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hscience@coc.fiocruz.br

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Uribe, Carlos Alberto

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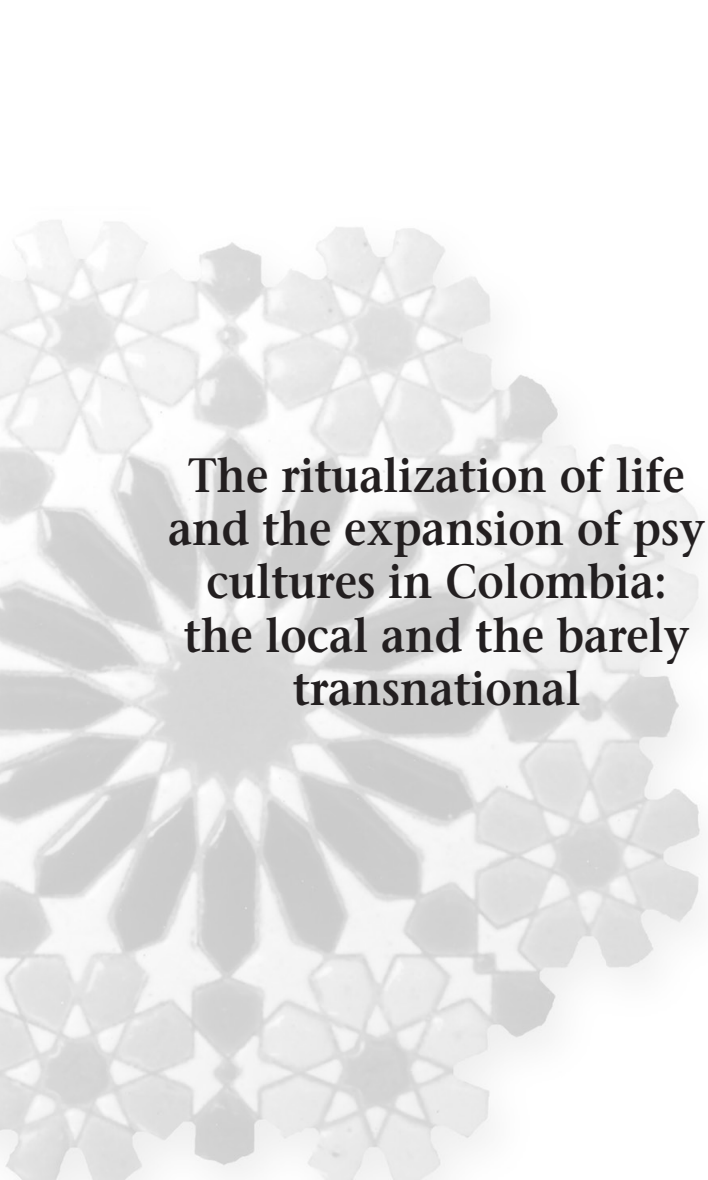
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The ritualization of life and the expansion of psy cultures in Colombia: the local and the barely transnational

Carlos Alberto Uribe

Professor, Department of Anthropology/Universidad de los Andes.
Cr 1, n.18A-12, Cundinamarca
111711 – Bogotá – Colombia
curibe@uniandes.edu.co

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Abstract

This paper exposes the status of psy cultures in Colombia. It is shown how the country's official health system has transformed biomedical psychiatry and cognitive behavioral psychology into the dominant and hegemonic psy culture. However, far from being hegemonic, as presented, both serve to foster and sustain the existence of different "religious" or "sacred" therapeutic systems and practices that denaturalize human existential and psychological suffering. In general, the latter are ritual practices with a strong spiritualist, anti-materialist and antimonist content, that deal freely with a wide range of cosmologies, beliefs and symbols, even including the same concepts and practices of a biomedical origin. The result is a hyper-ritualization of daily life in the country.

Keywords: Colombia; psy cultures; official biopsychiatry; ritualized therapeutic systems; daily life and ritual.

This paper has a single theme. It seeks to discuss the paradox that characterizes the status of psy cultures in Colombia. I use the word “paradox” in its broader sense as a rhetorical figure that implies the existence of a contradiction. The challenge I face, therefore, is to reconcile these two interpretations that give rise to the contradiction. My proposal is to invite the reader to study a problem about which there is still much to reflect upon.

