf. Smith and Christakis 2008: 420). Especially when patients lived with relatives, treating clinicians reminded family members to assign them tasks like sweeping the floors or helping in the family store. The psychiatrists presented themselves as a resource and encouraged family members to similarly help patients make positive decisions throughout the treatment process so that they hopefully would develop or regain self-awareness and the agency to ultimately manage their condition themselves, as their parents would not be around forever. In that vein, psychiatrists regularly asked about their daily routine and suggested behavioral changes, such as exercising for 30 minutes a day. They consistently asked about where and how patients live and underscored the importance of attending therapy in order to learn how they react to stress and why "they got to this point," favoring a biopsychosocial[41] or adaptationist model over the dualism present in Western biomedical psychiatry. However, once the patient had left the clinic, the psychiatrist would regularly affirm that they knew a complete

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[41] As Buchbinder (2011: 466) writes in the context of pain medicine, "…the shift to a biopsychosocial paradigm requires a willingness to engage actively in various therapeutic modalities and accept that medication alone is not considered sufficient treatment."

change of direction was not likely, and that in the end, there would be a higher possibility of long term success if they reminded patients how to restructure their environment in order to lessen bad behaviors or replace those bad behaviors with modest frequencies of good behaviors. They felt like a broken record but stated that if patients learned to adapt and adopt one or two such changes long term, they would consider it a success.

As shown above, physicians equally engaged the patient and family in the treatment process, emphasizing how caretakers and family members are in charge of monitoring patients so that they take their medications each day. These actions do not easily parallel past accounts of how treatment is imbued with institutional logics that posit personal responsibility for care and recovery (Carr 2011; Davis 2010). Furthermore, if a patient came alone to a visit and was not doing well, their psychiatrist would require that a family member come to their next visit to help discuss their treatment and make medical decisions – or to sign off on hospitalization. Therefore, the emphasis that both Finkler (1991, 2008) and Lester (2007) place on the pervasive centrality of the family in Mexico is certainly supported in my data in ways that prescribe interdependence in and beyond the clinical realm. At the same time, the associated socialization toward interdependence or possibly even in-home monitoring raises new issues of selfhood and the process of envisioning community engagement which merit further study.

The Bigger Picture

Institutional and international forces can further facilitate or restrict local ways of being. This particular hospital's emphasis on the role of the family carries over to a more systemic, national level. Dr. Julio Frenk sought to redress social inequality in access to healthcare and, during his tenure as Mexico's Secretary of Health, he introduced universal insurance under the banner of

Seguro Popular. He rejected a unidirectional depiction of healthcare moving from producers to patients and instead advocated that the population of a health system is an essential part of the system rather than an external beneficiary of it (Farmer, et al., 2013:197-98). Frenk has noted that the state is responsible for the care of its citizens rather than offering segmented care through one's employer, given that "Healthy people are more productive, and healthier children are more likely to succeed in school and have better economic opportunities than those who are sick or malnourished" (Frenk 2012).

However, Finkler (2008) asserts that the IMSS provides a higher level of health care to employed persons than do the Health Ministry services available for the unemployed. She writes, "In this way, the Mexican state safeguards a healthy labor force for the capitalist industrialized sector of society" (ibid: 161). Homedes and Ugalde (2009) similarly remind us that this healthcare system is also imbricated with politics and World Bank loans. Despite its intention to be a portable and encompassing system, the implementation of *Seguro Popular* is heterogeneous between states (ibid: 7) even while the Ministry of Health - rather than individual state health departments - is expected to ensure systematic implementation of the policy across states.

Practicing psychiatrists at *El Batán* reported mixed feelings about *Seguro Popular* and whether it should be praised or taken with a grain of salt. One psychiatric resident stated that when he was still in medical school (back in 2009), the country had hoped to merge all of the disparate insurance groups and create a truly universal healthcare system, but that five years later, it had not happened. Instead, individuals across the nation are still variably insured under the Mexican Social Security Institute (IMSS) for corporate employees, the Mexican Institute for Social Security and Services for State Workers (ISSSTE), or *Seguro Popular* for those excluded from the other two insurance entities. He speculated that this movement had stalled due to the *sindicatos* having a lot of money invested in this system (field notes, May 12, 2014). Later, during a public talk of my findings at *Ciudad Universitaria*, an audience member stated that *Seguro Popular* should not be praised as the "achievement of free universal healthcare" (as I had just done) because it involved a lot of hidden costs and is as much about politicians securing votes as the country securing health for its citizens (field notes, August 21, 2014). Throughout the course of my fieldwork, it was clear that Mexican psychiatrists are a link in a local ecology (Das and Das 2006) where they receive information from a more global level and act not only as a gatekeeper but part of a me-and-mine collective where they harness their understanding of the local population to achieve an appropriate fit with global processes of institutional psychiatry.

If you examine the Mexican Ministry of Health's (*Secretaría de Salud de México* 2006) publication, "*Innovaciones en la gestión hospitalaria en México*" (Innovations in hospital management in Mexico), you will quickly notice that they do not describe the client or customer as merely the patient being treated – instead, this document consistently refers to the patient <u>and</u> their family, explicitly contrasting classical functional organization with "Management by processes… in which the client's vision about organizational activities has priority (internal client = services or functional units, **external client = users, that is to say, the patient and their family**)."[42] The document goes on to express (p. 37) that very few general hospitals achieve this aim, and that those which do are often private hospitals. Nonetheless, the ideology is still significant. The 'customer' is not an individual person but rather a family unit, and in theory, the party for the provision of care is decentralized and also collectivistic. To illustrate, among other services offered, the National System for Integral Family Development (*Sistema Nacional para el Desarrollo Integral de la Familia*, SNDIF or just DIF) strives to provide public service

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[42] Original text (p. 21, emphasis added): "Gestión por procesos… En ella tiene prioridad la visión del cliente sobre las actividades de la organización (cliente interno = servicios o unidades funcionales, **cliente externo=usuarios, es decir, el paciente y su familia**)."

carriage to *El Batán* whenever they can organize a busload of people traveling to the hospital, and city governments are encouraged to provide transportation if the DIF does not have coverage there and the family cannot manage it themselves – although in practice, buses rarely run if they do not fill up.[43] These policies do not match managed consumer healthcare practice in the U.S. (e.g., Lester 2009), but their focus on well-being simultaneously plays into larger governmental aims of economic development and the protection of the national workforce.

This language of nationalistic, collective caregiving units calls for an ethics of social responsibility that is variably enacted, but typically falls upon the family – especially if and when a person is hospitalized. In general hospitals, family members were often expected to visit frequently, bringing changes of clothing and food from home, and medication purchased from a nearby pharmacy (because these drugs are not provided internally). In contrast, at *El Batán*, food, clothing, and medication were all provided free of charge by the hospital during inpatient care, although relatives were encouraged to bring something to remind patients of home. If and when patients were hospitalized, family members sometimes requested to stay with the patient in order to maintain their family routine and continue caring for them, only to be told that was not a possibility given safety concerns in the dormitory-style units. Clearly, this regulated separation was a sharp departure from outpatient care as well as from normative cultural scripts that value familial support and collectivistic community care.

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[43] I saw this repeatedly in the hospital, where patients would not arrive for their appointment, and when they came days or weeks later, they shared their frustrations with “lazy bus drivers” refusing to carry them.

A Family Matter

As noted earlier, academic shorthand for ‘doctor-patient interactions’ often assumes a dyadic exchange (see, for example, Finkler 1991:126). However, the above findings show that the export of biomedicine or help-seeking through psychiatric specialty care does not necessarily sell Euro-American values of individualism or individual autonomy along with it. Of course physicians accept that psychotropic medications affect individual bodies and that these effects will vary for each patient - not to mention the problems of adherence, cost, and misinformation about dosage, among other things. At the same time, physicians clearly recognize and say that the medications can be used to help finesse the family dynamic and ensure a calmer climate in the home. Psychiatrists would regularly state that in the short term, they hoped to make the patient calmer (*más tranquilo/a*) by having them sleep longer hours, and they acknowledged that it would take much longer to resolve their symptomatology and begin addressing the underlying problems residing in both their biology and their environment. Referrals to psychotherapy were frequent, giving patients the opportunity to decide whether they would prefer to be seen by a psychologist at *El Batán* or schedule with a therapist closer to home. If they chose to receive psychotherapy at *El Batán,* their therapy sessions were scheduled to directly precede or follow their psychiatric visits, reinforcing *El Batán’s* integrative system of care. Psychiatrists encouraged patients to attend psychotherapy and learn how they got to this point, and they spoke to family members about incorporating diet and exercise as valuable components of their treatment. In a geographic area where obesity and diabetes were prevalent, psychiatrists voiced the following common refrains: “Eat fewer tortillas at your weekly family meal.” “Drink less Coca-Cola.” “Avoid burning the midnight oil.” Whether they felt like a broken record or not, psychiatrists in Puebla introduced discrete behavioral changes one by one, such as avoiding alcohol while taking certain medications, exercising more, eating less fat and sugar, and developing healthy sleep hygiene over time while working toward holistic well-being.

As characterized by Kirmayer (2006:126), the psychiatrist “attends to psychological processes but understands these as not exclusively located within the individual but as including discursive processes that are fundamentally social.” In line with larger aims set by the Caracas Declaration and international organizations such as the WHO to move away from institutional care to community-based care, outpatient visits serve as vehicles to push psychoeducation and send treatment into the community – and they are directly contrasted with long-term inpatient care, using involuntary hospitalization as a personalized cautionary tale to encourage outpatient compliance and dissuade families from disintegration or patient abandonment, seeming to extend decision-making responsibility and the production of treatment outcomes beyond and away from the individual patient.

This rationale of familial and social responsibility broadly benefits from a long history of studies demonstrating negative outcomes of ‘institutionalism’ leading to human rights violations and chronicity (WHO 2001: 49) as well as the progressive loss of health and life skills (Wing and Brown 1970). There are also positive associations with non-specialized *community*-based care in terms of health outcomes (Tansella 1986) and greater family participation in treatment with fewer relapses or longer delays before each relapse (Miklowitz, et al., 2000; see also Karno and Jenkins 1993:344 and Good 1997: 234-35 for more information), both of which smoothly align with the pre-existing Mexican value of family. Throughout Mexico, psychiatric services reference the lauded example of the psychiatric hospital of *Villa Ocaranza,* which employed the *Modelo Hidalgo*. This model, developed by the Mexican Foundation for the Rehabilitation of People with Mental Illness in partnership with the Mexican government’s Health Department, advocates to incorporate community work and rehabilitation into the provision of healthcare in order to decrease rehospitalization rates (Rothbard, et al., 1999), decrease the per capita cost of treatment (Mental Disability Rights International 2000: 56; Simmonds, et al., 2001: 499-500), and to destigmatize mental illness via the reintegration of patients into society through primary care and community-based care. This requirement for rehabilitative community care was formalized in the Official Mexican Standard NOM-025-SSA2 (Secretaría de Salud 2014).

In *El Batán*, these findings have led to a hope to transition long-term inpatients from ward living to more independent villas under the *Modelo Hidalgo*, as outlined in Sandoval de Escurdia and Richard Muñoz (2001: 37ff). Unfortunately, very few current long-term patients at *El Batán* qualify to live there given assessments of their level of functioning, so as of my last visit in August 2015, the majority remain in dormitory-style halls with dozens of beds. The same is true of most of the country's 47 public psychiatric units, as only eight operate using the Hidalgo model (Secretaría de Salud 2008:51). Inpatients who have lived in *El Batán* or elsewhere for ten years or more remind us of the challenges facing mental health reform and the limits of thinking of care and abandonment as opposing concepts (Varma 2016: 794). Nevertheless, new outpatients feared family disintegration during the course of psychiatric outpatient and inpatient care, resulting in patients ending up like those "*pobre gente*" left behind, even though most of the new patients' situations and diagnoses differed substantially.

As shown above, psychiatrists constructed patients within a sick role that conferred diminished capacity for independent decision-making upon them and mounted a response that merged familistic and collectivistic caretaking. Psychiatrists would ask relatives to monitor patient compliance on a daily basis and they would tell relatives how to crush up pills in the patient's food if he or she stopped wanting to take them, emphasizing the value of psychoeducation and a supervisory role among kin, as stated in excerpts 5 and 6. Nevertheless, it was much harder to help relatives grasp an affiliative (rather than hierarchical) stance toward the patient's suffering or the experiential reality of mentally ill patients. Once optimal doses were identified and the medications started working as intended, often after two to six months, relatives asked why the patients need to keep coming to the hospital if they began feeling well. It took time to socialize the community to change their perspective from someone being dichotomously labeled "*loco*" or healthy (i.e., cured) to instead understanding the chronicity of these illnesses and the potential for relapse. Sometimes, it only made sense when psychiatrists would refer back to the long-term inpatients and say if family members were not careful, their loved one would end up being repeatedly hospitalized, or even living there like the long-term inpatients who would be seen wandering around the hospital's fenced-in yard. Treating psychiatrists aimed for patients to experience between six months and one year of asymptomatic visits before titrating down medications and stopping pharmacological treatment, but those physicians felt that as patient's symptoms abated, the problem became more contextual or psychological than physiological. Social and structural limitations including common misconceptions about mental illness and psychiatric medication and poor psychiatric infrastructure in rural communities slowed their progress, such that psychiatrists saw the institutional and the social body (cf. Scheper-Hughes and Lock 1987) as sick. However, they viewed largescale forces as much harder to change than an individual's neurochemistry – even with the high rate of patients who stopped treatment in psychotherapy and/ or psychiatry before being instructed to do so.

Discussion

The extant literature is rife with critiques of the reductionism in both biomedicine and psychiatry as ministering to the physical body and excluding broader socioemotional and structural concerns (e.g., Finkler 1991; Hamdy 2008; Lakoff 2005:7; Scheper-Hughes and Lock 1987:14). However, when you move beyond mechanistic reductionism and examine the structure and content of local psychiatric clinical practice, physicians do not serve as cookie-cutter messengers of some 'global' biological psychiatry. Instead, they think clinically about the specific case in front of them at any given time. Despite time constraints in their busy clinic, psychiatrists in Puebla recognized that patients could be very ill and confused, and the doctors pushed for the development of rapport with both patients and their families. In my study, eight patients traveled long distances but had few resources to stay at a hotel overnight,[44] meaning they needed to 'make a day' of their trip to Puebla for psychiatric outpatient care. With each of these patients, psychiatrists spent time asking about their hometown community or their daily activities, and at times they recommended a better bus route or a good place to eat before making the long journey home. Various psychiatric residents explained that it was the holistic perspective of the discipline attracted them to psychiatry. Dra. M noted that

> I like psychiatry because it doesn't only involve a person's behavior. As a doctor, I care about the biological component, right? But psychiatry also involves the behavior of a person, their attitudes, the people they associate with, as a whole. And not even just that. But also the sociocultural context – for example, that of their religion
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> Interview with Dra. M., 8/08/2014

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[44] The average quincenal (bi-monthly) income in my study was approx. 1,600 pesos, with a reported range of 635-3,500 pesos and some outliers who reported that they had no income but would receive food or remittances from their children. Given that two-way bus fare for two people could run above 2,000 pesos, transportation was a very high hidden cost in their treatment.

Almost all participating psychiatrists in *El Batán* endorsed a biopsychosocial treatment model and identified treatments other than medication as the most important element of their prescription. Psychiatrists and psychiatric residents alike would say, “The medication is forty percent of your treatment – the other sixty percent is coming to therapy, exercising, etc.” The percentage breakdown would change to some extent from patient to patient, but physicians were very clear that being well and avoiding relapse would require more than just biomedical treatment with medications, but also changing lifestyle habits and socio-emotional skills as the key to long term success. Below are just a couple of the dozens of instances found in the corpus integrating medication management with the development of psychosocial skills. Both pieces of data reveal that although psychiatrists prescribed drugs to give patients an initial “push,” they believed that the majority of their treatment would come from changing behavioral routines and working in psychotherapy.

Excerpt #7

> Doctor: But that’s anxiety. You also need to go - You need to <u>force</u> yourself to go to therapy because he/ she needs to teach you – when it starts, how to find a way to decrease it. I repeat - the medication has already had its effect. I’m going to add another to see how you feel and if, with this, the anxiety decreases a little more. But the medication has already had its effect. Now it’s your turn.
>
> Clinical visit with Rodrigo, May 8, 2014

Excerpt #8

> Doctor: You need to adapt to what’s coming. Because that’s a decision and a routine, that he [your son] is going to leave.
> Patient: Yes, I know. Um, I haven’t gotten used to be alone. Totally alone.
>
> Doctor: Do you believe that he will get used to living as a couple by himself?
> Patient: Uh, no.
>
> Doctor: Well, it’s your turn to begin to understand that you have to get used to it. Not get used to it. …First, understand that you have to be alone. Right? Being alone is an expression, but surely you can do many things.
> Patient: Yes.

Doctor: So, you must start doing things and start distancing yourself from doing many things for him. Now it's your turn to do them for yourself. Because if you don't, you are going to continue feeling this way, like you are feeling right now. I think this has a lot to do with it. And the day he leaves, how are you going to feel?
Patient: I'm going to feel bad.

Doctor: But you ought to know that he has to leave. That you have to be saying that every day. Because the decision isn't up to you anymore. Now it's his turn. Right? The use of the drug makes some things decrease. And I believe that's what is happening right now. That you are progressing with this- these features where you aren't sure what's going to happen. And as you can't control them, that's why they have you more distraught.

Fifth clinical visit with Margarita, August 18, 2014

This last patient was an especially memorable person. Margarita was a 71-year old woman with bright eyes and white hair who came from a humble farming background. Six of her nine children had migrated to the U.S. to seek work, and two had died during childhood. Her only remaining son lived at home with her. However, he had recently fallen in love and was living with his girlfriend rather than staying with her in his childhood home or helping her attend her doctor visits in her old age. As a result, Margarita had fallen into despair and found herself isolated, such that she suffered frequent crying fits. In moments such as the excerpt above (#8), the psychiatrist joked that he turned on an alter ego as talk show host "*Dr. Corazón*" (loosely, "Dr. Heart") to intervene and treat her social situation. Dr. B worked with Margarita not just as his patient, but as a mother as well. Despite not being her psychotherapist, he emphasized that everyone has problems, and that the challenge is learning how to live with them. Although Margarita was focused on the expectation that her son would stay close to her and care for her in old age, Dr. B encouraged her to accept the things she could not change while recognizing that her desire to repair this unstable relationship is valid and important to her health. Margarita's case showed how one's social life can gain primacy over one's medications in their quest for wellness, similar to arguments made/ as shown elsewhere by Venkat (2017).

In *El Batán,* clinicians also worked within the social constraints of the local system to constructively collaborate with families and, unlike families in past studies of American inpatient psychiatric care (e.g., Rhodes 1991), they were often successful in maintaining their involvement in the patient's treatment by encouraging their presence at *El Batán* for the time being. At times, work schedules or family tensions would disrupt this pattern, and physicians would then intervene and request the support and co-presence of kin. For instance, halfway through my fieldwork, I was surprised to see a middle-aged man with schizophrenia come into the clinic alone and ask for his medication for the next six months. Afterward, I wrote the following field note:

Excerpt #9

> A male patient with schizophrenia came alone because, according to him, "I am doing well and my sister is busy working." However, the doctor asked him to bring his sister to his next appointment (as he had always done in the past), explaining that she needed to be a part of the discussion regarding whether to decrease his dosage to ½ a pill. After the visit, the doctor turned to me and described the patient as "aplanado" (with flat affect), and he felt that decreasing the dosage could help correct that.
>
> Field notes, January 17, 2014

Kith and kin are relied upon for their intimate knowledge of the patient and their physical co-presence alongside the patient both inside and outside of the clinic. Their presence raises questions surrounding bioethical concerns of privacy and patient confidentiality (cf. Finkler 2008: 169), but in this setting, relatives provide social support and consent to treatment. Psychologists and psychiatrists alike recognize the value of the family, not only in terms of community-based healthcare outcomes, but also in terms of the interpersonal management of psychiatric disorders, given that the pharmaceutical or technological management of disorders is not perceived to be enough.

Excerpt #10

> In psychiatry, the family comes to the visit a lot, right? In the clinic they say, "Let's see if you took the medicine… And yes, (to a relative) is he/ she doing that?" And it's not as it looks to you, because they can say "I'm fine." But they're not [fine].
>
> Interview with psychologist, September 1, 2014

As shown by the four examples above (#7-10), socioemotional skills and social support were an explicit part of psychiatric care in Puebla, and were not left under the purview of only psychotherapy. The psychiatrists' emphasis on consistent family involvement and community-based care transformed not only their practice treating mental illness, but also their definition of what constitutes and maintains 'mental health.'

So although the family is highly valued among the cases in this study, it is also pragmatically useful to deputize relatives, friends, and community members as instruments for biomedical care delivery and for community psychoeducation who can accompany the patients on the long journey to *El Batán* and scaffold the patient's care while they are at home, hoping to keep these patients out of the hospital. In instances when patients and accompanying kin only spoke Nahuatl or another indigenous language, psychiatrists turned to those kin to act as translator/ interpreter – or if no one present spoke Spanish, they asked for them to "phone a friend" or other relative who was bilingual. Instead of intervening to support improved family social relationships as the focus of treatment - family relationships which psychiatrists recognize can be 'codependent,' unhealthy, and in fact *adding* to the problem - psychiatrists work with what they have with regard to family support and refer patients to psychology for more in-depth emotional and social work. While they do not provide family with specialized training support in this state with scarce human and institutional resources, psychiatrists do treat relatives like care workers or *accompagnateurs* (cf. Farmer, et al., 2013; see also Garcia 2010: 9) involved in bureaucratic medication monitoring and rehabilitation instead of an egalitarian *familistic* unit.[45] Rather than the ideological model of biomedical psychiatry being at odds with Mexican family life and therefore dissuading entry into treatment, these patients simply carry their everyday standard of family social support over to the psychiatric outpatient clinic (for better and for worse) and both sides make use of these family resources the best they can.

Conclusion

Empirically, this chapter illuminates how psychiatry in Mexico is currently practiced, and challenges the caricature of psychiatric care as synonymous with medication management, especially in developing nations. Despite having much lower ratios of providers to patients than recommended by the WHO (2011b: 15), psychiatric providers in Puebla have found a way to make the best use of their limited resources, and they clearly state that treatment will not work if just the medication and the patient are part of the equation. They must work inside the local ecology where lack of access to psychiatric facilities is a given in many parts of the state, and it is absent entirely in other states such as Guerrero, Morelos, or Tlaxcala. In addition, all parties

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[45] This reliance on untrained familial labor who will transfer their everyday standard of care over to the new setting - rather than assigning caregiving roles to professional nursing aids or other auxiliary staff - is extremely common (e.g., Nunley 1998; Wool and Messinger 2012). Wool and Messinger (2012) reveal blurred boundaries similar to those described in the present research within the context of the U.S. Army's Non-Medical Attendant program. Despite their involvement in bureaucratic paperwork and technical practices of being a non-medical attendant (NMA) that received a per diem and travel expenses, kin caring for injured service members did not identify with the formal role of NMA as part of their selfhood, and they did not view their loved one as a patient.

involved combat challenges with transportation, pathogenic kin, or medication shortages that arise over time. They use these visits as a time for familial psychoeducation that can then be disseminated to one's local community and hopefully decrease the entrenched stigma displayed toward psychiatric patients and psychiatric specialty care in the future.