First aspect of the paradox: the country’s official health care system has ensured that biomedical psychiatry and its psychotherapeutic ally – cognitive-behavioral psychology – have become the dominant and hegemonic psy culture. In addition, the two combined seek to exclude or circumvent any other approach that might compete with them in the field of mental health and individual or collective health care.

Second aspect of the paradox: according to Jorge Luis Borges (1994, p.368) in his publication “El Etnógrafo,” science – our so-called “science” – is a mere frivolity. And it is a frivolity because psychiatric science and its partner psychology, far from being hegemonic as they are usually presented, foster and sustain a multiplicity of therapeutic and support systems and practices that provide assistance to those needing solace and relief from their personal afflictions. Without claiming to be dominant or hegemonic, these other therapeutic skills and practices are generally based on denaturalized and non-reductionist concepts, which are almost always transcendental, involving both good and evil, health and sickness, life and death, the mind, the spirit and the body, happiness and suffering. These involve therapeutic systems of knowledge and practices that are more “religious” or “sacred,” which are unsettling terms, representing a high content of anti-materialistic and antimonistic spirituality that define the subject and subjectivity in idiosyncratic ways – and which are, in all cases, constantly undermined by the opinions of the theorists of countries of the center regarding what constitutes the modern subject. Thus, these are vitalist systems, whose practical and existential enactments are often through elaborately baroque rituals. These ritual scenarios freely mix together and transform all types of cosmologies, beliefs, practices and symbols – including the free use of concepts and practices of a biomedical nature. This undoubtedly represents a vast blend of rituals for a society of mixed rituals, such as Colombian society. A hyper-ritual to restore life, health, well-being and happiness, in a highly-ritualized society, which loves mimetic form, euphemism and imitation.

Between these two aspects of the paradox, Freudian psychoanalysis, in its orthodox and non-orthodox, Lacanian and non-Lacanian dimensions, today occupy a relatively marginal position in the context of psy knowledge in Colombia. A subject for illustrious minorities and professionals, say some. For some others, mainly the biomedical psychiatrists and their allies, the cognitive-behavioral psychotherapists, psychoanalysis is despised and attacked, *usually sotto* voice and behind closed doors. However, psychoanalysis has become a cult subject, at least in certain psychoanalytical scenarios and in certain cities of the country – such as Medellin, where using the word psychoanalysis is rather like mentioning the term Lacan. And, despite everything, this is a subject that is still discussed in resident training seminars staged in various schools of medicine, thereby establishing an eclectic group with other seminars that involve cognitive-behavioral, systemic and phenomenological psychotherapy.

Following this introduction, a summary is given of how psy sciences were first established in Colombia

In their initial institutional stages, university psychology and psychiatry demonstrated an eclectic combination of psychometric methods that would later serve to establish the basis of native cognitive-behavioral psychology, and other theoretical and sub-disciplinary approaches, including the psychoanalysis of Sigmund Freud. These trends worked hand in hand until the decade of the 1970s, when a gradual process began to eradicate psychoanalysis as the basis for psychiatric and psychological training.

As had been the case in several other Latin American countries, after the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) was published in 1980, Colombian psychiatry began to embrace North American biomedical psychiatry guidelines, to the point where a biomedical and pharmacological approach became central to therapeutic psychiatry for mental illness in Colombia. Thus, psychiatric journals and manuals from the United States became the principal source of local psychiatric knowledge. Such is the current situation in the 16 departments of psychiatry that exist today in Colombian schools of medicine.¹

From the standpoint of the teaching of psychology, the ratification of Law no.30 of 1993, that reformed the system of university education in Colombia and re-defined university autonomy, proved to be fundamental. This law marked a spectacular increase in the number of undergraduate psychology courses available in Colombian universities. There are currently 114 undergraduate courses on offer in psychology in the country, which represent, approximately, one course in psychology for every 395 thousand Colombians. Of these, 23 courses are held in public universities and 91 are offered by private universities, almost all of which follow cognitive-behavioral framework guidelines, which, under different labels – scientific psychology, experimental psychology – have replaced psychoanalysis in university courses in psychology.²

“Alternative” practices and the ritualization of daily life

At this point in the essay, I will attempt to respond to the question regarding the relationship between the expansion and bio-medicalization of “official” or “scientific” psy cultures, and the ritualization of daily life and of suffering in Colombia.