The evidence from this chapter adds to recent publications such as Duncan (2015, 2016), Garcia (2015), and Wanderer (in press) by providing further evidence of the everyday reality of local clinical worlds *within* the large and varied country of Mexico. These data do not support the notion of the hegemony of increasing globalization as purposively driven toward a Euro-American biomedical model [as if from a prior historical vacuum]. Psychiatry is an established discipline in Mexico and lay knowledge of mental illness – in some form – dates back to the early 1900s, when La Castañeda was the largest asylum, and later, the largest psychiatric hospital in Mexico (see also de la Fuente and Heinze 2014: 523-26). Although pharmaceutical drugs and neuroimaging technologies can maintain their original form when shipped internationally, psychiatric practice and the ideologies and lessons it holds are not contained within a particular cultural toolbox. These ideologies and practices are molded by the particular political, technological, and social arrangements of practitioners and patients who populate local clinics and negotiate clinical care. In Puebla, psychiatrists turn to the family for help with medication administration and social support, and only later transition to a view that the patient can care for him-/ herself. Although the global advancement of neoliberal economic policies can foster self-care and private doctor-patient interactions (see Matza 2009), these analyses show that local value systems and structural constraints influence the reception of such variables from the bottom up, just as treating physicians capitalize on the family's presence for pragmatic reasons. The psychiatrists act as both a gatekeeper and an advocate because they understand that some of the values this population holds can translate to medication adherence and social support, just as they simultaneously understand that receiving free medications and therapy will not remove some of the barriers this population faces. This indicates that we should forgo the binary juxtaposition of “the West” and “the rest” in order to study how local experiences connect to global phenomena. Moving forward, we also need to recognize distinctions between public psychiatry (including the current study) and private, office psychiatry, as the two systems function independently despite the fact that providers may operate in both worlds.

CHAPTER 3

Explanatory Models Have Some Explaining To Do

Introduction

> [There is] a central hermeneutic problem in clinical transactions: there are different interpretations of clinical reality reflecting different systems of meanings, norms, and power. In this sense, each of the health care system's sectors can be supposed a separate 'culture.' ~ Arthur Kleinman (1980: 53).

Kleinman (1980) has described personal and social meanings ascribed to the experience of illness episodes, including explaining otherwise inchoate symptoms, suggesting cause, prescribing treatment, and striving to predict the course and outcome of a disease. He groups these efforts under the rubric of an Explanatory Model (EM) for cross-cultural explanatory systems surrounding illness, which consists of five basic components: its etiology or origin, onset, pathophysiology or the functional changes associated with a disease or syndrome, prognosis, and treatment. EMs can vary in the extent to which they address some or all five of those components, but they function to "…offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness" (Kleinman 1980: 105). Through the development of tools like the Short Explanatory Model Interview (Lloyd, et al., 1998) and the Explanatory Model Interview Catalogue (Weiss 1997), the Explanatory Model's five components arguably still comprise the most commonly used schema for eliciting illness beliefs even today.

Although Explanatory Models are intended to address "the notions about an episode of sickness and its treatment that are employed by *all those engaged in the clinical process*" (ibid, emphasis added), in practice, the vast majority of studies focus on patients and their families (e.g., Ahn, et al., 1996; Hess, et al., 2014; McEvoy, et al., 1981; Perrin and Garrity 1981; Sajatovic, et al., 2008; Williams and Healy 2001) rather than studying treatment providers. When studies do examine providers, especially psychiatric clinicians as in the current study, EMs are often elicited from practitioners during interviews (Bromley 2005, 2007; Gaines 1979; Young 1981) or focus groups (Hedenrud, et al., 2013; Mikesell, et al., 2015; Patel, et al., 1995) rather than being elicited through clinical interactions between doctors, patients, and co-present kin, as called for by Kleinman (1980: 111-118, 205-258). The context of elicitation is important because scientific and social concepts can diverge widely (Eisenberg 1977), and the theoretical EMs elicited during research interviews can be decidedly different from those transmitted to patients through clinical practice (Kleinman 1980: 109). The explanations of illness and its treatment which are shared during clinical encounters can influence the perceived strength of congruent cause and treatment focus (Iselin & Addis 2003) as well as the patient's perceived control can affect prognosis. The clinical encounter provides an opportunity to study possible translations made to accommodate patient understanding, as well as how successful such clinical communication is in achieving its intended outcome. The present chapter recognizes that very little is known about how clinicians explain mental illness to patients with a variety of psychiatric diagnoses during naturalistic clinical interactions, and it takes up that task.

Theoretical Problem

Very little ethnographic data exists in the U.S.A., let alone elsewhere[46], to characterize and analyze the dissemination of physician EMs during the actual practice of psychiatric care. This is surprising given that causal attributions are valued as part of patient-centered care due to their

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[46] With rare exception, such as B. Good (1977) and of course, Kleinman's (1980) seminal book.

demonstrated influence on patient behavior. Illness attributions are thought to guide clinicians' cultural competence and influence a patient's satisfaction with treatment (cf. Bhui and Bhugra 2002; McCabe and Priebe 2004a), as well as affect health variables such as blood pressure and immune function (Petrie, et al., 1999) and health outcomes like perceived illness severity (Turnquist, et al., 1988) or time before returning to work following a heart attack (Petrie, et al., 1996). When looking for the best way/ format to integrate such EMs into clinical practice, qualitative research such as Kirmayer (2000) acknowledge that clinicians and patients can enter into the treatment encounter with disparate assumptions and Lakes and colleagues (2006) posit that those clinicians with the ability to tack back and forth between their client's perspective on illness etiology and their own perspective can provide better healthcare by achieving narrative congruence in their clinical communication. However, it is unclear how such EMs are disseminated across time in clinical practice, especially in light of the fact that both the content of such illness explanations and how fervently an individual believes in a given explanation may change over time (Williams and Healy 2001).

Notable exceptions include Buchbinder (2011, 2015), Mattingly (2010), and Skultans (2003). Buchbinder's (2011, 2015) interactional research documented the EMs provided during clinical transactions, and patients' subsequent uptake over the course of 18 months in a multidisciplinary pediatric pain clinic in southern California. During her work with neurodevelopmental disorders, Buchbinder (2011: 460) observed that "…physicians routinely draw on metaphors, images, and other rhetorical strategies to clarify communication about symptoms and to justify a particular course of clinical action." Physicians would use a neurobiological framework to attach moral characteristics and personal traits to the brain, as when particular patients were told they had "sticky brains" (Buchbinder 2012). Physician EMs then recruited patients into compliance with treatment obligations as well as academic and social obligations the children had outside of the clinic. Having studied clinician talk in closed meetings as well as in clinical interactions, Buchinder (2015: 61) wrote that, “clinical explanatory models are shaped less by scientific knowledge of a disease than they are by the practitioner’s therapeutic objectives.” Jenkins (2015:25) echoes this sentiment that scientific EMs are not only complex biological facts, but when performed, they can also serve ideological and pragmatic functions within the constraints of local cultural settings. Thus, EMs not only describe clinical diagnoses, they accomplish clinical actions as well.

In her expansive ethnographic research on African-American families battling the chronic illness or disability of a child, Mattingly (2010) used video-recording of clinical encounters and small and large group interviews to identify and characterize three canonical genres of healing storytelling that provide “authorized action frameworks” to young patients and their families (ibid: 55-76). These genres included 1) healing as science detective story, 2) healing as battle, and 3) healing as machine repair, and the genres served to forge partnerships with caregivers and kin. Although the overall persuasive function of EMs is consistent across these studies and instructive for my own work, we will see that the content of psychiatric EMs in Puebla also diverge in important ways from the cultural assumptions that guide Mattingly’s healing genres.

According to Healy (1997), medical explanatory models can be categorized as clinical or scientific in nature, much like the parallel divide between biological and psychoanalytic psychiatry discussed by Luhrmann (2000). Clinical work is focused on therapeutic empiricism, conducted to help patients get better, and theoretical empiricism is employed to understand the properties of medications and how external influences affect psychological processes or illness etiology (ibid: 80, 111-142). For Healy, the pharmaceutical industry’s prominent role conducting clinical trial work in order to attain FDA approval has led to pragmatic therapeutic empiricism winning out. Both of these arguments underscore the fact that EMs can be an ad hoc justification for treatment alternatives or advancing the practitioner's therapeutic objectives, thereby potentially separating a clinician's emphasis on cause versus effect and how much they emphasize to patients the 'why' behind a phenomenon or 'how' it works.

Indeed, Explanatory Models are a translational process, and may therefore employ idioms, metaphors, or logics that are substantially different from those of scientific medicine. Clinical EMs are subject to the characteristics and culture of the interactional participants (Good and Good 1981; Jacob, et al., 1998; Kleinman 1980: 107; McCabe and Priebe 2004b; Ryder, et al., 2002; Waxler 1977), and interpretations of the nature of an illness may be contested in settings of local power relations (Good and Kleinman 1985; Kleinman 1987; Kuipers 1989; Mishler 1984). Using this fact as a starting point, this chapter examines how psychiatric providers in Puebla, Mexico, explained mental illness and its treatment to patients. As shown below, physicians work to make pharmaceutical and psychological therapies understandable, manageable, and hopefully – through successful patient buy-in and familial treatment engagement – more effective. To accomplish that, participating psychiatrists offer an EM framework founded on biopsychosocial causation and adaptive treatments aimed at holistic health rather than segmented biological or somatic conditions, which are presented as typical of Western views of disease (Marsella and White 1982: 16-17).

Materials and Methods

The present chapter draws from data collected with five psychiatrists explaining mental illness to patients during 63 clinical visits in the state psychiatric hospital in Puebla, Mexico. These data were supplemented with post-visit debriefs with all participating psychiatrists regarding specific cases and multiple one-on-one interviews with four of the five treating psychiatrists who participated in the study. The interviews covered topics such as each clinician's background and professional training, a psychiatrist's ideal role and its actual implementation in practice, common challenges that psychiatrists face with patients and with other physicians (such as stigma, patient fears, and difficulties with interdisciplinary medical referrals), the rationale guiding their selection of a treatment timeline with individual patients, and the accepted mechanism of action for psychiatric medications. These data comprise part of a larger study incorporating participant-observation, interviews, and audio-recording of clinical visits in Puebla, PUE, Mexico during 14 consecutive months between July 2013 and September 2014 and a follow-up visit between July and August 2015. The protocol was approved by the Institutional Review Boards (IRB) both at the University of California, Los Angeles, and *el Hospital Psiquiátrico Dr. Rafael Serrano* (henceforth referred to as *El Batán*) prior to start of data collection.

Using transcriptions of audio-recorded interviews and clinical interactions, the data were coded for all instances of the treating psychiatrist explicitly discussing any of the five components of an EM - that is, the origin, onset, pathophysiology, prognosis, and therapy of an illness – in a coherent narrative fashion after the patient had related their current complaint(s). This corpus was then analyzed, per Weiss and Somma (2007: 128-29), not only as causal accounts of illness etiology, but "representations of illness, described with reference to a set of cognitive explanations; symptomatic, emotional, and social experiences; and to prototypic personal history and associations that collectively characterized the illness at a particular point of inquiry." For my purpose, that point of inquiry was the present moment.

Consent Process

After a triage physician confirmed patient eligibility during their initial visit to the hospital, patients were introduced to the study and given time to review the consent form and consider participation. Most participants signed consent and initiated study procedures at their second visit, where their clinical history was taken. In addition, verbal consent of all parties present in the room was provided before recording each clinical visit. The five psychiatrists who participated were introduced to the study during a group staff meeting, and they were given the opportunity to speak with the principal investigator afterward and voluntarily enroll themselves at a later date. All study procedures analyzed here were conducted in Spanish.

Clinical Visit Structure

A brief outline of the structure of clinical visits and the context of psychiatric care in this setting will be provided. At *El Batán*, new patients underwent a rapid assessment of symptomatology during a 20-minute triage visit. When appropriate, medication was started at that time, and a second visit was scheduled with a different provider (either a staff psychiatrist or a psychiatric resident in training) approximately two to three weeks later in order to evaluate the patient's tolerance for the medication and gather a complete clinical history. During that second visit, psychiatrists were encouraged to put the initial diagnosis aside and see if they independently arrived at the same diagnosis as the intake psychiatrist. At the end of this session, a diagnosis was verbally given to all 27 participating patients using the DSM-IV-TR terminology. A table outlining the diagnoses given is provided below (see Table 3), with moderate or severe depression being the most common diagnosis. Some patients in the study sample received multiple diagnostic labels at the same time. During the course of treatment, only one patient's diagnostic label changed (from Obsessive-Compulsive Disorder to Bipolar

Disorder) in light of significant evolution in her symptoms,[47] and six patients were formally diagnosed with a mood disorder and a personality disorder. Irrespective of their diagnosis with depression, schizophrenia, or another mood disorder, psychiatrists reported that the presence of specific personality traits consistently complicated treatment and they speculated that it worsened patient prognosis in the general clinical population.

Table 3. Breakdown of diagnoses assigned to returning patients in study sample (N = 27)

Diagnosis	**Frequency (# of patients)***
Depressive Disorder (moderate or severe)	13
Generalized Anxiety Disorder	5
Mixed Anxiety-Depressive Disorder	3
Paranoid Schizophrenia	2
Obsessive-Compulsive Disorder	2
Attention Deficit Hyperactivity Disorder	1
Bipolar Disorder	1
Dysthymia (low-grade, chronic depression)	1
Personality Disorder	6

* Note: Some patients received multiple diagnostic labels

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[47] This patient was named Guadalupe for the purposes of the present research. Her story is discussed in more detail elsewhere.

After a patient received a diagnosis, an extended explanation of the diagnostic label, as well as the onset, appropriate therapy, and prognosis of their ailment followed in more than half (16/27) of the above cases, indicating the expression of an explicit explanatory model or EM (cf. Kleinman 1980: 104-118) that addressed some or all of the five components described earlier. Psychiatrists detailed various aspects of illness presentation throughout clinical visits, including what to expect with new medications, the appearance of new life stressors that would merit recognition, and/ or management of comorbid health problems that arose over time. Our focus here is on the clearest examples– often delivered through one-sided speech by the psychiatrist.[48]

The EMs provided in the course of clinical transactions were supplemented by interview data with the participating psychiatrists, conducted privately, separate from clinical visits with patients. As mentioned earlier, these interviews covered topics such as treatment guidelines and common presenting fears among new patients, as well as broader questions such as their personal motivation for studying psychiatry, how to characterize the local practice of psychiatry, and how they view their role as psychiatrist within the institutional system. These conversations detailed how treating psychiatrists balanced their roles as subjective clinical interviewer and objective analyst of patient reactions to the medications they administered. Psychiatrists selectively packaged scientific findings when explaining them to their lay audience, and both interview data and post-visit debriefs enriched my understanding of their decision-making process in integral ways. Fein (2011: 47-8) has said that "…reductions are metaphorically compelling and do significant social and interpretive work, and it is worth examining more closely what, in fact, this

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[48] A technical error with recording resulted in the visit dialogue for three patients not being successfully captured.

is."[49] The subsequent analysis examines the representative themes from physician explanatory models in an effort to do exactly that.

Background

Historical explanations for mental illness in science

There is a long, complicated history of research and critique on the subject of the etiology of specific psychiatric disorders (cf. David Healy 1997, 1998a, 1998b, 2000). Psychiatrists often refer to the widely known monoamine hypothesis of affective disorders (Schildkraut 1965; see also Castrén 2005: 241; Healy 1997), which hypothesizes that a chemical imbalance in the brain underlies mental disorders and a medication specifically targeted to the offending neurotransmitter system can correct the underlying pathophysiology. For the sake of argument, the case of the serotonin hypothesis of depression will be reviewed, as depression is identified as the most common mental disorder in countries all over the world (WHO 2009). Nevertheless, it merits mention that the dopamine hypothesis of schizophrenia follows a nearly identical history (cf. Healy 1997: 147-48), as both drug classes were born out of an original interest in antihistamines (Healy 1997: 43-44, 48).

The well-known serotonin hypothesis of depression originally postulated that drugs which increase catecholamine production (esp. norepinephrine) were associated with behavioral stimulation or excitement, thereby producing an 'antidepressant effect' in humans, and that likewise, a drug that causes depletion or inactivation of catecholamines would produce sedation or depression. In reality, a cascade of disturbances across physiological systems influenced disease presentation, meaning that depression is unlikely to be a disorder of one neurotransmitter

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[49] Fein wrote this specifically in relation to the generalization of the Asperger mind-as-machine metaphor.

or receptor type. The catecholamine hypothesis was reverse engineered from the drug effects of antidepressant administration rather than an understanding of etiological disease mechanisms (Radden 2003; Lacasse & Leo 2005: 1212). This empirical proof-by-association is similarly implied when labeling a psychotropic medication as an ‘antidepressant’ or a ‘mood stabilizer’ due to its mechanism of action and intended effect.

Afterward, research continued to challenge such functional labeling given that although SSRIs should help symptoms of both mild and moderate depression, “…strictly speaking this has not been shown… There is increasing evidence [see Katon et al. 1995] that patients with milder depressions do not always benefit from antidepressants” (Healy 1997: 103). Furthermore, a double-blind, placebo-controlled study of an antipsychotic medication named reserpine verified that medication was an equally effective treatment for anxious depressions (Davies and Shepherd 1955). Even half a century later, this uncertainty regarding the mechanism of action of such mediations endures, with in light of the fact that available antidepressants work in only 60% of patients (Gartlehner, et al., 2007) and attempts to cause depression by depleting serotonin levels are unsuccessful (Heninger, et al., 1996).

Although debates rage, findings are inconclusive regarding the identification of stable [bio]markers in the pathogenesis of depression, such that most data indicate that mental illness has a multifactorial etiology. Causal theories of mental illness, like the dopamine hypothesis of schizophrenia, should be viewed as the final common pathway, where neurochemical changes could just as easily *result* from the convergence of multiple environmental risk factors, structural abnormalities, and functional impairments (Nemeroff 1998: 42; Howes and Kapur 2009). Until proven otherwise, the direction of influence between experiential and environmental stimuli and physiological processes remains unspecified (Hess, et al., 2014: 182-185).

At the time of Schildkraut's seminal research on the catecholamine hypothesis of depression, he acknowledged that it was not possible to definitively confirm or reject the hypothesis given currently available data. Even so, he wrote that this hypothesis was "of considerable heuristic value, providing the investigator and the clinician with a frame of reference integrating much of our experience with those pharmacological agents which produce alterations in human affective states" (Schildkraut 1965: 518). This remains true today, where neurobiological and neurochemical etiological explanations of psychiatry dominate in the media and among laypersons in the U.S. (Cohen and Hughes 2011; Dumit 2004; France, et al., 2007; Luhrmann 2000), even though in practice, most American psychiatrists view such explanations as a metaphor for drug treatment rather than an accurate representation of such drugs' mechanism of action (Pies 2011).

Notions of chemical imbalances and medication metaphors have been widely mobilized by pharmaceutical companies to advertise that medications such as the atypical antipsychotic, aripiprazole, work in the brain "like a thermostat to restore balance" (Lacasse and Leo 2006:1192). By emphasizing that psychotropics produce positive results, such neurochemical imagery persuasively fills a conceptual and experiential gap. In turn, this causal model can generate specific metaphors that allow for shifts in patient experience and attitudes over time (cf. Rhodes 1984: 59). In other words, given that medications 'work,' they provide adequate proof for patients seeking solutions and are sufficiently generic to apply to changing illness symptomatology. Therapeutic empiricism trumps theoretical empiricism (Healy 1997: 122) and the catecholamine hypothesis remains appealing when managing affective disorders and determining the fit of psychotropic treatment.

Recent research by Kemp, et al., (2014) has tested the effects of using the chemical imbalance theory as an explanation among individuals who were themselves suffering with depressed symptomatology, and they found sobering results. Investigators randomized 73 individuals with a self-reported history of past or present depressive episodes to conditions where their symptoms were to be explained as either caused or not caused by a chemical imbalance of serotonin in the brain. They then administered a sham biological test of saliva collection and provided participants with a bar graph of their test results, which told participants in the test condition that their serotonin levels were much lower than other neurotransmitter levels in the brain. Afterward, a battery of tests was performed to screen for depressed mood[50], as well as patients' causal attributions for depression, their beliefs of personal control and blame, their perceived efficacy of pharmacological and psychotherapeutic treatments for depression, and a deception credibility questionnaire to assess the efficacy of the test manipulation. The study team found that their test manipulation strengthened the belief in a chemical imbalance causing depressed symptoms, but this explanation did not affect self-blame, and it failed to reduce stigma as defined in their study. Significantly, this biochemical imbalance theory made participants in the test condition feel less capable of self- regulating their mood and managing their symptoms, as well as more likely to believe that pharmacological treatment was more credible and more effective than psychotherapy. The research team speculated that the 'chemical imbalance' EM engendered negative beliefs about the intractable nature of their illness that could worsen the course of depression and weaken treatment response.

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[50] Please note that this study screened depressed individuals using a single question rather than a validated inventory such as the Beck Depression Inventory (BDI) or the Center for Epidemiologic Studies Depression Scale (CES-D), which would have provided stronger support. The question ("Have you ever experienced a period of at least two weeks during which your mood was depressed most of the day, nearly every day, that was not a normal response to a significant loss in your life (such as the death of a loved one)?") was drawn from criterion A.1 for major depressive disorder in the DSM-IV-TR.

Reflecting back on the predilection for neurochemical or neurostructural EMs with the above findings in mind, the emphasis on the mechanism of action for medications simultaneously obscures the issue of *how* such treatments work. If mental illness results from an underlying chemical imbalance or a damaged neuronal network caused by a 'short' in the system, then that suggests that a structural abnormality exists and the medication would compensate for the difference. This perspective is echoed among American psychiatric patients in the oft-quoted phrase, "If you can't make your own neurotransmitters, store bought is fine."[51] If instead, mental illness results from developmental changes in the brain across the life course, then the brain (or specifically, its neural networks) are malleable. In this adaptationist framework, ailing neuronal connections could theoretically 'reconnect' or adapt by either repurposing existing networks or creating new neuronal connections, allowing for the eventual removal of the need for medication.

Physicians in the present study consistently aligned with the adaptationist framework I described second. Psychiatrists' EMs were consistent among psychiatric residents in training and attending physicians in the clinic, with little variation as a function of years in practice. Using a multi-pronged treatment intervention to biopsychosocial patient care (cf. Deacon 2013: 856), physician EMs described the role of multiple factors in causing parts of the brain to 'disconnect.' Then, local psychiatrists would use pharmacological treatment to intervene on acute distress/ symptoms and 'rewire' the highway of neural connections before following up with subsequent - but not secondary - treatment with psychotherapy and lifestyle changes (such as dietary changes, sleep hygiene, and exercise). They emphasized that the primary work of psychiatric care was done through these later 'maintenance' treatments, which would help restore the patient's health

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[51] This phrase can easily be found via a Google web search.

and well-being, rather than merely managing a particular symptom set. Of note, they regularly provided an estimate for the length of time patients would need to remain in psychiatric treatment before they weaned them off of medications – typically lasting 8 months to 1.5 years. Finally, they demonstrated concern over family life and transportation challenges that might bar access to the hospital, although they did not personally offer psychotherapy.

This is a significant departure from the narrative of psychiatric treatment and recovery without cure in the United States of America (e.g., Jenkins and Carpenter Song 2005; Rhodes 1984: 55; and many others), which suggests that medication – particularly antipsychotic medication - must be taken for life in order to maintain certain chemical levels in an impaired or broken system. However, American EMs have not been elicited during clinical interaction, and further ethnographic precision is required in research on psychiatric Explanatory Models in order to evaluate the actual emphasis placed on the biology of mental illness across patients[52] and across cultures.

As argued by Deacon and Baird (2009), bioreductionistic explanations have the potential to negatively influence patients, making it even more important to stress that psychiatric disorders stem from multiple factors and cannot be directly linked to a single genetic mutation or the dysfunction of a certain brain area (Panksepp 2004). Such biological explanations can imply that psychiatric disorders are intractable and that patients lack control (Fein 2011: 37-38, 43) and will become violent (Angermeyer and Matschinger 2005; Walsh, et al., 2002; see also Link, et al., 1992). Subsequently, laypersons (Schomerus, et al., 2012; Watters 2010) and psychiatrists alike (Loch, et al., 2011) may desire greater social distance from individuals with psychiatric illness,

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[52] The issue of symptom severity should also be evaluated in this framework, albeit separately, recognizing that the content of a psychiatrist's EM may vary considerably for someone with chronic, treatment-resistant paranoid schizophrenia as opposed to someone with dysthymia.

and in turn foster further stigmatization. These studies underscore the subjective and interpersonal effects of the cultural construction of illness as a biological disorder and the value of expectation management in relation to illness course and treatment timelines. It is imperative that researchers and clinicians heed these results and work to reduce stigmatization, which patients identify as one of the most devastating parts of having a mental illness (Corrigan, et al., 2004). Researchers and clinicians alike need to be extremely clear regarding what they know, how they present that information, and what an explanation implies.

Results

Psychiatric Explanatory Model of Mental Illness

The EM held by psychiatrists in the present study was elegant and outlined at length. Review of the data reveals three overarching points: 1) psychiatric disorders were assigned a neurological foundation localized in neurochemicals or neuronal networks, where stressful or traumatic life events could trigger symptom presentation, 2) EMs were surprisingly generic, irrespective of the psychiatric disorder being treated, and 3) EMs did not address each of the elements of the comprehensive treatment plan which followed. Whether the diagnosis was depression, bipolar disorder, anxiety, or obsessive-compulsive disorder, proximal causal explanations located the problem in their neuronal network and its disregulated firing.[53] Such neurochemical metaphors of imbalance avoided specifying whether the problem was an overproduction or underproduction of chemicals such as serotonin or norepinephrine, or rather an issue of a 'short' in the wiring of neuronal networks. No structural or functional brain differences were identified *between* psychiatric diagnoses, and etiological explanations did not

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[53] The two schizophrenic patients in my study sample served as an exception to this statement. Their ailment was described as more biologically based, more chronic, and requiring lifelong treatment.

invoke particular treatment assignment. This is directly in line with the background literature cited above, which has shown that the monoamine hypotheses of depression and schizophrenia emerged out of the observation of drug effect, rather than through an understanding of the basic science research regarding the underlying disease mechanism. In other words, physicians spoke only to the available data accepted by the scientific community, and they left out other elements that remain uncertain. However, physicians still successfully performed expertise and marshaled respect even though, owing to the fact that science has not parsed the pathophysiologic process, their EM of neurochemical imbalances was quite vague and incomplete.

Thus, the first step for all patients was to take a medication that would intervene on this abnormal neuronal firing and retrain the brain, with psychotherapy and lifestyle changes (including dietary changes, sleep hygiene, decreased coffee intake, and exercise) intended to follow after the medication took effect and alleviated acute symptoms. Psychotherapy and lifestyle components of the multistage treatment model were raised by the psychiatrist once patients transitioned into the maintenance phase, giving primacy – but not prominence - to medication.[54] As mentioned in Chapter 2, hospital psychiatrists at *El Batán* would stress that "The medication is forty percent of your treatment – the other sixty percent is coming to therapy, exercising, etc." Other common saying were that "the drug is like a boost," but that the patients would benefit most from comparing their current symptoms to their intensity when they first began, as the relative comparison would help them see that they were adapting and effectively, getting better. For example, Dr. B told Providencia "As you've seen, the drug is like a boost. And it has calmed you down, but that's only fifty percent. Maybe even less. The rest is understanding what to do if a stressful moment comes along, and therapy is the fundamental

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[54] Past research (Rhodes 1984: 62) echoed this sentiment that medication "comes first" in treatment, and once patients have better control over their symptoms, they can work through psychotherapy or other interventions.

aspect of that" (clinical visit on 6/2/2014). These perspectives on medication and behavioral interventions contrast with Kemp and colleagues' (2014) concerns that 'chemical imbalance' EMs reduce self-efficacy and a patient's ability to regulate their own negative moods, and have the potential to produce significantly different patient outcomes.

The psychiatrists sought to impress upon patients that the maintenance treatment phase lasted much longer and, with the exception of schizophrenic patients,[55] was more focused on long-term behavior change than medication in order to avoid relapse. The beauty of their explanation was that all five participating psychiatrists recognized that the brain is just the final step, and they acted in favor of separating out the demonstrated effects of medication on specific symptoms such as sleep, mood, etc.[56] during their presentation and explanation of diagnosis. This is in line with the fact that psychotropic medications do not fit the old analogy of a 'lock and key' for precise drug action, as outlined by John Langley's receptor theory in 1905, but rather act on multiple targets (Healy 1997: 146; Hopkins 2007).

Data Analysis

Below, an extended excerpt recorded on May 30, 2014, has been reproduced in its entirety in order to better depict the psychiatric EMs employed in Puebla. The selection opens with a female psychiatric resident closing her first visit with a 44-year-old female patient whom she has

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[55] Among schizophrenic patients, physicians identified a stronger genetic component in the presentation of illness and medication – not psychotherapy - was viewed as central to their treatment.

[56] The alternative in this situation would be for psychiatrists to use medications only for their approved indications (i.e., an antipsychotic only for schizophrenia or psychosis, rather than also using it off-label to treat sleep problems). Healy (1997: 103) explicitly reminds us of the broader context of drug development and approval as relevant our guidelines for implementation, writing that "If the rules under which the 'game' has been played for the last thirty years were different and the drugs were produced for sale over the counter, where tension reduction rather than the cure of a disease would be more likely to sell the product, it seems quite probable that an entirely different package of study designs and rating instruments would have come into being.

diagnosed with Generalized Anxiety Disorder. This example was chosen because it provides a comprehensive picture of the overall format of physician Explanatory Models in this setting, and it is representative of the broader themes raised in the dataset. The lengthy 5-minute excerpt provided below begins 53 minutes into the visit, after the physician has covered various topics relevant to the patient's history, including her age, education, employment history, socioeconomic status, family history of disease, living situation, access to running water and light, sexual development, and her presenting problem.

Excerpt #1

Doctor: Okay, in terms of your diagnosis, now with everything you've told me, obviously this will get enriched as I continue to see you. Okay? But right now, from what we've discussed, I was able to determine a diagnosis: You are presenting with Generalized Anxiety Disorder, based on what I see to have started a long time ago. It's just that, as I've told you, there are many life factors that help it further express itself. Okay? What happened? You began with physical symptoms. That is, with gastritis, pains, and all those things. This is how our body expresses itself, okay? But not everyone expresses themselves the same way. However, in certain individuals it gets expressed that way. And people might call it "stress," right? But if it [the stress] advances and isn't controlled, it will present itself as Generalized Anxiety Disorder.

(approx. 2 minutes later)

Doctor: Okay, now: What's the plan? Or rather, what are we going to do? Well, the treatment that they started, and with which you have already had results, we're going to leave as is. The treatment that you have, Fluoxetine, is the indicated treatment for… for what you have, Generalized Anxiety Disorder. This treatment is very safe. It's a safe medication and it has to be followed closely. Good. Now, the treatment plan or the time that it'll take is approximately 1 to 1 ½ years.

Patient: Mm hmm. Yes.

Doctor: Why? Because this disorder, as I have already told you, isn't just because "This happened and then I felt this." I mean, <u>no</u>. It has been growing through certain situations. Okay? Apart from the situations and the external stressors, it's something you already carried. Okay? Due to certain things. For what you lived in your home, maybe, if you hadn't experienced this, things would have been different. There are lots of things, okay? We call this being "multifactorial." Why? Because they are the things that you've lived, moreso than just in this moment, through these stressful factors, certain neurotransmitters in your brain are changed. Okay? These control mood, anxiety, in other words you feel this way, such as feeling nervous…

Patient: Yes, yes, yes.

Doctor: Or worried.

Patient: Uh huh, exactly.

Doctor: These neurotransmitters regulate all of our mood and these are things that - I'm telling you - happen in everyone. Not just you. In everyone. In you, in me, in him. Okay? It's just that in these situations, they get disrupted. Your mechanism changes, okay? Then, the drug has to regulate them. For this reason, it has been shown that this amount of time is what's needed to regulate it. Until we arrive at the moment where it's already been cured.

Patient: Yes.

Doctor: Yeah? Okay. I need for you to take it correctly, as we indicate for you to take it. Because if you stop taking the medication because you already feel well, something is going to happen. At the time that you stop taking it, the brain will not see what happened. So here [in the brain], that regulation you were having will be cut. Then, in… I'm not sure – two, three days after suspending the medication, that will be lost. So it's as though, again…

Patient: You start over and have the same symptoms again?

Doctor: Exactly. Maybe, in the beginning, you might not have any problems. But afterward, yes.

Patient: In fifteen days?

Doctor: Yes. So it will not see what happened there. Therefore, for exactly this reason, you need to achieve taking the medication correctly for this year to year and a half, okay?

Patient: Uh huh.

Doctor: I, obviously, as I see you over time, I am going to be determining the time, okay? I'm giving you an estimate. If you are doing well, if everything goes well, this will be the time [limit to take the medication]. Okay?

Patient: Mm hmm.

Doctor: But it depends a lot on how you develop. Okay? It's an estimate. What is the prognosis? It's a good prognosis. You obviously need to continue with psychotherapy- psychotherapy, as much with psychotherapy as with psychiatry. Why? Because I've identified that there are things, past things in your life, that we should remove and heal, so that as an endpoint of all of this, you can continue getting better with the medication. Okay? So this is going- this is a treatment combined with psychology.

Patient: Yes.

Doctor: For this reason there is a good prognosis. It is a common ailment that has a solution. It has treatment. That's why we're here. Uh huh.

Patient: Yes, doctor.

In this encounter, the psychiatric resident divines a diagnosis of depression from the history-taking interview that had directly preceded this conversation. The psychiatrist reviews the five components of an Explanatory Model: she provides a diagnostic label for the patient's symptomatic experiences, the contributing factors affecting neurotransmitters as the final common pathway spurring illness presentation, the neurochemical changes that were referenced as clinical evidence and served as the proximate locus of the problem, the psychiatrist's desired treatment plan for this patient, and the patient's predicted prognosis. However, it is unclear whether a chemical imbalance is the fundamental cause of mental illness or the physiological manifestation of various developmental changes over time. In other words, neurobiological changes are posited as a final common pathway validating and warranting medication usage, but not necessarily the ultimate cause of the patient's problem.

She explicitly presents depression as a multifactorial illness with a strong corporeal component ("something you already carried") that could be a genetic predisposition or more specifically housed in the brain's neurotransmission system. At the same time, she does not reduce psychological phenomena to their biological basis. Instead, culturally recognized psychosocial stressors are identified as posing a threat to disrupt normal neurochemical transmission and activate one's dormant predisposition, resulting in physiological symptoms or alternative modes of expression (possibly referring to cultural idioms of distress), and ultimately, the presentation of mental illness. Thus, the patient's anxiety is depicted as starting a long time ago but the onset was enabled by many factors helping it express itself and compound normal stress into an entrenched problem. However, this Explanatory Model omits the process by which environmental stressors got 'under the skin' and disrupted the patient's neurochemical transmission through a multifactorial developmental process.

It is significant that Dra. M describes this disorder as something that "has been growing through certain situations," as it reveals some of the cards in this psychiatric resident's hand. Repeated examples in the data corpus reveal that the brain is not seen as part of an "assembly-line body" (cf. Emily Martin 1994) that has interchangeable parts, but it can be fixed or replaced. For example, when another patient asked "Why did this depression make itself at home in me?" the psychiatrist responded:

Excerpt #2

Doctor: Look, depression is an illness that changes part of the brain. There are – at times, it results from many things that we live in life. Okay? Family members die, um, things went wrong in life, we had many unfilled needs, they [our parents] treated us poorly as children. These are factors that can give me this disease. But sometimes it comes out of nowhere. Then there is simply something up there, above, that disconnects. And the medication makes it reconnect again. Okay?

Patient: Mm hmm.

Doctor: So, um, I think you have some of everything, since you were a little girl-

Patient: (interrupting) -For what happened with my mom due to my dad, because I saw her crying a lot…

Rather than reducing the disorder to genetic predispositions and/ or neurochemical imbalances, Dr. B situates the disorder in relation to chronic stressors which change the pragmatic functioning of the overall neural network. Disavowing a single 'ultimate' cause of mental illness, Excerpt #2 suggests that a cascade or grab bag of multiple predisposing factors (genetic predispositions as well as traumatic life experiences such as grief, poverty, starvation, and abuse) produce a functional change or 'short circuit' in the neuronal network. Then, either immediately following or some time later, symptoms arise and create functional impairment. By specifying that mental illness can come "out of nowhere" and that it "changes part of the brain," Dr. B implicitly nods to the fact that neurotransmission serves as the final common pathway (Howes and Kapur 2009) but not necessarily the ultimate cause of psychiatric disorders – that is still unknown.[57]

Returning to the five components of Kleinman's EM framework, psychotropic medication was presented as the "indicated treatment" (see Excerpt #1) for various symptoms of psychiatric disorders. In both excerpts above, treating psychiatrists explained that the medication would intervene and help correct a neurochemical imbalance and regulate the brain in the short term. One of the female residents explained that,

> Our brain has different areas, and each area has a different function. There's an area for emotion, and we have a light that turns on and tell us when there's a lion in front of us that we should be afraid of and run away from. Normally, it helps us survive by turning on when it needs to kick us into gear. But in some people, that light gets turned on more often or all the time. So here, we give medication that teaches it when to turn on and how to operate. Once that area is trained, the light will go on at normal times and you'll feel better.
>
> (fieldnotes, 2/27/2014)

Physicians felt that the brain was always learning and changing, and that with time, medication could model correct functioning until the brain learned to do so on its own again. In other words, medication could effectively retrain or 'rewire' the brain. In Excerpt #1 above, the psychiatrist explained that, "through these stressful factors, certain

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[57] The possibility exists for stronger biological predispositions or stress autonomy models in the literature (cf. Monroe and Harkness 2005), although little research has been done on the assessment of "everyday" stress rather than major life stressors.

neurotransmitters in your brain are changed/ disrupted…. Then, the drug has to regulate them." This neurobiological representation of the treatment model was consistently supported by all psychiatrists working with mood and psychotic disorders.

In line with this view, psychiatrists almost always included a specific treatment timeline as well. In Excerpt #1, Dra. M estimates that it will take one to one and a half years to correct the problem, which did not start overnight and will not be corrected overnight either. Other psychiatrists similarly estimated a treatment timeline between six months and one and a half years, as seen in the bold section below:

Excerpt #3

Doctor: How do you explain what happened to you? Why do you think this happened to you?

Patient: I still (haha) don't find any explanation. Ha.

Wife: Well, it could be that… because of his brother and that same [happened] to his father.

Doctor: It could be. But it's not – if you have children, it doesn't mean that will happen to them. It could happen to them. If you have four [children], maybe one could- could end up having that happen. Why do I ask you this? Because maybe – I'll answer it. It's something that happened to your brain. For some reason, some flaw [there]. It created a short circuit. But that's something that can be corrected. Right? And that's done by taking the medication, especially Citalopram, which is the medication that interests me the most. **You need to take it for about six, eight months – up to one year. That's the one you need to take. If in six months, you feel well and stop taking it, there's a high probability that this will happen to you again in five, in ten years. And the idea is that this doesn't happen to you. Therefore, that's why it's important that instead, you take it for one year**.

Comparable timelines were estimated in other cases as well, such as Excerpts #5 and #6, which will be discussed shortly. When I explicitly asked psychiatrists about the rules guiding their treatment timeline recommendations, they stated that there are two kinds of studies that support these baseline estimates and guide their decision-making process. Dra. M concisely explained it in the following manner (see Excerpt #4):

Excerpt #4

Investigator: Are there rules regarding the amount of time that a patient needs to take the medication. For example, I've heard many doctors here say, "Between eight months and one year." But why? Is there a study that says that in that period of time, something changes in the brain, is it only the recommended clinical maintenance period, where afterward a patient can stop the medication, or how is it?

Doctor: From what I know, there are two kinds of studies. Yes, there are studies that have demonstrated that after one year, there are certain structural changes to what existed before. Or rather, there's a difference, right? Maybe (given that we obviously haven't seen it because we never get an MRI of it), but yes, there are studies about this. And clinically speaking, um, in terms of the clinical assessment of how the patient improves, there – yes, I've also seen it and there are studies regarding how long… For example, there are studies where they are treated for one year and stop. In others, [that happens] in a year and a half. Then, they saw which of them relapsed. Thus, the patients from [the treatment group] of one year relapsed more. So, those who were given less time relapsed more. It's those taking it for a year and a half who relapse less.

Therefore, the desired effect of antidepressant treatment is produced primarily through long-term adaptive changes in the structure of the neural network and information processing (cf. Castrén 2005) rather than only the initial effect of chemicals on monoamine metabolism (whose concentrations are expected to change alongside changing neural networks). This hypothesis is supported by research identifying impairments in depressed patients among the coordinated activity of several brain regions involved in behavioral processes such as emotional processing, memory, and attention processing (cf. Treadway and Pizzagalli 2014), and these adaptive changes are estimated to require 12-18 months to occur. Physicians recognized that many patients feel no need to continue treatment after they "feel well," and therefore underscored the fact that regardless, patients should continue their medication for at least one year to produce the desired structural effects. This part of the treatment plan required patients to place trust in the clinical expertise of their psychiatrist and accept that even though the desired neurobiological changes were invisible, those clinicians would know when to stop the drug.[58]

As noted above, psychiatric treatment at *El Batán* was almost always a two-pronged combination treatment using psychotropic medication(s) and psychotherapy to achieve successful recovery.[59] Once patients' symptoms improved and stabilized so that patients could successfully transition to the maintenance phase of psychiatric treatment, psychotherapy and adjusting behavioral habits became the preferred 'first line treatment' (cf. Chisolm 2011) because, as another staff psychiatrist put it, "We won't stop having problems just for having come here [to the psychiatric hospital]" (clinical visit, 6/2/2014). However, in contrast to the time spent visualizing neural networks in the brain, no etiological rationale or treatment timeline was provided for psychotherapy. Psychotherapy was constructed as integral to the treatment process, but not the underlying problem, as shown in the excerpt below between Dra. O and a patient named Juana:

Excerpt #5:

Doctora: Okay. Look, I have a very important assignment for youto talk about everything you've told me with your psychologist. Remember that the treatment – pharmacological treatment is a help. But a depressive disorder goes best with psychological treatment. Regardless, I'll adjust your dosage now so that you can also feel more *tranquila.* And what psychology will do is give you a way to confront all of these conflicts that you face in a more relaxed way (*de una manera más tranquila*) than you tell me. Uh huh? But you have to share <u>everything</u>.

Clinical Visit #3 with Juana on 4/02/2014

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[58] I thank Elizabeth Bromley for this insight.

[59] This contrasts with Whitney Duncan's (2016) research in Oaxaca's psychiatric hospital, which found that disciplinary biases made it so that referrals to psychotherapy were rare between psychiatrists and psychologists at the hospital (287), as were referrals from other medical specialties (183). Moreover, in contrast to Puebla, Oaxaca's status as one of the most ethnically diverse states with a thriving tradition of indigenous medicine also made it so that cultural practices or indigenous healing regimes were seen as mutually exclusive with so-called 'Euroamerican mental health ideologies' (210-217).

Dra. O emphasizes that psychology – not medication – is the ultimate answer, as it will teach people new skills, breathing techniques, and ways of viewing the world. Juana received psychotherapy at *El Batán*, with those visits directly proceeding or following her visits with Dra. O. On this particular day, Juana had just come from psychotherapy, and Dra. O encouraged the patient to go home and begin working on this additional "homework assignment," and she recognized that changing psychological and behavioral patterns is a process that would take time and work. Other psychiatrists, such as the staff psychiatrist Dr. B, echoed this same stance, emphasizing the importance of psychotherapy and behavioral changes: "Your treatment, or rather, the motive that brought you here, is not just to take drugs, but to also do additional activities. One is coming to therapy here, or going to therapy elsewhere. And the most important thing is that you also need to exercise… and be consistent about it" (clinical visit with Laura, 5/06/2014). Psychiatrists valued psychotherapy as a way to teach patients "how they ended up here" and what they can do to channel their emotions and avoid having another psychiatric episode. However, they did not explain how therapy or exercise would work to change their symptoms.

At first glance, it is unclear why more time was dedicated to explaining the use of medication than psychotherapy, especially in light of the value that treating physicians place on psychotherapy and behavioral changes. To some extent, they construct psychotherapy as more focused on gaining insight and coping skills than they do on understanding the diffuse, body-wide effects of the brain as the site of disordered mental functions that influence stress and emotional responses. Although this was partially a product of the disciplinary division of labor in the hospital, which houses psychiatrists as well as social workers and psychotherapists, individual interviews with participating psychiatrists gave further insight into why psychiatrists explained the brain and not behavior. In order to explain why he took so much time discussing medication adjustments and neurochemical levels, Dr. G said "[Neural] receptors get regulated and an antidepressant will start serving us after three to four weeks. Even so, the medications start working on the very first day. Or rather, patients take them and they start to act on this area [of the brain], but clinically speaking, that won't manifest until many months later, when the brain begins adapting to that regulation" (interview on 8/05/2014). Dra. M agreed that patients were suffering and seeking a quick fix, such that there needed to be a rationale behind why they should stick with their treatment even though they might not see changes after one day, one week, or even one month on medication. Although participating psychiatrists fretted that psychologists should explain the theory behind their actions, they did not realize that they only selectively do so themselves.

Multiple psychiatrists bemoaned the lack of patients who follow through with psychotherapy, speculating that those patients viewed it as "just talking" without a theoretical framework behind it (Dr. O., Aug. 25, 2014; Dr. G., Aug. 5, 2014). Unfortunately, they did not recognize their complicity in this problem. As suggested by past research cited above, emphasizing a problem to be 'neurological' or 'biochemical' in origin could imply that talk therapy would not fix the problem. Although psychiatrists were emphatic that medications were only part of the solution – and often, a small part at that – they spoke vaguely about exercise, psychotherapy, and dietary changes in comparison to the targeted, time-limited design of psychopharmaceuticals. The data presented above identify a tendency for psychiatrists to emphasize a specific mechanism of action for medications, even though they did not identify a parallel explanatory framework for psychotherapy. In spite of a strong shift from body as biochemical machine (Osherson and AmaraSingham 1981; Kirmayer 1988, as cited in Garro 1994) to viewing it as an interacting network, scientific EMs still support a psychological desire to localize problems within specific neurochemical signals or brain regions when conceptualizing mental illness rather than the interconnected <u>systems</u> of a whole person working together across various levels of analysis (neuronal, psychological, behavioral, and social). One psychiatrist underscored the evidence-based logic permeating psychotherapeutic care by explaining that even personality disorders are related to structural disorders in the limbic system which increases impulsivity and causes functional problems for patients (Dr. M., Aug. 9, 2014). This structural analysis isolates the body or brain from the self and does not factor in a subjective, phenomenological understanding of why individuals react in certain ways in response to particular settings or interactions.

Finally, Mexican physicians frequently emphasized lifestyle factors were integral to patients' overall health and well-being as well. Although physicians referenced the use of both psychotherapy and pharmacologic treatment to support a return to normal functioning, they added informal reminders to get outside and walk 30 minutes every day; sometimes, psychiatrists would simply check in on how a particularly volatile family relationship was going. Dr. B repeatedly remarked that "What we [as psychiatrists] try to do is help you get better and have a normal life." Patients reported that these questions instilled trust in their psychiatrist and led to patient satisfaction, but instead of viewing the content of the entire visit as part of their medical treatment, patients viewed psychiatric treatment as synonymous with medication.

Global Metaphors for Parity in Mental Healthcare

An additional finding in this study was that two psychiatrists also included the statement that "mental illness is an illness like any other," listing it from time to time alongside diseases such as diabetes and heart disease. This statement was typically said during the clinical history-taking visit, and it emphasized that mental illnesses are medical conditions in the same way that diabetes is a disorder of the pancreas (NAMI 2006). To take one example from the data (recorded on April 22, 2014):

Excerpt #6

Doctor: Okay, very well, *Señora*. I'm going to reiterate again. I think that what you have is something called depression.

Patient: Mm hmm.

Doctor: Depression is a disease. Just like you have hypertension, or high blood pressure, depression is another disease, it's just that depression attacks here (tapping his head), the brain. Because of that, you need medication. And you need to take the medication for a minimum of six to eight months, okay?

Similar statements were made in other visits, such as Dr. B telling Alicia, "This illness is like any other illness. It needs to be looked after and cared for, which is why you come here, so that we treat it and over time, as we see improvement, the symptoms will go away" (clinical history taking with Rosa, 4/21/2014). On a basic level, what mental illness had in common with other chronic illnesses is that both are medically managed through clinical check-ups and regular medication. Patients were expected to take the medication as indicated for a particular length of time, and remember that mental illness was not a life sentence - if it was treated, the symptoms would go away. The implications of this Explanatory Model were best expressed by a patient named José. After almost five months of treatment, the psychiatrist was wrapping up a visit when he said:

Excerpt #7

Doctor: Very good, Mr. (name). I'm glad that you're doing well. I think we've discussed, the kind of thing that happened to you – anxiety, depression – is something that you have to learn to… not <u>live</u> with, but it is something that isn't easy to get rid of. It is going to last a couple of … months, may be even years, right? I think you're moving along, you're improving, but I'm going to recommend that we use the medication for another six months. Okay?

Patient: Yes, doctor. What I think is if, for the past ten years, or no- maybe even fourteen [years], my life was pure, pure disaster, and I always only thought of myself, well right now is the time that I can remain in recovery. It doesn't matter if it took one, two, three years. The punchline is that if it's for my own good, let's do it, no?

José eloquently accepts that his recovery will not happen overnight, and that fact makes sense to him given that his mixture of anxiety, depression, and pathological jealousy developed over time. He was religiously committed to his psychiatric visits and bimonthly psychotherapy, and remained consistent even when I returned during the summer of 2015. In relation to the EM presented thus far, José's stance posits that if the brain can change in response to genetic predisposition as well as various external stimuli, then getting it to adapt or 'reconnect' could work through the same diversity of channels. Rather than feeling like their neuronal network is damaged and their situation is hopeless, this perspective indicates the brain is plastic and people are able to adapt.

Other patients similarly emphasized the importance of explicitly giving someone a timeline – and the hope that accompanies it. Rodrigo, for example, told me at the end of his study participation that he had never thought about how long he would need to take medication. After assuming it might take five years or more to feel well,

> The doctor here motivated me more than past doctors because he said I'd only have to take the medication for months – less than a year – before I get better. At the higher end, he expected to be able to discharge me after a year and a half. And, well, that motivates you to feel better and get better. One year is nothing after so many years of feeling badly
>
> Interview on 8/05/2014; timepoint: 13:24-14:05

Physicians worked to destigmatize psychiatric illness and quell patient fears regarding addiction to psychiatric medications by using these comparisons and indicating an endpoint to their treatment, and hopefully, their suffering.

Holistic Care and the "Mental Illness is an Illness Like any Other Illness" Trope

As noted above, a biological perspective of mental illness has gained support in recent years, advanced by an alliance starting in the 1980s between the American Psychiatric Association (APA), the National Institute for Mental Health (NIMH), the pharmaceutical industry, and the US National Alliance on Mental Illness (NAMI) (Whitaker 2010: 280). Similarly, international programs like the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) and the Mental Health Gap Action Programme (mhGAP) give priority to medication over non-pharmacological treatments as more portable and arguably more cost-effective (Sayers 2001: 1085; see also Biehl 2007; Farmer, et al., 2013). Although the deployment of neurochemical and neurobiological models of mental illness across the globe seeks to decrease moral blame by situating the illness outside of one's volitional control and in one's bodily predispositions and development, these high-profile actions might advance a singular emphasis on the biological basis or underpinnings of mental illness.

Thomas R. Insel, the past director of the NIMH, has championed the biological perspective, stating that mental illnesses are no different from heart disease or diabetes, except that it attacks the brain instead of another organ in the body. In 2014, he announced that NIMH would no longer fund psychiatric trials that addressed symptoms without working to parse the mechanisms underlying disease. Likewise, Eric Kandel, a Nobel Prize laureate and professor of brain science at Columbia University, has posited that, "All mental processes are brain processes, and therefore all disorders of mental functioning are biological diseases" (Weir 2012).

This viewpoint, alongside a desire to combat stigma, infused campaigns like NAMI's brochures and blog posts (e.g., https://www.nami.org/Blogs/NAMI-Blog/October-2015/9-Ways-to-Fight-Mental-Health-Stigma) displaying the slogan "mental illness is like any other illness" in order to promote a blameless, biogenetic framework of psychiatric illness, and put it on par with other ailments in order to foster better acceptance of the mentally ill among the public.

The literature in medical anthropology has tracked this slogan and other metaphors about mental and physical illnesses for several decades (Jenkins and Carpenter-Song 2005; Kirmayer 1988, 1992; Rhodes 1984:53, 57-66; Sontag 1978). As shown earlier in this paper, irrespective of the intended message behind arguments for blameless biological causation of mental illness, lay understandings of mental illness are strongly primed by social and moral beliefs that may negatively affect stigmatization of psychiatric patients. To drive home the point, during a comparison of the 1996 and 2006 General Social Survey's mental health module vignettes, conducted by Pescosolido, et al., (2010), found that although the "disease like any other" approach led to more of the public endorsing a neurobiological understanding of mental illness and supporting psychiatric treatment, stigma remained largely unaffected – and when it was associated, stigma increased rather than decreased.

When this trope was employed by psychiatrists in the present study, mental illness was often identified as comparable to particular chronic illnesses, such as hypertension or heart disease, thereby introducing the notion of it being something that should be 'managed' across the lifespan. At the same time, Mexican physicians in this hospital emphasized that the treatment timeline should be a relatively short course (6-18 months), and they did not want mood disorders to become incurable diseases like diabetes that required people to take a pill daily for the rest of their lives.[60]

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[60] Confining treatment to 6-18 months and then discontinuing it is in direct contrast to research in the U.S. For example, both Jenkins and Carpenter-Song (2005: 399) and Dumit (2012) indicate that patients are instructed to take these medications for the rest of their lives to chemically control their symptoms and avoid relapse.

Thinking back to our framing discussion of “mental illness is an illness like any other illness,” there are additional moments of breakdown. Although it would be a high-risk procedure, a patient can undergo a heart transplant. No human brain transplant has ever been performed. Furthermore, using that slogan still feds into a false division between mental and physical health by specifically comparing ‘mental illness’ to the unmarked category of ‘any other illness.’ When hearing that slogan or its inverse (“Mental health is just as important as physical health”), residents would joke “Is there even a distinction to be made?”, reflecting the DSM-5’s removal of the multi-axial system of disease in favor of a more dimensional approach (APA 2013:16) in order to align with international classification systems and scientific research regarding the problems with separating physical and mental health disorders.

This emphasis on the integration of the whole patient, across organ systems and various clinical complaints that patients might raise, represented the broad, comprehensive clinical role of psychiatrists, and their endorsement of practicing a biopsychosocial model of diagnosis and treatment.[61] Psychiatrists frequently fielded complaints of low blood pressure, rashes, excessive sweating, or medication refills for non-psychiatric ailments, and many of them explained that distress affects both the body and mind. Guided by scientific research, physicians indicated that alterations in neurotransmitters could lead to alterations in behavior, and vice versa. As demonstrated in Excerpt #1, where the patient began with stomach pains and nausea, and was later diagnosed with Generalized Anxiety Disorder, it was possible for an emotional stressor to

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[61] Ramón de la Fuente Muñiz, the founder of the Mexican Psychiatric Institute, was a strong proponent of the holistic and humanistic nature of psychiatric medicine. As he once wrote, “In my opinion, the value of current psychiatry not only is based on the fact that it is more scientific and experimental but also on its perspective, on its broader and more coherent guiding framework that does not lose sight of the subjective and social side of human predicaments” (Ramón de la Fuente and Heinze Martin 2014: 530).

lead to a physiological symptom or vice versa. Therefore, it was necessary for them to examine the whole patient, and not just the 'organ' (the brain) specific to their disciplinary specialization.

Psychiatric residents explained that globalization has made it so that scientific knowledge is shared and all psychiatrists can study the same things, but a divide exists between psychiatric care in the U.S.A. and countries like Mexico, stemming from the organizational infrastructure of Mexican healthcare making it so that a patient might travel all day to see their psychiatrist or wait six months or more for a brain scan. As a result, Mexican psychiatrists feel that their responsibilities are "*muy amplias*" ("quite broad") and require them to be more clinically focused (Dr. M, Aug. 9, 2014). Distilling the task at hand, Dr. G stated,

> The role of the psychiatrist should be - and I believe that it is – to be an intermediary between the medical sciences and – although it's terrible to say [that it's] rare – mental health. … Our role is to be comprehensive. To see the individual medically as well as socially because everything – everything, in the end, affects people. From the fact that they are sick with something to that they have diabetes or hypertension, everything, everything, everything can produce a symptom. But that's not all either. I mean, if you have problems at home, with your son, with your work, that can also give us a symptom. It's not that we are situated here saying, "Ah yes. We only give you drugs and the social workers should give you their advice"
>
> Interview on Aug. 5, 2014

Many physicians would conduct a general physical, order blood work, and at times request a brain scan in order to holistically assess a patient's health, with the rationale being that many things are relevant to their practice as psychiatric providers. Participating psychiatrists also emphasized that their comprehensive role became more important given the rarity of referrals from primary care to psychiatry as well as the fact that few patients in this particular population are up to date on their healthcare check-ups.

Discussion

In the cases presented above, it is evident that psychiatrists presented patients with nuanced understandings of mental illness. They emphasized that various influences (hereditary, biological/ neurochemical, environmental and socioeconomic) incrementally influence the course of neural development and affect someone's susceptibility to particular disorders, rather than psychiatric disorders having a direct biological cause that bypasses the mind and individual experience. Then, situational stressors were framed as 'triggers' that alter the brain and could push these physiological propensities to culminate in the presentation of mental illness for an individual patient. In this framework, no individual factor is assigned etiologic primacy.

By examining clinical interactions, it quickly becomes clear that clinicians at *El Batán* present psychiatric treatment as consisting of three free-floating components, where the treatment pathway may not be the same and individual patients may require more of one element than another. For example, some patients were directly referred to psychotherapy without receiving a prescription for medication. Others were instructed to take medication by itself for four to six months in order to get severe negative symptoms under control, and then add on psychotherapy and lifestyle changes during the maintenance phase of treatment. Yet others were instructed to immediately schedule psychotherapy and carry out both treatments simultaneously. This aligns with evidence that patients with milder depressions do not always benefit from antidepressants to the same extent that those with moderate or severe depression do (see Dowrick and Buchan 1995). Instead, physicians must determine the best clinical treatment plan for the individual patient in front of them.

Therefore, examining local practice in Puebla indicates that physicians clinically reason about the specific case in front of them. The clinical encounter in Puebla simultaneously attends to biological, psychological, and social dimensions of illness that may not be explicitly discussed, or at least documented, in other settings. The format of the history-taking interview, for example, explicitly incorporates socioeconomic status and the assessment of poverty and translates it into a psychosocial factor in psychiatric pathogenesis. Psychiatrists ordered labs (blood, urine, and sometimes CT scans) to check baseline values and would use that information to not only refer to a primary care provider as needed, but to evaluate comorbid diagnoses (e.g., hypothyroidism, diabetes, epilepsy) that might explain psychiatric symptoms or further predispose someone to mental illnesses like depression. So physicians did in fact voice an integrative, non-reductionist engagement with patients.

However, the data indicate that the etiological descriptions psychiatrists provided were more powerful than their proscriptions to change patient beliefs and behaviors. It is plausible that the lack of philosophical coherence in a truly biopsychosocial explanation makes it vulnerable to the dominance of one domain by either the clinician or the patient (cf. Benning 2015). As Jenkins (2015:39) has noted, parsing the key symbol of mental illness as a problem of ‘chemical imbalance’ serves to signal

> the neurobiological mechanism of illness and to suggest the psychopharmacological strategy for its treatment. It is precisely its imprecision and openness to polyvalent interpretations that allows the cultural notion to accomplish this work and thus that appeals to patients, kin, and physicians as a symbolic interpretation of what the problem could be.

At the same time, there seems to be a breakdown when presenting variables that are perceived as necessary versus sufficient for illness presentation. The aforementioned study by Williams and Healy (2001) highlighted the under-theorization of ‘conviction’ in most quantitative modeling of illness explanatory beliefs, where many researchers assume that belief strength and belief stability are one in the same. In actuality, patients may hold onto beliefs strongly for a short period of time in their search to sufficiently explain what they are experiencing, and with time, patients may be less receptive to new information that would substantially alter their beliefs (McCabe and Priebe 2004a: 164). Similarly, physicians may change the primary 'presenting problem' as medications make some symptoms abate or social factors change.

Research on narrative (Ochs and Capps 2001) and the structure of explanations (Lombrozo 2006) indicates that less detailed elements of a story reflect that they are less relevant, and these details are less likely to be incorporated into a cohesive narrative with prior beliefs. In this case, when fleshing out the logic of a biochemical or neuronal etiology as the rationale for taking medication, the psychiatrists provide invisible but tangible support for that decision. They do not do the same for behavioral changes by linking them back to the body or brain and how they are inscribed. The data encourage us to ask whether these generic etiological explanations, which are the same for patients with schizophrenia, depression, or a personality disorder, appropriately reflect the mechanism of change and anticipated timeline for it to come to fruition. When judging its rhetorical efficacy, it is important to explicitly state that the *subjective person's behavior* will be the long-term predictor of success.

Statements that mental illness is an illness like any other illness are indeed attractive to patients seeking a 'real' physiological basis of otherwise mysterious, invisible mental disorders. In light of the current pace of new publications coming out – 250 neuroimaging articles per year in PubMed alone (Treadway & Pizzagalli 2014: 1) – the rhetorical value of such explanations when seeking compliance is likely to be high. For example, research such as Weisberg, et al., (2008) and Racine, et al. (2005) have shown that despite identical content, explanations of psychological phenomena are more satisfying if they include seemingly objective neuroscientific information. At the same time, such images reproduce long-standing debates about objective measures and subjective assessment, as they are much better at showing structures and tissues than indirectly assessing functional, metabolic processes (Rose and Abi-Rached 2014:9-11), which are more closely tied to real-time patient mood and behavior. Such slogans could compartmentalize the illness (cf. Ferguson 2011:99-101) in a way that ignores the biopsychosocial etiology and implications of psychiatric ailments and may make it harder to move from interesting details to encode and later recall the main arguments (Weisberg, et al., 2008: 8).

Science still needs to produce a unified theory of the mental illness across its contributing factors in a non-hierarchical manner, as our current understanding leaves physicians with only partial causal evidence. Systems theory would imply both top-down and bottom-up directions of influence across different levels of organization, and this would be valuable to make explicit in psychiatric practice. Nevertheless, as will be seen in the next section, by imaging the structures and biology of our body, we may limit the imagining of our capacities.

Study Limitations

This study demonstrates that there is rhetorical, pragmatic value in using causal explanations in order to direct behavior, and that psychiatrists in Puebla hold an adaptationist framework for mental illness and its treatment. However, several limitations should also be mentioned. This study only examined outpatient clinical care, and may not be generalizable to inpatient care. The EMs presented to the acutely or extremely ill may be substantially different – or even absent. In addition, the multiparty interactional framework which functions as the norm in *El Batán* allows for open dialogue between the psychiatrist, patient, and co-present kin and clinicians use this space to advance psychoeducation as well as monitor medication management. This may not be consistent across national or cross-cultural clinical settings, and variation in the organizational structure of clinical visits may change the interactional dynamic and/ or the level of detail provided in EMs.

Clinical Implications and Future Directions

Using these data, clinicians may benefit from updating their neurobiological argument of chronic mental illness to carry over their metaphors of ‘rewiring the brain’ and include psychological and behavioral treatments in their explanatory framework – or alternatively, recognize the shortcomings of their current EM viewing the brain as the final common pathway and formulate a new explanation for public dissemination. Emphasized in non-clinical populations as often as clinical ones, cognitive activity (Gould, et al., 1999) and positive/ negative life experiences create synaptic plasticity/ pruning (Hebb 1949; Schwartz and Begley 2002) such that “what fires together, wires together.” Such synaptic and neural plasticity lasts into adulthood and can result from SSRI administration, but neurogenesis has also been found in response to exercise among individuals with schizophrenia (Pajonk, et al., 2010) and Parkinson’s disease (Petzinger, et al., 2013). Therefore, although our brains shape our predispositions toward illness and its malleability does have limits, patients can consciously act on their brains through therapy and physical and cognitive exercise and over the long-term to not only decrease stress but to some extent, to also ‘rewire’ their brains and their destiny. Such rewiring of the brain indicates a postsynaptic change that speaks more to direct or indirect medication effects (which could be achieved through other means) than it does to correcting abnormal presynaptic development. Emphasizing an adaptationist stance to mental illness can foster greater perceived agency among patients, and it would remind patients that the medication is not a ‘magic bullet’ that will resolve the physiologically localized problem on its own. Instead, patients need to address social and environmental challenges exacerbating their condition, and the government needs to support economic and infrastructural concerns in order to foster an adequate quality of life.

Likewise, if mental illnesses are comparable to other chronic diseases, then such metaphors should influence the way that individuals think about other chronic diseases as well, such that treatment of heart disease and high blood pressure would also benefit from the contextualized consideration of psychological influences and social determinants of illness – and health too - as has been suggested by Izquierdo (2005), Link and Phelan (1995), and many others. Of course, physicians would still need to emphasize that specific treatment timelines are still necessary to produce the desired effects, but they could then build psychotherapy and lifestyle changes into the Explanatory Model in a way that truly reflects a biopsychosocial model of health and not just of disease.

Finally, treating physicians need to be cognizant of what is left out of the clinical explanatory model that they develop when proposing a treatment plan. As Garro (1994: 776) has noted, there is interpenetration between individual schema and broader cultural [or professional] EMs, such as perspectives on mind-body relationships, which will influence an individual’s narrative sense-making of their illness and result in variability between individuals of the same cultural group.

Conclusion

In his closing post as director of the NIMH, Thomas Insel wrote that he had two deep convictions while leaving his position. “First, we can do much better by delivering the treatments we have today. We can save lives – many lives – simply by closing the unconscionable gap between what we know and what we do. Second, we don’t know enough” (http://www.nimh.nih.gov/about/director/2015/farewell.shtml). Insel’s quote reminds us that psychiatrists are both scientists and clinical practitioners, throwing Healy’s theoretical distinction between therapeutic empiricism and theoretical empiricism into empirical/ actionable relief. When it comes down to it, the currently available psychiatric treatments – which I emphasize include *both* pharmaceutical medications and talk therapy, per existing research evidence – can help many people if they are appropriately employed. At the same time, it is crucial to recognize that, despite having effective treatments for these disorders, scientists and psychiatrists do not have all of the answers with regard to the causation of mental illness.

This study contributes to the existing literature on professional EMs as disseminated during actual psychiatric care and goes beyond the tendency to focus primarily or even solely on causation and treatment to the exclusion of Kleinman’s three other EM components. As Buchbinder (2011, 2015) and Jenkins (2015) have shown, physicians selectively structure metaphors and other rhetorical strategies to warrant their treatment plan and secure the patient’s agreement. However, the present data go beyond that to also reveal more of the story regarding psychiatric providers’ explanatory models. Mexican psychiatrists’ EMs seek to pass on an accurate explanation of what they know, even if that explanation must necessarily be incomplete.

By tracing the above research developments, it becomes clear that biological phenomena or data are not inherently more fundamental or accurate, and they may not be as relevant to the daily lives and experiential knowledge of psychiatric patients. In Puebla, many patients struggled with the transition from taking medication in order to treat current symptoms and to then recognizing that coping and behavioral change were equally important to their ultimate success in psychiatric treatment. Young (1981) calls such connections "theoretical knowledge" that they can incorporate into their own knowledge and use as a model for future episodes. However, when psychiatrists in *El Batán* were interviewed, they noted that patients did not ask many questions. Despite being unclear whether it was due to an inability for patients to generalize from their current, known situation to a hypothetical future episode or due to physician EMs primarily reinforcing psychopharmaceuticals as viable treatments for this illness, when symptoms abate and patients felt better, both those patients and their family members oftentimes saw no reason to return. Therefore, physician EMs, just like patient EMs, would benefit from adopting a non-interactive, dimensional approach responsive to developmental change (Helzer, et al., 2008; Miller and Keller 2000:214) as each patient (with their own place on the spectrum of vulnerability and resilience) adapts and attempts to come to terms with the world in which she lives.

CHAPTER 4

Ecologies of Care and the Desire to be '*Más Tranquilo*'

Introduction

'Stress' can be a colloquial and imprecise term. In Selye's (1956) original formulation, the term was adopted from engineering terminology and referenced a force or "strain" which causes deformation in bodies. It was also ever-present, such that freedom from stress would be equivalent with death (Murray and Huelskoetter 1983). Initially, "stress" referred to "the collapse that may be witnessed in cardiovascular systems in response to blood loss or infections, rather than the emotional state that the word suggests to most people" (Healy 1997: 43). Now 'stress' encompasses the physiological reactions to stressors as well as psychological or social interpretations of external influences (Le Fevre, et al., 2003:727-730), which include symptoms of somatic and symbolic importance (Nichter 1981: 395) and can likewise catalyze positive or negative adaptation. As a result, a tension exists between individual and societal explanations for stress, where "Stress is at once the product of the fast pace of modern life and the failure of individuals to adapt to this environment" (Buchbinder 2015: 143). Successful adaptation to life's challenges allows individuals to de-stress in the face of acute and chronic stressors and attribute new meaning to previously stressful events (Garland, et al., 2009), viewing it as conquerable rather than insurmountable. Such responses can foster positive mental states such as contentment, peace, and well-being. However, once the demands placed on the body exceed the body's limits and are embodied as felt distress, existential upset or stressed social relations then create disturbances of body perception and body functioning (Low 1994: 157) that snap us out of the taken-for-granted experiences of the everyday.[62] These embodied metaphors of distress provide strong analytic purchase for researchers interested in moments of breakdown and change (cf. Zigon 2007), as a person goes through a challenging experience with the opportunity to respond actively, passively, or not at all, and in the process, that person can consciously or unconsciously throw the expected or desired order of life into relief.

Ten years after Mark Nichter's seminal work on idioms of distress, Kugelmann (1992: 3) wrote that stress constitutes 'both an experience and a [problem-solving] discourse." He noted that people oftentimes speak of stress as a way to identify problems and work toward adaptations or solutions to those problems, but many people feel discomfort from being on that threshold to produce positive or negative results. Stress certainly disrupts normal activities and functioning, and depending on one's personal coping style, stress and vulnerability can have very negative impacts on one's health (Nichter 1981: 402; Singer and Baer 1995; Young 1980: 137).[63] However, overcoming distress can lead to the revision of personal expectations or schema (Miles, et al., 1999) or provide growth experiences and greater fulfillment in life (Frankl 1986). Ultimately, stress is a given, and the grounded process of how an individual responds is an empirical question worth exploring further.

Research Methods and Setting

This chapter draws from 14 consecutive months of fieldwork in the capital city, Puebla, in the state of Puebla, between July 2013 and September 2014 and a follow-up visit in 2015 to

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[62] In its most extreme form, Jenkins describes "the profound bodily and psychic vertigo that is commonly experienced as one's sense of reality being ruptured (often recurrently) by traumatic events of penetrating assault" (2015: 241).

[63] One only need think of chronic illnesses resulting from persistent, high-level stress, which are also known as "diseases of civilization."

supplement existing data with homestays. I gathered naturalistic recordings of 63 clinical visits with 27 psychiatric patients, their psychiatrists, and any co-present kin in the only public psychiatric hospital in the state, named *el Hospital Psiquiátrico Dr. Rafael Serrano*, and colloquially known as 'El Batán'. Patients were diagnosed with a variety of psychiatric disorders, ranging from depression to obsessive-compulsive disorder to schizophrenia. The protocol was approved by the Institutional Review Boards (IRB) both at the University of California, Los Angeles, and *el Hospital Psiquiátrico Dr. Rafael Serrano* (henceforth referred to as *El Batán*) prior to the start of data collection. This chapter focuses primarily on the longitudinal audio-recording of clinical visits with psychiatric outpatients, all of which were transcribed and coded. The larger study administered demographic questionnaires, participant-observation in the clinic and the home, the Strauss-Carpenter (1972, 1977) Levels of Functioning interview, and family network drawings to participating patients. In the case of three participants, the data were supplemented by one-on-one interviews in order to better contextualize ambiguous uses of the term *estar más tranquilo*.

Past research identifying *tranquilidad* as a Latino value has most frequently been conducted among individuals from lower socioeconomic strata (Clark, et al., 2009: 388-392; Lewis-Fernández 1998; Martínez Pincay and Guarnaccia 2007: 20), although statistical correlations between low SES and the use of idioms of distress like *nervios* are inconsistent (Angel and Guarnaccia 1989: 1230; Baer, et al., 2003: 331; Finkler 1985: 45, 51). In the present study, all participating patients were enrolled in *Seguro Popular* (rather than covered by corporate or government insurance) and came from a low to middle socioeconomic status when compared to national averages.[64] At the time of this study, the Mexican Secretariat of Labor and Social Welfare (2014) had identified Puebla's minimum wage to be 63.77 pesos per day, earning an individual who works a standard 5-day workweek 637.70 pesos every two weeks. Among participating patients, the average household's *quincenal* (bi-monthly) income[65] was 1,614 pesos, with a reported range of 635-3,500 pesos every two weeks coming from personal employment or (in rare cases) dual earner households, cash transfer programs like *Oportunidades* (now known as *Prospera*), and family remittances. Using the IRS's average exchange rate for 2014[66], this average translates in U.S. dollars to $116.62 USD every two weeks or $3,032.12 USD per year (range: $1,192.92 USD to $6575.14 USD per year). Although Mexico boasts a large informal economy which makes it difficult to accurately track and compare average income, these values fall well below the national average household per capita income of 13,239.67 pesos per month (INEGI 2015b: 1) or $12,806 USD a year (OECD Better Life Index 2017). There were also two outlying data points. One participant reported that they had no income but would receive food from their children, and another reported receiving a meager 'allowance' from her spouse to buy groceries. Overall, economic difficulties were a common worry among study participants, and transportation to the psychiatric clinic was frequently mentioned as an additional stressor.

Early on in my research with psychiatric patients in Mexico, I noticed the high frequency with which psychiatrists, patients, and co-present family members alike mentioned being "tranquilo"

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[64] In comparison to INEGI's (2014) national averages, this study sample's range would parallel income levels of individuals living anywhere from the lowest income bracket (earning 7,717 pesos quarterly or 964.5 bi-monthly) to the sixth highest of ten income levels (earning 29,852 pesos quarterly or 3731.5 bi-monthly).

[65] Income was evaluated on the basis of households, rather than individuals, in consultation with local staff. This approach is also in line with other research regarding social class in Mexico (Gilbert 2007:12).

[66] https://www.irs.gov/individuals/international-taxpayers/yearly-average-currency-exchange-rates, accessed April 20, 2017.

or “tranquila” as a way to access arenas of suffering that they felt merited intervention. When I asked a staff psychiatrist about this term, he confirmed that the word can mean many different things in the psychiatric context, such as the patient being appropriately medicated and therefore non-aggressive at home, an individual being able to sleep through the night, or experiencing relief from their bodily symptoms or mental preoccupations (field notes, 9/23/2013). Psychiatrists used this language of being *más tranquilo* when asking patients to assess their subjective distress or subsequent improvement. However, patients and their co-present kin also spoke of being more calm, balanced, or tranquil. Relatives typically accompanied patients to the psychiatric clinic and would use the term *tranquilo/a* to reference moments when their relative was doing better. Patients sought it as a desired outcome of starting treatment, and after initiating treatment, *tranquilidad* indexed an interim state of improvement in not only the patient’s own body, but also broader social relations.

Seventy four percent of the study sample (7/8 men and 13/ 19 women) used the term *tranquilo/a*. In total, there were 65 contextualized references to either seeking or achieving *tranquilidad*[67] with enough surrounding context to analyze the meaning of the term. Thus, tranquility emerged as an important area for analysis, and I found that tranquility was a way to mediate or release stress and get better. Even though the term was consistently associated with social distress and troubles talk in this population, it served to identify what patients viewed as a goal of treatment. Having said that, this high frequency of use and clear relevance for both patients and clinicians was not an initial focus of my fieldwork, and only developed as an

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[67] For sake of clarity, a general definition of the word ‘tranquilo’ and its connotations is merited. The Royal Spanish Academy (*Real Academia Española*) defines the gendered adjective *tranquilo/ tranquila* as 1) quiet, calm, placid, peaceful; 2) (when said of a person) someone who takes things in time, without nervousness or stress, and does not worry about being right or wrong in others’ eyes. Wordreference.com, an online translation dictionary that is frequently updated for usage and includes regionalisms, lists ‘*desesperar (quitar la tranquilidad)*’ as an antonym, meaning “to exasperate or provoke anger, fill with despair, or to make lose hope.”

emergent finding through the course of fieldwork.

Theoretical Background

Tranquilidad can be translated as tranquility or equanimity (Lewis-Fernández and Aggarwal 2015: 444), and a collection of studies have identified tranquility as a desired state throughout Latin America (Ballesteros, et al., 2006; Clark, et al., 2009; Fabrega et al., 1967: 707; Lewis-Fernández and Aggarwal 2015; Martínez Pincay and Guarnaccia 2007; and others). Some of the above studies identified tranquility as synonymous with mental health or the well-being enjoyed when living ‘a tranquil life,’ based on data from focus groups or interviews. In my longitudinal data, however, this term is often employed when serving as an embodied response to extreme positive or negative emotions, or to physiological symptoms of *nervios*, which reveals how to realistically attain it through actions such as emotional management, physiological comfort or calm, social reassurance, and proactive engagement with environmental resources or sociopolitical factors. The term references equilibrium and control and is therefore an antonym and antidote to *nervios*.

At the same time, *tranquilidad* is not simply synonymous with happiness or wellness, as noted above. Instead of referencing a stable trait (*ser tranquilo*), conditional phrases such as *sentirse más tranquilo* (‘to feel calmer or more relaxed’) or *estar más tranquilo* (‘to feel calmer’ or ‘to be calmer’) were commonly employed. Such conditional expressions reference interactional behaviors and demarcate how both ordinary stress and extraordinary violence (cf. Das 2007) are woven into the language and experience of everyday life. When these phrases are used to reference tranquility/ equanimity, a person is typically not ‘there yet’ and may not feel holistically well, let alone better than well (cf. Elliott 2003; Rose 2007). The desire to be relatively more calm, rather than cured, echoes Euro-American psychiatry’s dominant model of recovery without cure (Jenkins and Carpenter-Song 2005; Myers 2015) and it fits with patients' temporal experience managing their inner emotional and physiological volatility, as well as the volatility of their immediate surroundings (cf. Jenkins 2015:12-13).

In the sections that follow, I review the primary findings from thematic analysis of the use of the term *tranquilidad*, which patients and their relatives used to index their struggles and hopes in relation to the pace of life in urban versus rural settings, financial (in)security, smoothness of familial interactions, physiological exertion or stress, and emotion control (or lack thereof). The evidence shows that the discourse surrounding *estar más tranquilo* unveils the good, bad, and the ugly for patients and co-present kin – that is, it references a broad array of current symptoms and dissatisfactions, as well as desired states and aspirations that are more appropriately reflected in phenomenological states and practices (i.e., one's habitus) than an idiom of distress or wellness. After all, as Jenkins (2015: 20) writes in her recent book, "… One must recognize that the magnitude of the suffering is matched by no less mighty a struggle to live and to be well."

While working with individuals with mental illness at a psychiatric clinic in Puebla, Mexico, I found it extremely common for participants – especially women – to say how rare it was outside of the clinic to have the opportunity to *desahogarse* (meaning 'to unburden oneself' or 'to get something off their chest') when faced with social and economic constraints. Within their cultural community, they felt the need to suppress most of their troubles while coping with the demands of day-to-day life (see also Cartwright 2007: 538; Lewis-Fernández and Aggarwal 2015: 454-456). They feared that these troubles might otherwise overwhelm them or make them ill. Despite this wariness, these patients developed a 'plan b' – or you could say, a 'plan be' - for coping with stress. They would openly discuss ways to foster positive emotions like inner tranquility (*tranquilidad*) and achieve a more placid home environment, placing value on the opportunity to decrease their stress reactivity and thereby offer them increased endurance during hard times. This focus on decreasing stress and fostering tranquility held true whether a patient was diagnosed with an anxiety disorder or not, mirroring the pervasive popularity of 'stress' as a common explanatory model.

For a couple of patients at this hospital, tranquility directly referred to tranquilizers or anti-anxiety medications that calmed their felt agitation and associated physiological responses, such as a constantly tapping leg. Esteban, for example, suffered extreme anxiety and he was a patient who constantly tapped his legs or fidgeted during his visits. He experienced anxiety attacks where tension built up until he suffered from terrible headaches and body aches. After our first interview, he emphasized how severe these attacks were for him, noting they had even culminated in momentary paralysis of his face or other body part. I have reprinted my field notes below to reflect what we discussed:

> Excerpt #1
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> After turning off the tape recorder, Esteban mentioned that the left side of his face had once 'frozen' after a past anxiety attack. This led him to visit a private doctor's office, where he was given an injection. He wasn't sure what the medication was when I asked, but he thought it was a tranquilizer. It quickly helped him be able to move his face again, but he emphasized that in the long term, it didn't stop the problem.

Field note on Esteban's first research interview, 4/10/2014

In the past, when Esteban experienced an attack, he used to go see a general physician and receive an injection for *los nervios.*[68] Although he could not recall the name of the medication when probed, he guessed that it was a tranquilizer, which are typically benzodiazepines. In this

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[68] Treating *nervios* with tranquilizers is common practice elsewhere as well (Barnett 1989: 166; Low 1988: 422, 1994: 149).

particular instance, the injection reduced his physiological tension enough that he could move his seized muscles again; however, he reported feeling '*traumado'* (traumatized) when reflecting back on this experience because it had not corrected the underlying anxiety causing the problem. He had been treated, but not cured. In contrast, after five months visiting the psychiatric clinic and taking clonazepam and venlafaxine, he happily described feeling 'stable' enough to calm himself down and resist the '*inquietud'* (meaning 'restlessness' or 'worry') in his legs (Interview #2, 8/05/2014). His anxiety had improved and he was more able to stop himself from tapping his leg – although even then I could hear his leg tapping from time to time while considering his present concerns and future plans.

For most patients, additional steps came in their search for tranquility after medicine took the edge off. They sought to not only calm themselves down and alleviate their psychiatric symptoms, but to also address financial or social problems that added pressure to their day-to-day life. It quickly became clear that the desire to be *más tranquilo* served as more than a personal adjective. It was an embodied response spanning psychological, physiological, relational, political, and socioeconomic issues that resemble Scheper-Hughes and Lock's (1987) 'three bodies' approach[69] to understanding the multiple layers of health, as well as illness. This paper reviews the various levels of turbulence or tranquility engaged by the expression of 'being more tranquil,' which yield an access point to arenas of suffering perceived to merit intervention.

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[69] Scheper-Hughes and Lock (1987:7) detail their 'three bodies' approach as connecting the individual body (with its lived experience) to the social body (i.e., society and culture's influence) and subsequently to the body politic (which involves the regulation, surveillance, and control of individual and collective bodies).

Environmental Stress

A brief glimpse into daily life in Mexico can help us understand how urban life and noise pollution disrupts one's daily life and produces stress for the average citizen of Puebla – let alone someone also suffering from strained gender roles, familial separation or disintegration due to migration, high levels of poverty and unemployment, or mental or physical illness. In many American neighborhoods, you might hear the mid-afternoon sound of the ice cream truck calling to kids as they pour out of school, but in Mexico, the soundscape is much louder and more complex. Early each morning, the city's silence is punctuated by the sound of the gas truck driving by. Soon after, you are likely to hear the call of the tortilla *motociclista*, the horn of the mailman, and the blaring music announcing the approach of the garbage collectors. As you go about your day, you may cross paths with street vendors yelling out their wares (*empanadas*, *tacos*, and ice cream) or feel startled but drawn to the squealing whistle of the *camote* (sweet potato) cart that appears at dusk. On top of the noise pollution from bustling traffic and public transportation, this lack of silence is also accentuated by loud house parties and religious festivals. While some of these sounds engender warm feelings of nostalgia much like that of the American ice cream truck, the sheer volume of sound in some neighborhoods has led to petitions to limit the noise level and hours of operation of these merchants and punish those who violate the ordinance (see for example, http://mexiconewsdaily.com/news/municipality-has-had-enough-of-loud-noise/). Even among Puebla's urban public parks which benefit from tree canopy cover absorbing sound, almost half exceed Mexico's noise emission threshold and three quarters of them exceed the WHO's more stringent limits (González-Oreja, et al., 2010: 489-90)[70]. For the average citizen, noise is simply a pervasive part of life in Mexico*, lindo y querido*. Peace and

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[70] Governor Rafael Moreno Valle Rosas has invested in the construction of new park spaces such as *el Jardín del Arte* and *el Parque Ecológico* since he took office in February 2011, indicating that an updated analysis is merited.

quiet is not.

The aforementioned issues matter because they contribute to the "rhythm of life" (cf. Jenkins 1997: 23-24; Jenkins 2015: 244-45) and they affect one's subjective involvement in not only symptomatic episodes but also everyday routines and institutional activities (see also Desjarlais 1994: 890). Traffic noise has been shown to correlate with elevated blood pressure, sleep disturbances, trouble concentrating, and emotional effects (Bluhm et al. 2007; Öhrström 2004; WHO 2000: 21-36). Study participants in Puebla endorsed various environmental factors as affecting their quality of sleep. A 40-year-old patient named Javier described his struggle over the past several years to "turn off his brain" and tune out various environmental factors that affect his sleep quality:

> Excerpt #2
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> Patient: Yes, I feel tired at night, but I close my eyes and tell myself "Sleep deeply, sleep deeply." Because I've closed my eyes but any noise makes me… You know what happened to me during the first few days? Mostly the first fifteen days? Um, I was asleep and heard the sound of the door or a horn or the passing of the bus, and I became upset. The next day was going to start and *los nervios* began, BUM!
>
> Doctor: But it's getting better?
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> Patient: It happens suddenly because I do... it stresses me out but not with everything. I calmly say, "You don't have to wake up for another half hour," but I lose sleep over it.
>
> Clinical visit with Javier, 5/22/2014

Javier had lost his job in Acapulco back in 2008. Since then, he had suffered from serious anxiety, where hearing a door slam or a rooftop dog bark would startle him awake and leave him troubled by the relative time he had to fall back asleep before the next day began, which in turn only made it harder to get the sleep he sorely needed.

Javier's experience shows that some stressors, such as ambient noise, are shared by all residents of Puebla proper, while other challenges and stressors that disrupted routines and well-being, are uniquely tied to an individual's sense-making and suffering. Rosa demonstrated how everyday contextual factors like hearing a neighborhood dog could morph into an extreme cause of distress. She was a 33-year-old woman who had worked as a *campesina* in the fields, but after the sudden death of her mother, she stopped working and began spending most of her time in her room. She could not remember why it started, but she developed a compulsion to wash her hands and her clothing whenever she saw a dog or heard one barking. With time, it had led to the formation of tough callouses, discoloration and scarring on her hands and forearms. After one month of treatment, she reported that, "The anxiety or – *los nervios* remain. I feel that I'm not *tranquila*… due to my hatred of dogs" (clinical visit, 6/04/2014). She went on to explain what went through her mind, giving us insight into her social context and what was "at stake" (Yang et al. 2007) in her daily life:

Excerpt #3
Patient: But, I was just thinking about "How I am going to wash?- How am I going to do this?…" I mean, the dogs are there, and everything gets me dirty. I feel that if something comes, that they are going to come in- before it wasn't that way. Before, it was only if I saw a dog nearby. But lately, if a dog were to bark, I feel like my dish or my clothing are already dirty. I don't know.

Doctor: Hey- and do you have dogs nearby?
Patient: Yes, one.

Doctor: Where?
Patient: In the house.

Doctor: Okay. Have you touched the dog?
Patient: No.

Doctor: And where does this dog live- or sleep?
Patient: Um, in the patio. Yeah.

Doctor: And do you go near the patio?
Patient: Yes. But I throw it out of there.

Doctor: Okay. Why do you get sad… now that we're talking about this?

Patient: I mean, because I feel like I don't (crying), um, I feel badly because I know that this isn't normal but I can't avoid it.

Clinical visit with Rosa on 4/4/2014

Her family had always kept a guard dog on the property, but about six months ago, the sound or sight of it started producing growing distress for her. Although Rosa described her behavior as unexplainable and burdensome, her sister connected her compulsion back to the loss of her mother and the possibility that Rosa felt life was out of her control. Her sister explained, "She was left with everything… she was left with all of the sadness and didn't let it out." Even though they tried to talk to her and encourage her to take a walk to distract herself, Rosa shut herself in more. She felt unable to leave and be away from a sink in case she encountered a dog and felt dirty, but recognized that these behaviors were overtaking her normal routines and sapping her energy. She was suffering. Therefore, she had agreed to come to the clinic and take medication, hoping that "I can be *tranquila*… Or rather, be well."

Although Rosa presented with more extreme symptoms, both Javier and Rosa remind us of the jarring social and physical surroundings that compose someone's "lifeworld" (cf. Desjarlais and Throop 2011) in Puebla. Some of these factors were there to stay, while patients could intervene on their interpretation of other sensory stimuli in order to feel *más tranquilo* and ultimately, be well.

Stepwise States of Tranquility

Expressions such as *sentirse más tranquilo* and *estar más tranquilo* highlight the dynamic process of working on physiological and emotional management; such expressions move beyond an evaluation of one's symptoms that might influence the stigma associated with a psychological or symptomatic framing (cf. Jenkins 2015:92). As noted above, these conditional expressions let patients indicate a stepwise change in one's condition or emotional state, even though an individual does not feel fully well. Javier, who struggled to get restful sleep in the face of various noises and his *nervios* in Excerpt #2, reinforced this process of improvement at his second clinical visit when he said:

Excerpt #4
Patient: With the medicine that the doctor gave me last time, better. I can't say that (in a high voice) "I feel happy" or…
Investigator: No, it's not like that.
Patient: No. But, I feel *más tranquilo.*

1st interview with Javier on 5/22/2014

At this time, he had taken the antidepressant fluoxetine for three weeks, as well as short-term treatment with the benzodiazepine alprazolam. Although Javier noted that he could not rid himself of his worries about employment, money for basic clothing, putting food on the table, and raising his children, during his interview, he reported feeling better – calmer – when reflecting on the three weeks that have past since his last clinical visit. Even though he could not say he is serenely focused or happy, his mood had improved and he felt less anxious or overwhelmed. While in the past he suffered terrible nightmares and trouble "turning off his brain," he was increasingly able to get restful sleep and recuperate after a long day in order to face whatever might come during the next one. By not having to "exert so much physical energy" in order to stay awake as the day wears on, he had reserves to work on his emotional responses and his interpersonal management style, and he took medication to change his biochemistry. At the end of this visit, he cited improved sleep and social relations as interim indicators of clinical improvement, and he looked forward to how things would develop during the course of his treatment.

A few weeks later, I met Tepin, who was a mother of two children living with her husband and seven family members in a three-bedroom house. One of her two children suffered from severe developmental delays, and she struggled to accommodate his special needs while also battling recurrent sexual assault by an uncle and her own depressive illness. She rarely had time or energy to speak with a friend or her spouse and *desahogarse*, so for her, the clinic offered a rare space to focus on her own needs and happiness. When she began taking an antidepressant at the clinic, she remarked on the relatively rapid changes that followed:

Excerpt #5
Investigator: And did you feel more energy that day?
Patient: Yes, I felt better… In fact, after I finished with everything, I already… It made me sleepy. And well, I went to bed relaxed (*me acosté tranquila*) because I had already had insomnia.
Investigator: Yes.
Patient: There are times, I can't sleep for the same stuff, because the entire kitchen sink was there, me sleeping, and my children. I don't- it's that I don't even feel comfortable to sleep. For the same reason. But now, what I do hope is that you all can help me to not feel what I feel, so that I don't feel tired, and now- I can be more… How can I put it? Well yeah, hurry up more in my household chores, with my things, with my children. Give them more attention because I also neglect them. For the same reason.

Interview with Tepin on 6/23/2014

Like many other people, this woman described her efforts to be less strongly affected by the jarring social and physical surroundings composing her "lifeworld," such as struggling to sleep soundly in spite of noisy appliances, her uncertain life circumstances, and the never-ceasing responsibilities lying next to her. From the beginning, she spoke of depression as a "passenger," rather than a core part of her identity, and she stated that "I came here to feel *más tranquila*" and improve (7/23/2014, timepoint: 7:17-7:22). After four months of antidepressant treatment, Tepin reported success at having found ways to tune out harsh relatives and maintain inner peace.

Without diminishing the gendered power relations and structural challenges that she faced, which could be validly read through the rubric of "social suffering" (Kleinman, et al., 1997: ix), she underscored the subjective, dynamic process of working on psychological and interpersonal management during hard times. She estimated that certain struggles in her life wouldn't change, but that she could change the felt pressure of her situation by working on the elements that were under her control.

Both Javier and Tepin sought to change their stress reactivity despite enduring financial woes or family discord that would not 'leave them in peace,' and they experienced a feeling of relief or being reassured after taking action, whether that be taking medication for their psychiatric symptoms, confronting a difficult person in their life, or proactively assessing their financial woes and seeking new work. Rather than feel immobilized by the structural challenges and power struggles in their lives, they raised their ability to endure stressful times by modulating their stress reactivity as an indication of successful psychotropic or psychotherapeutic treatment. This was seen in other clinical cases as well:

Excerpt #6

> Patient: [The medication has changed me] a little in terms of my character. Now I don't get so angry. I'm a bit – in that sense I'm calmer (*estoy más tranquila*). Or rather, now they [family members] say things to me and I don't answer them anymore, I don't say as many things any more. But… in that alteration I feel, in those worries, um- they come to me in the moment, I'm okay and then I start to tremble.
>
> Clinical visit with Laura on 5/6/2014

After recognizing that she had responded well to the mix of medication and therapy, Laura noted that she still struggled with the sudden sensation of anxiety (*esa sensación de ansias*) that would come upon her in the moment and leave her feeling hopeless and lacking energy. She had taken up knitting and exercising but hoped that she could gain further control over her emotions as time progressed, as she was still unable to sleep through the night.

Another patient named María Camila was further along in treatment, and she identified similar changes in emotional reactivity and her ability to sleep as her personal benchmark for evaluating the success of her treatment for moderate depression:

Excerpt #7

Doctor: Okay, how have you been? How have things gone for you?

Patient: Well, um… Very sleepy. I began with headaches and it went away, and… beyond that, relaxed, doctor. That is, the problems have been… economically difficult, but thanks to Jehova, I've taken it with great tranquility (*con mucha tranquilidad*), um, as though… I don't know if it's good. Well, for me it's been good because I've slept. No? And this- although the strong pressure is present, we've been overcoming it without as much concern as I had before – at times, I had been hopeless (*hubiese estado desesperada*) before.

Clinical visit with María Camila on 7/2/2014

Despite the fact that her situation remained the same, with time, María Camila felt less sadness about her estranged husband and the abuse she had suffered during her upbringing. She realized that she had been ignoring other important aspects of her life. For María Camila and others, religion played a major role. Eighty eight percent (30/34 participants) of my study sample reported either actively practicing religion or culturally identifying as religious,[71] closely mirroring national trends (INEGI 2011). Furthermore, research has found that religious involvement is significantly associated with self-reported health status and psychological well-being (Levin and Chatters 1998), indicating that religious involvement can serve as a coping

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[71] Of the 32 study participants who completed the demographic questionnaire, 24 identified as Catholic, 3 identified as Protestant, 2 identified as 'believers' (*Creyente*) in God, 1 identified as Jehovah's Witness, 1 identified as atheist, and 1 identified as having 'none.' INEGI (2011: 3) reports that 82.7% of the population over the age of five identify as Catholic.

resource[72] or provide the ability to reframe physical limitations. As illustrated above in Excerpt #7, patients benefitted from the ability to separate out the sacred and profane, as it gave them powerful perspective on the challenges they faced. Specifically, religion had taught a patient named Renata to stop asking "Why? Why is this happening to me?" and shift to instead asking, "For what purpose? What will He do with me?" (interview, 8/12/2015, timepoint: 13:41-13:55). As a result, she was able to be "more stable" in how she responds to people or problems and strength as time revealed that 'this too shall pass.'

The psychiatrists at *El Batán* adopted the same language of *tranquilidad* when checking in on treatment progress, benefiting from the conditional phrases' ability to reflect successive gradation in one's condition. Treating psychiatrists would ask for patients and any co-present kin to reflect on their current state in relation to how they used to respond, typically contrasting whether someone was restless (*se pone más inquieta*) or more relaxed/ *tranquilo* in order to reflect that their symptoms were more controlled. During Rosa's third clinical visit, the psychiatrist asked:

Excerpt #8

Doctor: How are you doing with the washing of your hands?
Patient: Um, well yeah, less.
Doctor: Okay, great. Have you slept better?
Patient: Yes.
Doctor: Are you *más tranquila?*
Patient: Yes.

……

Doctor: How has she looked to you (plural)? How's it going?
Father: Um, we see already… that she's so much better, doctor.
Sister: Yes.

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[72] I wish to emphasize that religion does not necessarily serve as a positive resource, and it can be a double-edged sword, as noted by Jenkins (2015: 211). For example, another patient experienced stigmatization and feelings of isolation after converting from Catholicism to become a Jehovah's Witness.

Doctor: Yes. Is she calmer (*más tranquila*) now?
Father: Yes. She's calmer now (*Ya más tranquila*) than she was– before we came here, well… she didn't she didn't even want to talk to us. Nothing at all! She only looked at us. But now she chats with us. Now the family gets along better.

Clinical visit with Rosa on 7/3/2014

Psychiatrists and patients reminded one another that "You won't stop having problems simply as a result of coming here," and that "If you don't advance, you'll get set back" (*Si adelante no vas, atrasarás*). Even when taking medication, patients would be most able to keep things balanced when their world flipped upside down if they could achieve balance in their emotions and their lifestyle habits. Both inside and outside of the clinic, advocacy and adaptation were the best way forward.

In other instances, tranquility corresponded to cultural sayings like "*No comas ansias*" (be patient, don't worry about it), "Dalay" (which refers to a supplement marketed to treat stress while employing imagery of Zen Buddhism), or the refrain "Calmantes montes," which is akin to saying "Keep calm and carry on." Each of these phrases juxtaposes turbulence with tranquility, thereby activating calm (*que te tranquilizara*) in an eventful way. This call to action is similar to Zigon's (2007) interest in the imperative to "Keep[s] Going!" through personal and social responses to breakdowns in one's unreflective moral disposition of everydayness. Throughout Mexico, you will hear such motivational sayings in moments where the speaker wills another person to control his or her desires and persist in the face of change.[73] Tranquility is a call to practice calm in the face of precarity, and the expressions above shape speakers' experiences of

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[73] Unfortunately, these positive expressions were not the only way that people willed one another to carry on. Patients were also told to "echarse ganas" (i.e., 'to do your best' or 'to put a lot of effort into something') when their depression left them feeling sapped of the energy to restart their everyday routines. Such phrases critiqued an individual's effortful output, similar to the attitude that the ill or homeless should "Pick themselves up by their bootstraps," and stigmatized their intended recipient.

distress, as well as others' responses to it - arguably promoting allostasis, adaptation, and coping (McEwen 2000: 174) in the process.

Furthermore, Excerpts # 6-8 contrast being *más tranquilo* with suffering from strong emotions[74], financial distress, or interpersonal struggles. For many patients, they sought to avoid being *loco*, which one patient defined as "not having control" or "being out of your mind" (Antonio, interview, 7/15/2014), and another described as "when a pressure cooker explodes" (José, clinical visit, 7/09/2014). In many of the data presented here, direct contrasts were made between experiencing *nervios* or being agitated in the past and seeking or achieving *tranquilidad* or being *más tranquilo/a* now. Low (1985: 190) found that for Costa Ricans, "The opposite of 'having nerves' is 'being tranquil," and the same holds true here: *nervios* and *tranquilidad* are two sides of the same experiential coin, allowing people to fall at various points along the continuum.

The juxtaposition between 'nerves' and 'tranquility' likely stems from pre-Columbian beliefs about equilibrium in Mexico. Kray's (2005: 343-344) research in Yucatán, Mexico, found that:

> Tranquility and balance are ideal states of the physical body. The body is imagined as becoming sick when tipped out of balance, which can happen by either disruptions in its hot-cold balance or by emotional upset… How one ensures physical well-being is through calm, smooth actions, and relations with others.

However, individuals do not differentiate physical and mental illness in this setting, which means that emotional imbalances can produce physical symptoms and vice versa. In order to achieve good health, people strive to be calm and maintain smooth social relations. I add to this debate by arguing that just as idioms of distress like *nervios* broadly communicate suffering to others

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[74] Patients would indicate the negative effects of strong emotions with phrases like "*ya me ponía yo de todo de malas*," meaning that they would quickly get angry and respond poorly to a person or situation.

despite being associated with a wide range of physical and mental possible symptoms (Baer, et al., 2003; Dahlberg, et al., 2009; Donlan and Lee 2010; Finkler 1989: 174; Lewis-Fernández, et al., 2010; Jenkins 1988a: 313-315; Low 1985: 189, 1994; and others), striving to be *más tranquilo* indexes adaptation or recovery across time while occurring on the individual, interpersonal, economic, and social levels.

Idioms of Distress and Practicing *Tranquilidad*

Similar to its use in Puebla, *nervios* or 'nerves' is a common idiom of distress in Mexico more broadly (Baer, et al., 2003; Campos 1997; Jenkins 1988a; Kray 2005: 345-46; Rehbun 1993; Salgado de Snyder, et al., 2000). In addition, there are other local idioms of distress that are equally well-documented in the literature: *susto* or 'fright' (Rubel, et al., 1984; Weller, et al., 2002), *coraje* or 'rage' (Cartwright 2007; Finkler 1994), and struggles with 'thinking too much' and *dolor de cerebro* ('brain pain') which are found in cross-cultural research both in Latin America and elsewhere (Hinton, et al., 2015; Kaiser, et al., 2015; Yarris 2011). All of these terms share an emphasis on strong emotions spurred by stressful events (as understood in the local context) or structural vulnerability in Mexico, and multiple authors describe the illness-producing constraints surrounding their expression both in Mexico (Crocker 2015; Farley 1998: 288; Finkler 2001:72; Lewis-Fernández and Aggarwal 2015; Low 1989:24) and elsewhere (e.g., Kleinman 1980: 133-170; Oths 1999; Skultans 2003; Wikan 1990). I argue that stressors and embodied stress responses are extremely prevalent, as is the imperative to respond to them in some way, although the terms used to describe such stress responses can vary widely across languages and cultures. These discussions typically center on idioms of distress that are influenced by the core values, norms, and health concerns shared by a given group and serve as the culturally authorized possibilities for responding to pathological situations (Nichter 1981).[75] Such idioms of distress serve adaptive functions in relation to how an individual responds to psychosocial conflict or social suffering, thereby providing an alternative to Euro-American concepts of disease. However, they also can fall prey to the same pitfalls as the biomedical system they critique if accepted idioms become reified metaphors rather than lived experiences in historical context (Lee, et al., 2007), or if they focus on somatization to the exclusion of other culturally constituted modes of verbal expression or emotional coping (Kirmayer and Young 1998).

Idioms of distress are useful for differential diagnosis and providing culturally competent care management (Nichter 2010: 402), but their focus on subjective risk and collective anxiety about living in poverty or oppression and feeling powerless to effect change falls under the purview of what Robbins (2013) calls "suffering slot" anthropology. Although this sound bite is a glib oversimplification of the research conducted in that area, idioms of distress are strongly focused on social suffering and illness terminology, and research investigations often stop after identifying the breakdown between values and experience and comparing it to our vocabulary of etiology, symptomatology, and healing. In those instances, such work distracts us from the broader cultural meanings of illness and 'health' (cf. Crawford 1984) that comprise a 'semantic network' among members of a society or cultural group (Good 1977) and index how suffering subjects respond to what their bodies are telling them through these embodied metaphors (Low 1994: 143; Dahlberg, et al., 2009: 303). In the current case, specifically, past studies on *nervios* or *thinking too much* often end with the identification of a state of being overwhelmed by rumination or tension, rather than also discussing the polysemic terminology of improvement

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[75] A few of the aforementioned studies (Baer et al. 2003: 321-322, 327; Lewis-Fernández 1998; Lewis-Fernández and Aggarwal 2015) do explicitly link the illness term *nervios* to calming medications or self-soothing practices, thereby corroborating my stance that patients aim to regain tranquility.

and interactional spaces for tranquility that might offer clinicians and researchers alike a way forward. By closing the story at that point, research cannot determine if the idiom of distress will lead to efficient communication and coping or destructive behavior and feelings of helplessness. We may forget that by decreasing one's dis-ease[76] or psychological distress caused by life's pressures, patients can move toward attaining homeostasis or balance, which is a central value of the literature on tranquility. By focusing on culturally salient types of interaction within their original context, the present data demonstrate that the subjective and intersubjective desire in current day Mexico to be more calm or tranquil creates space for clinical treatment goals, as well as life goals that exceed the purview of any medicalized space or an individual patient's body.

Theoretical Intervention: Breakdown versus Breakthrough

Janis Jenkins (2015) and others (e.g., Hamdy 2012; Jackson 2005) have stimulated renewed interest in experiential 'struggle' rather than reductive talk of psychiatric symptoms, as it highlights life as lived. This framing is a project that I support, as it moves beyond a language of disease and diagnostic categories of mood disorders in order to deal directly with the human embodiment of emotion and behavioral responses to life's circumstances. It also allows for the stepwise assessment of one's condition across time within clinical, sociocultural, and political-economic conditions of 'precarity.' As Jenkins wrote in her most recent book, precarity matters when a medication might not work well for a particular patient, when strained family relations may worsen a psychiatric patient's symptoms, or when prolonged civil war can lead to enduring feelings of distress (*nervios*) and heat (*el calor*) in places like El Salvador. These precarious

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[76] I use the term 'dis-ease' to refer to the embodied expressions of disruption and malaise that precede illness and at least partly serve as a manifestation of sociocultural stress or disorder. For further discussion, see Ware and Kleinman (1992: 553).

circumstances have uncertain outcomes and, as I have described earlier, they provide fertile ground for meaning-making as they snap us out of the taken-for-granted experiences of the everyday. However, Jenkins' focus on precarity during traumatic events foregrounds financial or physical insecurity, familial abandonment, disaster, and violence (ibid: 227-28) to the point that it "…poses threats to the very structure of meaning" (ibid: 243) and fosters self-protection through coping mechanisms like dissociation when a person fails to adapt to chronic stressors. Certainly there are extraordinary experiences of violence that can leave us speechless or struggling with the limits of language to make sense of those 'senseless' experiences. Previous sections of this chapter have shown many patients speaking of the need to 'distract' oneself from one's problems or one's pain. Although "the pain of suffering takes noisy possession of our consciousness" (Wilkinson 2004: 119), various authors have studied situations in which the desire to pinpoint and parse the cause of a person's suffering is not the ultimate goal (Das 2007; Jackson 2004). Instead, individuals can use the "double binds" (Bateson, et al. 1956) engendered by their precarious reality to propel them into action. John F. Kennedy was once quoted as saying that the Chinese word for 'crisis' is composed of the characters for danger and a moment open to opportunity, reminding us that true precarity sits on the cusp of change – for better or for worse.

Jenkins' focus on predisposing factors for mental illness results in her book reporting the negative outcomes of ruptured reality far more often than the potential for the seesaw to swing the other way. Nevertheless, I argue that calming one's mind through meditation or refusing to react to goading statements from kin are discrete actions that could potentially *produce* subsequent resilience. Physical actions and speech acts of resilience are under-characterized in Jenkins' book, leaving us assuming that transcendence of such problems is due to the individual ingenuity of participants like Rosa (ibid: 177), rather than discrete actions of social support or co-opting protective features of religious engagement[77]. As mentioned in the introduction, anything that upsets one's habits can be stressful, and individuals will work to reframe and respond to this unsettling experience – whether or not the stressful stimulus goes away. Some of these disruptions are part of the urbanization and globalization that many people experience, and other disruptions are specific to the clinical population with which I worked. Ultimately, these data reveal that study participants were motivated to privilege tranquility and smooth relations above a return to pre-ill normal or seeking health, and it supports notions of 'allostasis' (McEwen 2000) or the active effort required to maintain a perception of stability through change. By merging Jenkins' theoretical interest in precarity with my present data, patients emerge seeking ways to address moments of breakdown and achieve a breakthrough or pause in the grammar and experience of crisis.

Building on Jenkins' implementation of 'struggle,' I found that the discourse surrounding *estar más tranquilo* included current symptoms and dissatisfactions, *as well as* desired states and aspirations that would be more appropriately reflected in practices than an 'idiom of distress.' Patients suffered from serious mental illness but they did not only struggle to regain a 'normal life.' Rather, they strove toward positive social values (cf. Rogers 1951: 487) like creating a more tranquil life, where the subjective and intersubjective desire in current day Mexico to be more calm/ tranquil spans far beyond an antidote to one's struggles and pathogenic stressors. This construct of endurance and adaptation fashions space for treatment goals as well as life

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[77] Jenkins describes how religious practice and experience are woven into the lives of the Salvadoran women with whom she worked (2015: 202-210), but largely discusses beliefs and experiences surrounding witchcraft, spiritism, and indigenous healing as they relate to mental illness. She notes "My data offer no grounds to suggest that religious experience is symptomatic of psychopathology or that religious activity can cause or exacerbate mental illness. Neither can religious involvement simply be said to buffer mental illness since, particularly with respect to vulnerability to malevolent magic, it can be as much a source of distress as a relief from distress" (ibid: 211).

goals, placing it in conversation with Robbins' (2013) Anthropology of the Good and Mattingly's (2010) research on cultivating hope through socially embedded practices.[78] Participating patients strove to cultivate positive emotions, and their loved ones were encouraged to distract patients from their unhappiness or help patients do their best both inside and outside of clinical settings with the hand they are dealt. Oftentimes, the road to feeling *más tranquilo* was formed through joint familial efforts rather than medicating the patient and telling them to simply be less stressed. To better understand the chronological process of cultivating hope and tranquility, I present the story of Guadalupe and her husband.

Ecologies of Care: Precarious Health Trumped By Precarious Income Flows

Guadalupe was a 27-year-old woman who was always accompanied by her husband of two years. At Guadalupe's first visit, she had dark circles under her eyes, and wore an assortment of ill-fitting clothing including a sparkly purple dress with a chunky sweater on top. The psychiatrist and I learned that she had been hospitalized for three weeks at the age of 16 for intrusive thoughts, which the doctors believed might be the beginning stages of schizophrenia. She characterized these thoughts as "suffocating" to the point that she did not want to get out of bed and face the day. She feared that something would happen to her mother, or that her husband would tire of constantly being by her side, and that he would leave her. She worried that she would always have to take medications in order to be able to care for a child, and that her medications would preclude her ability to give birth to a healthy child, even though one of her

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[78] I intentionally follow Mattingly's grounding of hope in her focal clinics as not simply an emotional state, but a socially embedded practice. Despite different diagnoses and prognoses, both of our projects work with patients with various chronic or sometimes terminal illnesses and address settings of underfunded clinics with stark health disparities in order to find spaces of possibility in the midst of precarity and sometimes, structural violence.

greatest hopes was to start a family. During her second visit to the clinic, she fretted that if and when they found the answer to her mental illness, they would just find something else – and something worse – that was wrong with her. Her worries propelled her to the point that she once told me, "The mind is bad. If you do not dominate it, it will dominate you. And for me, well, at times, it has dominated me quite well" (interview on 8/17/2015, timepoint: 21:28-21:39). She said that she had never had a stable life, like that of everyone around her, and she hoped this would alleviate her suffering, as well as that of her husband.

Despite being a staff psychiatrist with several years of experience, her previous psychiatric history left the psychiatrist at *El Batán* unsure whether she had bipolar disorder or schizophrenia, and he used trial and error to reverse engineer her most likely diagnosis. At first, he gave her an antidepressant and an antipsychotic and her symptoms worsened, but when he gave her a mood stabilizer approved for Bipolar Disorder, she got better. Five months into treatment, her husband thought back to Guadalupe's nervous fretting and frequent headaches, recalling:

Excerpt #9

> Husband: In the beginning, when the doctor gave her the very first pill, he gave her, um, a high dose more or less in order to calm her down (*para que se tranquilizara*), because it was that all the time… from dawn until dark with the discomforts. And she couldn't have a quiet moment (*un rato tranquilo*), with peace. For nothing.

Interview on 8/17/2015

Guadalupe's husband aptly noted that the medication served to physiologically stabilize her early on. She felt sleepy much of the day, but spent less time worrying after taking her pills. With time, she noted that "*me desbordo menos*," meaning that her emotions overflowed less often. She adjusted to her medication and began feeling re-energized rather than sleepy. Unfortunately, her precarious health was trumped by the precarity of income flows.

After their marriage, they'd decided to move to his parents' *pueblito* (population 1,100) in order to save money and have social support and had struggled to maintain regular psychiatric care for her. This meant they traveled 3 ½ hours each way on public transport to attend their monthly check-ups at *El Batán*, and yet they faithfully arrived like clockwork. After seven months of treatment, they stopped coming; they called the psychiatrist to say that she was doing well and they would rather buy her mood stabilizer medication locally than spend a full day traveling and paying for two round trip bus tickets in order to receive a check-up and her medication refills free of cost. During a summer home visit with them the following year, they contrasted the tranquility of small-town life with their financial insecurity:

Excerpt #10

Husband: Yeah, sometimes I talk with her and want to head to the city. At least go to Puebla and have a modest job,
Guadalupe: Stable.
Husband: Something that is daily, daily.
Guadalupe: Stable.
Husband: Stable, stable there. At least every week, every 15 days, there you'd have your money.
Guadalupe: But honestly, here there's…
Husband: Here, the only good thing here is: it's peaceful (*está tranquilo).*
Guadalupe: Uh huh.
Husband: That's it. You can walk wherever you want and… it's calm (*tranquilo*).
Guadalupe: There are no muggings.
Husband: It's peaceful. (*Está tranquilo.)* But what definitely does not help is the economy.
Guadalupe: Yeah. Because truly there's nothing- absolutely no work. Sometimes they'll call you in for one day. Two days….
Husband: A week at the most.

Interview on 8/17/2015

Despite supposed 'access' to care and free medication, daily survival was a struggle for Guadalupe and her husband. There was no gainful employment, and no mall or movie theater nearby to visit and distract themselves. Even so, they did not paint themselves as passive victims when it came to her care. They found a local pharmacy that let them continue her medication and were in touch with their treating psychiatrist via phone. They had discovered that Guadalupe often "thought too much" when she was left alone, so she and her husband began caring for the house while other family members traveled to work in Puebla or Mexico City during the week, such that Guadalupe stayed occupied and did not ruminate on real or imagined problems. The couple planned to return to El Batán as soon as they saved up enough money and hoped that their doctor would decide Guadalupe is ready to taper off of her medications so that they could consider starting a family. She recalled how her mind had "dominated" her in the past, and told me that now, that was no longer true, and she can *seguir adelante* ('to continue forward' or 'carry on'). It remains to be seen whether these practices will become an embodied disposition (cf. Bourdieu 1977), but like Guadalupe and her husband, I am hopeful.

Conclusion

Guadalupe's story made it clear that treatment was always a moving target, where medications might alleviate some symptoms but let others surface and life circumstances could rapidly change their primary presenting concern. It also showcased the couple's problem-solving strategies while struggling to adapt as best they can to not only the illness but also their surroundings. Identifying the experientially-based amelioration of distress as being *tranquilo/ tranquila* and achieving an interior and exterior state of calm is an extremely powerful concept in a world of biomedical objectification and the frenetic daily life experienced by many across the globe. By merging theoretical contributions to psychological distress with the experiential 'struggle' and desire to seek balance and smooth relations, this polysemic terminology of improvement targets behavioral practices and thus focuses on both culture and ‘functioning’ in ways that are directly applicable to clinical work and everyday routines. By breaking down the categorical distinctions between biological and cultural explanations of illness and wellness and examining tranquility as a moment of breakthrough, these findings give mental health professionals a positive language and powerful treatment strategy to use as they move forward.

CHAPTER 5

Conclusion

In the preceding chapters, I have reviewed the broader structural forces and intimate interpersonal interactions that influence the present provision of psychiatric care in Puebla. As I wrote in **Chapter 2,** this dissertation has worked to move beyond simplistic global/ local, developed/ developing, or institutional/ subjective binaries of social change and throughout, this work has challenged the value of linear causal explanations for institutional change, culture change, or the symptomatic change of an individual patient.

Mental illnesses are complex disorders with various etiological factors, such that someone's presenting symptoms can change over time in ways that surprise clinicians as well as the patients experiencing those symptoms. **Chapters 2-4** brought flexibility, learning, and adaptation to the fore as a powerful way to understand how psychiatric symptoms and their treatment are constantly moving targets. In **Chapter 3**, the presentation of an adaptive explanatory framework for psychiatric disorders made patients like José and Rodrigo feel better about their prognosis. Both of those patients continued in treatment throughout the course of my study, indicating the potential power of such EMs to shape reality and modulate patient behavior.

Although not all study participants completed both the pre and post treatment research interviews, additional information on the course of illness could be provided for a portion of study participants by having two or more independent raters code the results of the Strauss-Carpenter Levels of Functioning (LOF) scale (1972, 1977) among those who completed both sessions. After analyzing the results, if individuals with an increased LOF score were taking considerably less medication than their peers without a significant change in LOF, it would predict a decrease in felt distress and/ or an increase in patient Quality of Life.

I returned to Puebla during the summer of 2015 in order to conduct home visits with 3 families from my larger patient sample and to learn how patients were doing one year later. Eleven patients from my original sample continued attending visits at *El Batán*, including people like José and Providencia, who were introduced in earlier chapters of this dissertation. While I was unable to follow up with all patients who stopped attending treatment, I was able to meet with a handful of them, including one woman whose story taught me how self-mastery is a thorny subject. Like all personal transformation, it takes time, and not all patients achieve a feeling of tranquility while enduring the precarious and waiting for a positive change as strong as the negative ones they currently bore. Instead, the drama or suffering of one's life can dominate and overshadow his or her own quest for wellness, as was the case for Juana.

Juana was a fiery 42-year-old woman with a short temper who spoke very matter of factly about her struggles in life during her visits to the clinic. Her father was a disciplinarian who was rarely at home, and Juana later learned that he had an affair and a second family. She left school after finishing sixth grade in order to help her mother around the house and care for her younger sibling. Juana had been repeatedly raped by her older brother and a past boss, suffered physical abuse at the hand of both her past and present husband, and could no longer sit up straight after a car accident had thrown her through the windshield and left her in a wheelchair for many months. As if recognizing the sheer number of miseries she recounted might make her story unbelievable, she offered for the psychiatrist to feel her spine for the deviated bones that popped out like braille, and the doctor obliged during their first clinical visit. The doctor and I learned that she had attempted suicide twice, but each time, thoughts of her three children had stopped her. Her husband worked as a farmer and was away most weekends, harvesting grain for sale, which left her alone to pay the bills and care for the children. She frequently exploded (*me saca de mis casillas*) at those around her and had recently begun forgetting things and seeing fuzzy shadows of people and animals while she was awake on a daily basis. She was diagnosed with recurrent Major Depressive Disorder and Borderline Personality Disorder, and was prescribed mirtazapine, citalopram, and the antipsychotic risperidone. The psychiatrist ended their first visit with a reminder that they would increase her medication little by little and that her symptoms were not a mountain that could be knocked down all at once with dynamite.

Nevertheless, for Juana and other patients with severe mental illness, it is likely quite challenging to imagine other possible selves or a time without depression. Past experiences had marked her, physiologically and psychologically, such that she was annoyed in later visits when the psychiatric resident treating her tried to encourage her to undertake small activities that could result in small victories:

Excerpt #1

Doctor: Okay, good. Right now you've partially improved. Um- I could optimize the dose of your antidepressant but I'm going to give it another – or rather, give it a chance for another twenty days. If at your next visit, we see that rather than improvement, you relapse, we'll see if we adjust it. Grab on to these people that are helping you right now. And the homework that they're giving you in psychology is also good.

Patient: Well, but I stopped that.

Doctor: But the little bit that you told me, that you are writing down daily goals, even if they're tiny: "I'm going to do this." I'm going to set aside an hour for this." Even if we don't meet that goal. But that there are things, little by little, to motivate you. It'll also help.

At this visit, Juana explained that she had decided to stop psychotherapy. Even though she felt her therapist was good [at her job], Juana felt that "she doesn't take much interest in me." Although Dra. O remarked that two sessions was not a long time and encouraged her to try again, perhaps with a different therapist, Juana's response was that "All she tells me is to keep going, and I feel the same after two sessions." Juana was seeking a fundamental change, and without evidence that that would happen, both time and treatment felt inert.

This psychiatric visit did not proceed overly smoothly either. Although people around her had remarked that she looked *más tranquilo,* she felt as though *nervios* had risen up in their place and reared their head daily. Juana had tried to pull herself out of it and could not, so she hoped the medication would raise her out of the fog she felt. Even when Juana's husband had invited her to go out dancing one night during the previous week and she went, she said that she did not enjoy it and only went because she felt obligated to go. In response, the psychiatrist encouraged Juana to grab on to the few people who were providing social support (as mentioned in Excerpt #1 above), given that Juana felt close to no one in her family and she never went out with friends to have coffee and talk. However, Juana felt frustrated by her psychiatric treatment over the past three months, much like her psychotherapy sessions, given that in her view, the multiple medications she took had not helped her. The psychiatrist began to say that they should give her current antidepressant "another shot," but she quickly corrected herself to specify they would "give it a chance for another twenty days." It is possible that twenty days more was too long, or the lack of a rationale behind that time window made it feel formulaic and forced. Although I did not know it then, this would be Juana's last visit at *El Batán.*

When she missed her next visit, I called her to reschedule with the psychiatrist and myself. She answered and in lieu of her regular measured tone, she sounded upbeat as she repeatedly thanked me for checking in on how she was doing. She explained that her policy for *Seguro Popular* had lapsed since our last visit,[79] and apologized for missing her visit. I asked her how

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[79] Recipients of *Seguro Popular* must reaffiliate every three years to maintain current coverage.

she was doing, and she said that her symptoms had gotten worse. Things had gotten away from her, and she felt embarrassed to come and restart her treatment now. After I reassured her that her doctor and I were still there for her, we scheduled a visit for later that week. She thanked me for making her day and making her feel valued, and we hung up. The day of her appointment, Juana texted me with the simple phrase "Things got complicated." A moment later, my phone flashed again: "I'm sorry but won't be coming." I thanked her for letting me know, wished her well with whatever had happened, and encouraged her to e-mail or call when she would like to reschedule. That day never came.

Juana's experience is a significant departure from the patients in **Chapter 4** who benefitted from their medications and found support and solace in the ability to talk to their clinician, and in many ways, Juana serves as an outlier in my study. Unlike many patients at *El Batán,* Juana was not accompanied by relatives at her visits, and noted that the only person she had wanted to bring with her was her 10-year-old daughter. However, hospital regulations would not allow underage individuals into the building, so she left her daughter at home and she came alone. One could say that rather than being in a precarious place, Juana was in an experiential mode of constant crisis and breakdown that left little room for positive change and a breakthrough. She had felt hopeless enough to stare down the barrel of a gun and consider ending her life, and while in treatment, she constantly waited for an equally strong positive reaction to occur. Moreover, her past history might make it more difficult for her to develop trusting, therapeutic relationships with her psychiatrist or psychologist.

She struggled with social relationships outside of the clinic as well, and felt that whenever she went to family events or parties and tries to talk, someone would interrupt without fail. Therefore, she did not enjoy talking about herself and she said she would sit silently during what ultimately become oddly impersonal interactions. Although I cannot definitively assess why her experience was so different, her stories and demeanor foreclosed the possibility for a hopeful future, and thinking of such phenomenological matters leaves behind instructive questions of what produces evanescent moments as opposed to engrained habits, and how one's choices are not only narratively but socially negotiated.

As mentioned in earlier chapters, more than half (59%, or 16 out of 27) of my study sample stopped attending visits before being formally discharged from treatment or titrated off of their medications at their treating physician's request. Juana was one of these patients, and both her recent struggles with remembering things or tempering emotional discharges suggest changes in her reserves or her capacity for experiencing optimism or self-doubt (Gold and Olin 2009). It is a risky business to keep someone motivated for weeks or months while psychiatrists find the right medication, in the right dosage, and patients find coping mechanisms and other benefits from psychotherapy or effortful action on their own part. It is even harder when the physiological changes are invisible to the naked eye and the behavioral changes require that a patient 'emplot' everyday activities in a therapeutic narrative of personal transformation (Mattingly 1994). At times, psychiatrists would prescribe a fast-acting medication to help alleviate a patient's symptoms in the short term, while they waited for patients to start feeling the effects of their primary medication. However, one could say that they were prescribing hope alongside symptom relief.

Patients such as Providencia, who was introduced in Chapter 2, had continued in treatment and reported a very different clinical experience. When I met with Providencia again in August 2015, sixteen months after I had first met her, I was surprised to see her arrive alone. I was equally struck by the change in her demeanor. Instead of constantly being on the verge of tears, Providencia giggled while proudly sharing news that she had started a new job three months ago. “I feel happy because I feel powerful and fulfilled in my work life,” she told me. She was equally proud to announce that the doctor had weaned her off of Citalopram, and that she was only using medication when she suffered from an acute anxiety attack (or in her words, *una crisis*) and needed Alprazolam. She had been working on breathing exercises and distracting herself when a trying time hit, both of which were practices recommended to her by her psychiatrist and psychologist. She became pensive when noting “I started to think about how a feeling or my heart could generate so many things… something like this has never happened to me in my head before. And it happened so quickly” (interview on 8/26/2014). She was motivated to never go through that again, and even though she had experienced three strong waves of anxiety since starting her new routine, she felt better able to control it than she had been in the past.

Providencia had formed a couple new friendships, including one close friend who knew about her psychiatric treatment and encouraged her to keep involved with it. She sheepishly admitted that she did not have as much time to exercise now that she had started her job, but that beforehand, she had been very committed to exercising because “the doctor tells me that is very important.” When I asked her if she felt she would need to take medication forever, she replied that was ultimately up to the doctors, but that based on her illness’s evolution, she expected they would remove the last medication little by little, just as they had done with her antidepressant medication. She was at peace with her situation and said, “I think that you can also see it in my face” (interview on 8/07/2015, 16:45-16:50). Indeed, I could.

Such cases reveal the spectrum of experiences during clinical care in Puebla and the value of *tranquility* as a concept interjecting new life into debates on the chronicity of mental illness. They also reflect how various political, economic, technological, and social factors impact the provision of care and its perceived efficacy among patients. Several patients who left treatment early explained that they would simply return to the clinic if and when their symptoms came back, suggesting that they viewed treatment as cyclical but not necessarily chronic and lifelong. Rather than employing terminology of ‘sickness,’ ‘brain diseases,’ or ‘being cured,’ most patients focused on coping and achieving tranquility. Psychiatric symptoms *and* their treatment ebb and flow, such that patients like Guadalupe hope to return to the clinic when necessary, and in the meantime, they can focus on survival and family matters when necessary.

Chapter Connections

Across this dissertation’s analytic chapters, the data reflect that patients, providers, and co-present kin are not merely engaged in treating a localized disease in the body, but rather a psychiatric disorder that follows Hahn’s (1984) well-known definitions of disease/ illness/ sickness. He writes “Illness ideologies ascribe suffering and its causes to the sufferer’s person and his/ her immediate environment; it thus includes the body, but reaches beyond as well. Disorder ideologies localize (or disperse) suffering to persons as the foci [of] much broader social and/ or cosmological nexi and forces” (ibid: 17). In **Chapter 2,** physicians serve as a liaison between the global and the local and work to treat both the individual patient and the family dynamic. In **Chapter 3**, a cocktail of biological, psychological, and social or structural factors are validated as contributing to illness presentation and patient suffering. Finally, patients like Tepin and Javier (from **Chapter 4**) speak of their psychiatric symptoms but allude to larger struggles involving the sights, sounds, and people in their intermediate surroundings as contributing factors.

Hahn emphasizes that previous frameworks have oriented toward disease as primary and primordial, such that other terms are reactions to disease, but in reality, it is the patient's understanding of his or her suffering (pathos) that is central to our examination of pathology and "engenders the whole medical enterprise" (ibid). Ultimately, he posits that ideologies about disease or illness causality are powerful beliefs that can affect patient outcomes regardless of whether they correctly identify the underlying referent or reality (which will exist regardless). Although social science has long accepted that our beliefs about reality influence our experience of it, Hahn's emphasis on the power of belief surrounding ideologies and explanations of illness hearkens back to research on "the placebo effect" being reconstituted as a "meaning response" that has consequential effects on reality (Moerman and Jonas 2002). Similarly, researchers like Buchbinder (2011, 2015), Jenkins (2015, 2011b, 1988), Mattingly and Garro (2000: 171-176, 199-207), and others remind us that how doctors and patients communicate prognosis and explain treatment rationales can directly and profoundly affect treatment outcomes. This dissertation has identified the potency of hope as offered by clinicians when advancing discrete, manageable treatment timelines (**Chapter 3**) and patients making incremental efforts toward *tranquilidad* (**Chapter 4**). What these findings have in common are an emphasis on developmental change and adaptation driving both etiological explanations and treatment recommendations, despite such ideas coming from physicians and patients who have very different educational backgrounds and socioeconomic status.

It is possible that even though patients use different terminology to describe this process of developmental change, they are either consciously or unconsciously adopting concepts introduced to them by their treating psychiatrists. Even so, the narrative construction of adaptation exists on two analytic levels: Participating clinicians use scientific research to talk about an individual’s neurological, psychological, and behavioral ability to adapt. Biomedical research strongly supports an emphasis on neural development and brain plasticity. Molecular and cellular neuroscience has put forward a range of factors related to neural regulation that counter the old saying that “you can’t teach an old dog new tricks.” Cutting edge research on stress and neurogenesis in animal models (Bessa, et al., 2009; Malberg, et al., 2000; Zhao, et al., 2008: 654) has shown that neural growth is possible in *adult* rodents, and that this neurogenesis decreases anhedonia (inability to feel pleasure) and increases food intake and movement. Additionally, some neuroimaging research (e.g., Goldapple, et al., 2004) has found neural network growth after application of Cognitive-Behavioral Therapy or paroxetine administration. These findings move the focus away from one’s genetic blueprint and neurochemical etiological explanations, and toward experiential and epigenetic effects on how stress gets under the skin and acts on the brain. This is primarily expected to be accomplished in the brain through Hebbian learning (Hebb 1949), or the stronger connection of two cells through the stimulation of a postsynaptic cell that is more commonly summarized as “cells that fire together, wire together.” Although psychotropic medications can contribute to cellular learning or adaptation (Andersen and Navalta 2004), psychiatrists in Puebla maintain that changes in psychological reactivity and lifestyle behaviors contribute more to a patient’s recovery and eventual well-being. Ultimately, it appears that clinicians want behaviors to be habit-forming (in relation to Bourdieu’s habitus), but for medications to not be habit-forming (in terms of forming psychological or physiological dependence).

On the other hand, even though behavioral adaptation may result in biological adaptations, participating patients do not conceptualize their actions this way. Instead of thinking about increased neural sensitivity, they speak of *tranquilidad* yielding decreased behavioral sensitivity, and patients identify discrete, tangible efforts toward behavioral adaptation, whether learning to be less stress reactive or more tolerant to stressors in their social and environmental surroundings. Patients see medication as a temporary aid and their effortful coping as central to their rehabilitation.

Closing Thoughts

In the current climate of psychiatric care in the U.S., severe stigma actively inhibits its citizens from talking of mental illness, and those who seek treatment often do so privately, feeling alienated in the process. Marshaling motivation is even more difficult when global public health entities have advanced a “no-fault model of behavior” (Singh 2004; see also Garro and Yarris 2009). Although stating that mental illness is “an illness like any other” is intended to decrease stigma and increase the number of patients seeking psychiatric care, such essentialist rhetoric can inadvertently portray biological explanations of health conditions as synonymous with having a diseased brain (Fein 2011: 37-38) and lacking autonomous control, despite the fact that people actually live with substantial control over the management of such conditions (Read, et al., 2006). Even as extant research teaches us that patients should expect recovery - but not cure - from symptoms of chronic illness (Jenkins & Carpenter Song 2005), physicians call for their patients to persevere and continue taking their medications.

In contrast, the cultural context in Puebla accepts that change is constant – whether that be change in the form of continual construction around the city or the statement that “We won’t stop having problems just for having come here [to the psychiatric hospital]” (clinical visit with Dr. B, 6/2/2014). The psychiatrists and psychiatric residents working in *El Batán* are under no illusion that patients would return to normal or a “baseline” starting point; instead, they emphasize the need for the patient's brain and behavior to adapt in ways that necessitate a *divergence* from baseline and the development of new capacities or skills. In partnership with their psychiatrists, psychologists, and frequently co-present kin, patients strive toward new possible selves that are more tranquil and able to cope with the challenges they face. In the process, however, they also learn preventive practices to help them avoid relapse, and are socialized into cultural ideologies and preferred modes of intervention surrounding mental health.

Much of the work on global mental health and chronic mental illness focuses on psychosis (Cohen 1992; Cohen, et al., 2008; Estroff 1993; Hopper 2008; Jenkins and Barrett 2004; Myers 2010; WHO 1973, 1979; etc.) rather than also studying other psychiatric disorders, such as major depression, generalized anxiety, or bipolar disorder which comprise a large proportion of the Global Burden of Disease attributable to mental and substance use disorders (Whiteford, et al., 2013). The present study followed patients with various diagnoses, including depression, anxiety, paranoid schizophrenia, obsessive-compulsive disorder, and personality disorders. In contrast to Luhrmann's (2007) proposition that the United States has a "culture of chronicity" and "social defeat" surrounding severe mental illness, physicians in the present study establish timelines for patients to either graduate to very low doses of one or two medications or get off of medications entirely and remain symptom-free. Patients with schizophrenia or other serious mental or developmental illness live in their home communities rather than in "institutional circuits," and their psychiatrists encourage them to help around the house and serve a meaningful social role. In its most extreme form, patients in Puebla may be socially marginalized by being abandoned in *El Batán,* but patients rarely end up homeless as has been found to be the case in the U.S. (Desjarlais 1997; Marrow and Luhrmann 2012). Likewise, their fear of addiction to medication and their they do not develop a fear that they will be chronically ill and dependent on medication in order to recover normal functioning. This may be the result of the different historical trajectory that the discipline of psychiatry has followed in Mexico, the less prominent role played by advocacy groups, and the socialization into a distributed network of responsibility rather than a dependence on medications and case managers (Myers 2010: 503-504). However, many questions remain on if or how the American narrative of "recovery without cure" carries over to other disorders in other clinical settings. This study indicates a need for more research on the everyday experience of various psychiatric disorders as they wax and wane, and calls for further consideration of how familial, institutional, and ideological factors may contribute to changing notions of selfhood, illness, and stigma.

Appendix

Original Spanish transcriptions of excerpted audio clip data

Chapter 2: Family Life and Social Medicine

Excerpt #1:

Investigadora: La próxima pregunta es: ¿Se puede describir algunas preguntas o creencias que los pacientes tienen cuando lleguen acá la primera vez?
Doctora: Ehm, yo creo que lo más frecuente así, como de preguntas y… estigmas que traen es en primera, que se van a volver adictos. Creo que eso es lo muy más MÁS común.

Interview with Dra. M on 8/09/2014 (Part III)
Timepoint: 00:04-00:26

Excerpt #2:
Psychologist: Y otro factor que a ellos les impide – o como tienen que acertar pero no hacían - a ir a psiquiatría, es porque tienen un miedo al fármaco. Ellos creen todavía, muchos – o la mayoría – que todo el medicamento psiquiátrico, uno, es para locos y dos, que genera dependencia. Que los van a ser adictos. ¿No? Cuando vaya a una estadística, se ve que sola un veinte por ciento del medicamento genera una adicción. Solamente el veinte por ciento. Y… este, obviamente bajo de la supervision del médico, se lo va retirando y revisando cuando sea necesario. Si lo genera una addición.

Interview with psychologist on 9/01/2014
Timepoint: 17:11-17:50

Excerpt #3:
Doctor: No pensaría también - o usted ha oído que son como control[ados o (*ininteligible*)?
Patient: [Ah huh. Como drogas, más o menos.
Doctor: Y ‘orita, después de todo este tiempo que, son así?

Patient: No. Pues, yo creo que no. Que me han ayudado mucho mi estado de ánimo.

Clinical visit with María del Rocío on 6/03/2014
Timepoint: 5:11-5:24

Excerpt #4:
Investigator: También puede leer más sobre los medicamentos.
Patient: Ajá. Eso es lo que incluso voy a hacer. Me leer, me ver. Me gusta ver en las computadoras todo lo que tomo. Y voy a leer sobre esos medicamentos,sobre los que son muy controlados. ¿Ve que hay muchos que son controlados?
Investigator: Hay algunos, y hay otros que no, no son.
Patient: Ajá.

Investigator: Y eso es importante saber,
Husband: Sí.
Investigator: Porque algunos pacientes creen que "Nooo, el medicamento es controlado. me hace daño."

Patient: Sí, no a todo va a hacer daño.

Investigator: Hay algunos. No son todos.
Husband: Sí, el doctor nos dijo que – bueno, el primero que nos vino, nos dijo que iba a dar medicamento que no… que no hacía adicta al medicamento. Para que vayas mejorando, dice. No te pasa nada.
Patient: Ajá.

Interview #1 with Guadalupe on 4/29/2014
Timepoint: 11:15-11:55

Excerpt #5:
Doctor: Y esto, que te acabo de pasar, vamos a tratar de irlo evalorando, y a ver si disminuya en algún momento. Creo que has mejorado en tu estado de ánimo. Creo que has cambiado mucho, entonces, pues, ahora, nos toca atender estas cuestiones que van saliendo.

Patient: Sí, doctor.

Doctor: ¿Okey? Y usted, ¿cómo la ha visto?

Dad: Pues, yo casi no estoy con ella pero ahora que la acompaño, mejor. Se viste más alegre, la veo mejor.

Doctor: Muy bien. Pues, de esto se trata.

Fifth clinical visit with Providencia on 8/26/2014
Timepoint: 7:01-7:35

Excerpt #6:
Doctor: Lo que sí es importante es que los toma todos los días o que observan que se los toma.

Husband: Sí. No, que sí, que se los toma.

Patient: Es que a veces, yo le digo a mi esposo, "Véame si los tomo]
Husband: <u>Sí</u>, los está tomando]

Patient: Porque a veces me siento que no los tomo y…
Husband: Es que a veces no pon atención – nada más lo agarre y ya.

Patient: Yo ando distraída.

Husband: Distraída. Le digo, "NO. Centra en tu medicina y para que (.) no piensas en otras cosas."

Doctor: Yo sé que eres una persona adulta y eres responsable pero en este momento necesito que alguien le ayuda con los medicamentos.

Husband: Sí – que está tomando el medicamento. Sí.

Second clinical visit with Guadalupe on 4/29/2014
Timepoint: 14:02-14:31

Excerpt #7:
Doctor: Pero eso es ansiedad. Eso también necesitas ir -a fuerza, tienes que ir a terapia porque tienes que enseñar a que- cuando inicie? ... Buscar la forma de que la disminuye. Porque el medicamento – te voy a reiterar - ya casi hizo su efecto. Ahorita te voy a agregar otro para ver como te sientes. Si con esa, a ver si puede disminuir eso un poquito. Pero el medicamento ya hizo casi todo su efecto. Ahora te toca a ti.

Fourth clinical visit with Rodrigo on 5/08/2014
Timepoint: 6:28-6:52

Excerpt #8:
Doctor: Usted tiene que adaptarse a esto que venga. Porque esa es una decisión y una rutina, que él le va a vaciar.
Patient: Sí, yo sé. Pu's, como que ya no me acostumbré estar solita. Bien solita.

Doctor: ¿Usted cree que él se va a acostumbrar a uno estar como pareja?
Patient: Pu's, no.

Doctor: Pues, a usted le toca a empezar a entender que se tiene que acostumbrar. No acostumbrarse. Primero, entender que tiene que estar sola. ¿No? Yo creo que sola es una – es un decir pero seguramente puede hacer muchas cosas.
Patient: Sí.

Doctor: Pues, hay que empezarlas hacerle y empezarle a alejar de hacer muchas cosas para él. Ahora le toca hacerlas para usted. Porque si no, va a seguir sintiéndose como así, cómo ahorita está. Yo creo que tiene mucho que ver esto. Y el día que se vaya, ¿cómo qué va a sentir?
Patient: Me voy a sentir mal.

Doctor: Pero usted debe de saber que se tiene que ir. Que tiene que estar diciéndolo todos los días. Porque la decisión ya no le toca a usted. Ya le toca a él. ¿No? El uso de los fármacos hace que disminuyan algunas cosas. Y yo creo que lo que ahorita le está pasando es esto. De que está cursando con este- esta- estas características que no sabe que va a pasar. Porque como usted no las puede controlar, por eso las tiene más angustiada.

Fifth clinical visit with Margarita on 8/18/2014
Timepoint: 5:04-6:48

Excerpt #10:

> En psiquiatría, entra mucho la familia, ¿no? (Sí.) Dice en el clinic, "A ver, si tomó la medicina…. Y ¿sí, está haciendo esto?..." Y no es como te ve, porque puede decir que "Yo estoy bien." Pero no. En terapia, no. En terapia es poco, es menos que entra la familia, menos que se requiera.

Interview with psychologist on 9/01/2014
Timepoint: 46:05-46:26

Chapter 3: Explanatory Models Have Some Explaining to Do

Excerpt #1:

Doctora: Bueno, sobre el diagnóstico, ahorita ya con todo que me platicaba, obviamente esto se va a ir –este- enriqueciendo con forme yo la vea. ¿sale? Pero ahorita sí, cuando ya pusimos a platicar, este- yo he podido integrar, pues, un trastorno de ansiedad generalizada, por lo que <u>veo</u> desde hace mu:cho tiempo. Nada más que, como le comentaba, hay cosas- factores estresantes de la vida que apoyan que se expresen más. ¿Sale? ¿Qué pasa? Que usted empezó con síntomas físicos. Eso quiere decir con gastritis, con dolores y todas estas cosas. Es como nuestro cuerpo se expresa, ¿sale? No en todas las personas expresen igual, ¿sale? Pero en ciertas personas se expresa así. ¿Sí? Y a lo mejor, ha venido en la forma del estrés, ¿no? Pero bueno, si va avanzado y no se controla, se presenta así, como un trastorno de ansiedad generalizada.

Doctora: Bueno, ahora: ¿Qué plan? Osa, ¿Qué vamos a hacer? Bueno, el tratamiento que iniciaron, y como ya ha tenido resultados, se lo vamos a dejar así. El tratamiento que usted tiene, con Fluoxetina, es el indicado para… para lo que usted tiene, que es un trastorno de ansiedad generalizada. Este tratamiento es muy seguro. Es un medicamento muy seguro y tiene que llegarse <u>bien</u>. Bueno. Ahora, el plan del tratamiento o el tiempo que se debe de llegar es aproximadamente de año a año y medio.

Paciente: Mm hmm. Sí.
Doctora: ¿Por qué? Porque este trastorno, como ya le dije, no es nada más porque… "Pasó esto y ya me sentí mal." <u>No</u>. Osa, se ha venido creciendo a lo largo de ciertas situaciones. ¿Sí? Aparte de las situaciones y los estresantes externos, es algo que usted ya traía. ¿Sí? Por ciertas cosas, por lo que ha vivido en su casa, a lo mejor, por (ininteligible)... Son muchas cosas, ¿Sí? A esto le llaman ustedes multifactores. ¿Por qué? Porque son las cosas que usted ha vivido, más que ahorita en este momento, pero por esos factores estresantes se alteraban ciertos neurotransmisores en su cerebro. ¿Sí? Estos controlan el estado de ánimo, la ansiedad, osa, que usted se siente así, como nerviosa,
Paciente: Sí, sí, sí.

Doctora: o preocupada.
Paciente: Ajá.

Doctora: Esos neurotransmisores, regulan todo nuestro estado del ánimo y estas cosas que ya le digo- en todos. No nada más en usted. En todos. En usted, en mí, en usted. ¿Sale? Nada más que por cier- estas situaciones, se alteran. Su mecanismo se altere, ¿sí? Entonces, el medicamento necesita regularlos. Por eso, se ha visto que este tiempo es el que necesite el medicamento para regularlo. Osa, que lleguemos hasta ese momento para que ya, se cure.
Paciente: Sí.
Doctora: ¿Sale? Bueno. Necesito que lo tome bien, correctamente así, como se lo indicamos. Porque si usted en un momento lo suspende porque ya se siente bien, va a ocurrir una cosa. Al momento de que usted suspéndelo, el cerebro no se distingue si lo qué pasó. Entonces, ahí, esta regulación que estaba teniendo, ya se corta. Entonces, con un… no sé- dos, tres días que lo suspendan, ya eso se pierden. Entonces es como otro-
Paciente: ¿Otra vez con las síntomas?

Doctora: Exactamente. A lo mejor, al inicio, no, pero ya después, sí.
Paciente: ¿En quince días?
Doctora: Sí. Entonces- ya, no distingue allí qué pasó. ¿No? Entonces, precisamente por esto, es que se debe de llevar bien el medicamento por este año, año y medio, ¿Sí?
Paciente: Ajá.
Doctora: Yo, obviamente, con forma la vaya viendo a usted, voy a ir definiendo el tiempo, ¿sí? Le doy un aproximado. Si usted va bien, si todo va bien, sal- este es el tiempo, ¿sí?
Paciente: Mm hmm.

Doctora: Pero depende mucho de como va evolucionando usted. ¿Sí? Es un aproximado. ¿Qué pronóstico hay? Es un pronóstico bueno, ¿sí? Necesita seguir obviamente con psicoterapia, por- tanto como psicoterapia como con psiquiatría. ¿Por qué? Porque he identificado que hay cosas anteriores en su vida, que debemos esta carga, estos nervios, entonces cuando ya había- como que- un punto final de todo esto, ya se puede seguir avanzado con el medicamento. ¿Sí? Entonces, va a- es un tratamiento conjunto con psicología. ¿Sí?
Paciente: Sí.
Doctora: Por esto es un pronóstico bueno. Es un padecimiento frecuente que tiene solución. ¿Sí? Tiene tratamiento. Por esto estar. Ajá.
Paciente: Sí, doctora.

Clinical Visit #2 with Yiyo on 5/30/2014
Timepoint: 53:07-58:33

Excerpt #2:
Doctor: Mire, la depresión es una enfermedad que altera una parte de mi cerebro. Hay – en ocasiones, se da por muchas cosas de la vida que nos toca vivir. ¿No? Que mueren

familiar, que - pus, que nos fue mal en la vida, no- tuvimos muchas carencias, nos maltrataban de niños, esos son factores para que me dé este enfermedad. Pero a veces dar de la nada. Simplemente hay algo que allá, aquí arriba, se desconecta. Y el medicamento hace que se vuelva a conectar. ¿No?

Paciente: Mm hmm.

Doctor: Entonces, pos- usted creo que tiene de todo, desde muy niña-

Paciente ((interrumpe)): de NIÑA – por lo de mi papá que pasó con mi mamá, porque yo la veía que lloraba mucho.

Doctor: A lo mejor, todo esto – ((ella interrumpe otra vez))

Clinical Visit #2 with Margarita on 4/22/2014
Timepoint: 22:52-23:38

Excerpt #3:

Doctor: ¿Cómo te expliques esto que te pasó? ¿Por qué crees que te pasó?

Paciente: Todavía (jeje) no encuentro explicación. Je.

Esposa: Pues, puede ser ese: porque su hermano y igual, a su papá.

Doctor: Puede. Pero tampoco es- si tú tienes hijos, no quiere decir que les va a pasar. Pu-ede que les pasa. Si tienes cuatro, a lo mejor, uno pu-ede, <u>pu</u>-ede que le llega a pasar. ¿Por qué te hago esta pregunta? Porque a lo mejor- yo la contesto. Es <u>algo</u> que le pasó a tu cerebro. Por alguna causa, alguna falla. Hizo como un corto circuito. Pero eso se puede corregir. ¿No? Y eso es tomando el medicamento. El que más me interesa es el Citalopram. Lo tienes que tomar como seis, ocho, hasta un año. Ese es lo que tienes que tomar. Si en seis meses, tú te sientes bien y lo suspendes, hay mucha probabilidad de que te vuelva a pasar en cinco, en diez años. Y el idea es que no te pasa. Entonces, por eso es importante que mejor, lo tomes un año.

Clinical Visit #4 with Polo on 6/27/2014
Timepoint: 10:09-11:12

Excerpt #4:

Investigadora: Y hay reglas sobre la cantidad de tiempo que un paciente tiene que tomar el medicamento. Por ejemplo, muchas veces los doctores de aquí dicen "…Entre ocho meses e un año." ¿Pero por qué? ¿Hay un estudio que dice que en este tiempo algo cambia en el cerebro o es solamente un periódo de mantenimiento y después, uno se puede dejar el medicamento, o cómo es?

Doctora: Por lo que yo sé, hay dos tipos de estudios. Sí, hay estudios en los cuales nos han demostrado que al partir de un año, hay ciertos cambios estructurales del cual había. Osa, una diferencia, ¿no? A lo mejor, como que obviamente no los hemos visto porque nunca les sacamos una resonancia magnetica… pero sí, hay estudios de esto… Pero de lo clínico, osa, de cómo es lo clínico de cómo va mejorando el paciente, ahí sí, también lo he visto y hay estudios sobre cuánto tiempo… Por ejemplo, hay estudios donde lleva el tratamiento por un año y se quita. En otros, en año y medio. Entonces, vieron cuales de ellos recayeron. Entonces, recaían más los del año. Osa, recaían más los que ponían menos tiempo…. Está año y medio los que menos recurren.

Interview with Dra. M. on 8/09/2014
Timepoint: 6:43-8:50

Excerpt #5:

Doctora: Okey. Mire, ahorita tengo una tarea muy especial de platicar todo lo que me ha platicado con la psicóloga… que el tratamiento, eh- el tratamiento farmacológico es una ayuda. A lo que va principalmente en un trastorno depresivo es a psicología. Ajá. Sí? De todos modos, ahorita yo le voy a ajustar la dosis, también para que usted está más tranquila. Y lo que va a hacer la psicología es igual a dar todo esos conflictos que usted puede enfrentar de una manera más tranquila que se lo cuente. Ajá? Pero todo se tiene que hablar, todo, todo, todo.

Clinical Visit #3 with Juana on 4/02/2014
Timepoint: 11:27-11:33, 11:47-12:16

Excerpt #6

Doctor: Pues, muy bien señora (nombre). Yo vuelvo a reiterar. Yo creo que lo que usted tiene es algo que se llama depresión.

Paciente: Mm hmm.

Doctor: La depresión es una enfermedad. Así como usted tiene hipertensión, o la presión alta, la depresión también es otra enfermedad, lo único [es] que la depresión ataca aquí es el cerebro. Para eso necesita medicamento. Y el medicamento mínimo lo tiene que tomar [por] seis u ocho meses, ¿no?

Clinical Visit #2 with Margarita on 4/22/2014
Timepoint: 21:07-21:32

Excerpt #7

Doctor: Muy bien señor (nombre), pues me da gusto que vaya bien, creo que lo comentamos, este tipo de lo que le pasó, ansiedad, depresión, es algo que tiene que aprender a… este… ^no a vivir con ello, pero sí es algo que no es fácil de quitar, que va a durar un par de… meses, a lo mejor hasta años ¿no? Yo creo que ahí va, va mejorando pero yo le voy a recomendar que todavía otros seis meses usemos el- el, medicamento, ¿no?

Paciente: Sí, doctor. Pues yo, lo que pienso es de que por decir si, si de diez años para acá, o Sea, no- como de 14 para acá, o sea que, pues, mi vida fue de puro, puro desastre, y siempre pensé en mí y de mí, pues ahorita ya el tiempo que, que me quede de orita esté yo en recuperación pues no me importaría que fuera uno, dos, tres años. El chiste es que si es por mi bien pues, adelante ¿no?

Clinical Visit #4 with José on 7/09/2014
Timepoint: 10:34-11:40

Chapter 4: Ecologies of Care and the Desire to Be *'Más Tranquilo'*

Excerpt #2:
Paciente: Sí, siento cansancio en la noche, pero… cierro los ojos y estoy (nombre), "Duerme profundamente, duerme profundamente." Porque he cerrado los ojos pero cualquier oído o algo me… ¿ Sabe que me pasó los primeros días? ¿Sobre todo los primeros quince? Eh, estaba dormido y escuchaba el sonido de la puerta o un claxon o el…. O que pasaba el camión, y ya así me ponía un poco mal. Ya va a empezar el día y como que *los nervios*, BUM!
Doctor: ¿Pero fue bajando?
Paciente: Me llega a pasar de repente porque sí me – sí, me estresa, pero no con todo. Digo con calma, "Todavía falta media hora más para que despiertes," pero sí me – me quita el sueño.

Clinical visit with Javier on 5/22/2014
Timepoint: 9:00-10:13

Excerpt #3:
Paciente: Pero, ya nomás estaba en que cómo voy a lavar, cómo voy a hacer esto si… o sea, los perros están ahí, y todo me lo ensucian. Siento que sí van a entrar, antes no era así. Antes nada más si veía al perro cerca. Pero ultimamente, si llegara a ladrar, siento que ya me ensució mi traste o mi ropa o no sé.

Doctor: Oye y ¿tienen perros cerca?
Paciente: Sí, uno.

Doctor: ¿En dónde?
Paciente: En la casa.

Doctor: Okey. ¿Lo has tocado al perro?
Paciente: No.

Doctor: ¿Y dónde vive, o dónde duerme ese perro?
Paciente: Pues, en el patio. Sí.

Doctor: ¿Y tú te acercas al patio?
Paciente: Sí. Pero sí, lo corro.

Doctor: Okey. ¿Por qué te pones triste… ahorita que estamos hablando de esto?
Paciente: O sea, porque yo siento que no (llorando), o sea, yo [no] me siento mal porque yo sé que esto no era normal pero no puedo evitar.

Clinical visit with Rosa on 4/4/2014
Timepoint: 14:30-15:24

Excerpt #4:
Paciente: Pero con la medicina que me dio el doctor la vez pasada, major. No le puedo

decir que, (en tono alto) “Me siento feliz” o…
Investigadora: Nah, no lo es así.
Paciente: No. Pero me siento más tranquilo.

1st interview with Javier on 5/22/2014
Timepoint: 5:59-6:19

Excerpt #5:
Investigadora: ¿Y ese día se sentía más energía?
Paciente: Sí, me sentí más mejor. De hecho, ya- después de que me terminé de todo, me dio sueño. Y pues, ya me acosté tranquila porque ya me he terminado con insomnia.
Investigadora: Sí.

Paciente: Hay veces que, hasta que ni puedo dormir por lo mismo de que está todo el fregadero allí, yo durmiendo y mis hijos, y no. No me siento – es que no me siento ni a gusto para dormir. Por lo mismo. Pero ahora, sí, que espero que me ayuden ustedes para ya no sentirlo que siento, que ya no tener sueño, ya ser más, este- ¿Cómo le diré? Pues sí, apurarme más en mi quehacer, a mis cosas, a mis hijos, ponerles más atención porque te están- también les descuido a ellos. Por lo mismo.

Interview with Tepin on 6/23/2014
Timepoint: 4:58-5:47

Excerpt #6:
Paciente: Un poco en el carácter. Ya no me enojo tanto. Estoy un poco- como… En esto estoy más tranquila. O sea, ya me dicen, ya no les contesto, ya no les digo tantas cosas como les decía yo. Pero- porque en los… en esa alteración que yo siento, en esas ansias, este- que me vienen nada más en el momento, estoy bien y ya empiezo a temblar.

Clinical visit with Laura on 5/6/2014
Timepoint: 1:44-2:03

Excerpt #7:
Doctor: Bueno, ¿cómo ha estado? ¿Cómo le ha ido?
Paciente: Pues…este… >con mucho sueño, empecé con dolor de cabeza<, se me quitó, y…aparte, relajada doctor. O sea, los problemas han estado… económicos difíciles, pero gracias a Jehová, lo he tomado con mucha tranquilidad, o sea, como que…’toy así no sé, si sea bueno. Bueno para mí ha sido bueno porque he dormido, ¿no?, y…este…aunque está la presión fuerte, pues se han ido superándolo y sin tanta preocupación que me hice pasar antes - a veces hubiese estado desesperada.

Clinical visit with María Camila on 7/2/2014
Timepoint: 0:08-0:43

Excerpt #8:
Doctor: ¿Cómo vas con el lavado de las manos?
Paciente: Este- pues sí, menos.

Doctor: Okey. Muy bien. ¿Has dormido mejor?
Paciente: Sí.

Doctor: ¿Estás más tranquila?
Paciente: Sí.

……

Doctor: ¿Cómo la han visto? ¿Cómo va?
Padre: Pues, sí como vemos que ya, mejor a mejor.
Hermana: Sí.

Doctor: ¿Sí? ¿Ya está más tranquila?
Padre: Sí, ya. Ya más tranquila que estaba cuan- antes que viniéramos. Ahora sí, cómo que no- ni nos quiera hablar. Nada, ¡vaya! Le platicábamos y no más nos veía. No, ahora ya. Ahora ya, ya nos platica. Ya nos – pues ya, ya convivimos la familia mejor.

Clinical visit with Rosa on 7/3/2014
Timepoint: 0:36-0:55, 1:19-1:50

Excerpt #9:
Esposo: Al principio, cuando la primera, primera pastillita que le dio el doctor, este- pues, el doctor le daba un dosis más o menos algo elevada para que se tranquilizara, porque todo el tiempo era de- desde que amanecía hasta que oscurecía con los malestares. Y no podía tener un rato tranquilo, con paz. Para nada.

Interview with Guadalupe & her husband on 8/17/2015
Timepoint: 3:42-4:06

Excerpt #10:
Esposo: Sí, a veces yo le digo, a veces yo me gustaría irme a la ciudad. Digo, platicando con ella. Irme por lo menos a Puebla. Digo, eh, pues, tener un trabajito, pues,
Guadalupe: Estable.
Esposo: Lo que es de diario, diario.
Guadalupe: Estable.
Esposo: Estable, estable allí. Y por lo menos cada semana, cada quince días, ahí estar tu dinero.
Guadalupe: Pero aquí, de verdad hay….
Esposo: Aquí, lo único, lo único de aquí es: está tranquilo.
Guadalupe: Mm hmm.

Esposo: Eso es lo único. Usted puede andar donde sea, y… tranquilo.
Guadalupe: No hay asaltos.
Esposo: Está tranquilo. Pero lo que sí, no ayude es la economía.
Guadalupe: Mm hmm. Porque- de verdad que, no hay nada de trabajo, pero que es absolutamente nada. A veces te hablan por un día. Dos días…
Esposo: Una semana al máximo.

Interview with Guadalupe and her husband on 8/17/2015
Timepoint: 48:29-49:20

Chapter 5: Conclusion

Excerpt #1:
Doctora: Okey, bueno. Ahorita tiene una mejoría parcial. Este- le podría yo optimizar la dosis del antidepresivo pero le voy a dar otra- o la oportunidad por unos veinte días más. Si en la siguiente consulta, como que en vez de mejoría, te recae, vamos a ver si lo ajustamos, ¿sí? Agárete de estas personas que ahorita le están apoyando. Y estas tareas que están dejando, también en psicología, eso sí, está bien.
Paciente: Bueno, pero me dejó.
Doctora: Pero lo poquito que me dijo, de que se vaya apuntando como metas díarias, aunque sea muy pequeñitas, “Voy a hacer esto.” “Le voy a poner una hora para esto.”
O sea, que no vamos a cumplir, no? Pero que sean cosas así, que poco a poco, la motiven. También la ayuda.

Interview with Juana on 4/29/2014
Timepoint: 15:00-15:48

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