My initial approach consists in repeating, once again, a conventional saying used in medical anthropology, according to which, in complex societies, different therapeutic systems frequently coexist, some are “modern” and others “traditional,” some are derived from Western scientific medicine, while others meet the needs of local developments or of different historical-cultural traditions. All of them are involved in the challenge of how to treat and to heal – and often appear as real medical systems (Kleinman, 1980). Even the World Health Organization (WHO) admits that there is a need to closely examine so-called “alternative and complimentary medicines,” and to see what these can offer that is both valuable and useful in the art of treating the sick and restoring their joy in living. With this objective, detailed catalogues on alternative and complimentary medicine have appeared on the scene, and are available on an international scale. A few of these methods are well-known:

homeopathy, Ayurvedic medicine, traditional Chinese medicine and acupuncture, bio-energy and curing techniques and meditation that derive from various aspects of Buddhism. Conflicts arise when these systems are transplanted into a Latin-American context, where the adjective “Western” is problematic; and where concepts like “medicine,” “psychology,” “psychiatry,” “religion,” for instance, lose a good deal of their declared and propositional value. When faced with “alternative” systems, we are left not fully knowing if we should consider these as philosophical systems, religious (or “belief”) systems or ways of life, that include therapeutic prescriptions or healing practices that enable us to seek the health and happiness that have been lost.

This catalogue of methods, however carefully constructed, is of little help when having to deal with the problem raised in this essay, although several of these systems have been widely disseminated in Colombia, with a large following and many therapeutic centers, which are now sharing space with other forms of healing. Among the latter, so-called traditional indigenous medicine stands out, a repository of traditional herbal remedies that is still present in the collective imagination, especially in urban middle-class sectors, with the ritualized consumption of *ayahuasca* or *yagé* (*Banisteriopsis caapi*, also known as the caapi vine (*cipó-mariri*). This involves practices known by the imprecise terms of shamanism, or by the even more imprecise term neo-shamanism, which have had increased exposure and become famous locally as alternative therapies for mental diseases. Indeed, it is now quite common to seek, shall we say, a shamanistic medical opinion for such problems as depression, psychosis, eating disorders and substance abuse, for example, in the hope that an urban ritual of *ayahuasca* will enable patients to recover from their afflictions.

The reason this phenomenon is relevant is that we are confronting real networks of healing, that link the *taitas*, or indigenous shamans from the Colombian Amazon plains, to the travelling shamans, who go from town to town, offering their *yajeceros* services to heterogeneous masses of people, including middle- and upper-class sectors of society (Taussig, 1987; Pinzón, 1988). Many of these indigenous *taitas*, who have been recently qualified as such, and some of whom have a high level of education, establish themselves on a permanent basis in the larger cities of the country, where they organize their “consulting rooms,” which is the term they use themselves, and their centers of “traditional” indigenous healing. In these places, some non-indigenous shamans, who have adopted the “road of *ayahuasca*,” share the same space and patients, and offer their healing arts to a numerous clientele, anxious to find remedies for the sickness in their bodies and souls (Uribe, 2008; Caicedo-Fernández, 2015). These indigenous and non-indigenous shamans, who have consulting rooms or permanent ceremonial centers, or who use as their consulting rooms the boarding houses frequented by farmers travelling to the big cities, frequently travel to North America and Europe. There they encounter other “traditional doctors,” such as Native North American medicine men, Mayan or Aztec priests (who are also international travelers) and their expatriate European and Latin American *yajeceros* epigones, some of whom are members of Brazilian *ayahuasca* churches, such as the *Santo Daime* and the *União do Vegetal*. They also meet gurus from India, traditional Chinese doctors and a variety of other characters that form part of the complex that the WHO refers to as Alternative and Complementary Medicine. A few of these shamans

are arrested for carrying in their baggage doses of *ayahuasca* by those responsible for waging the so-called “war on drugs.”

We are therefore dealing with a fascinating scenario of healing, in which the medical, in the sense of therapeutics of *soma* and *psyche*, represents just one chapter of the drama, since the loyal adherents and their “shamanistic” guides bring together, with total freedom, ideas from aboriginal sources, with concepts and actions taken from a romantic naturism combined with New Age principles. This heterodoxy does not stop here. For the indigenous healing traditions, already hybridized, may also be mixed with Buddhist transcendental meditation, the *yin* and *yang* of Chinese medicine, the chakras of India as well as a good dose of acupuncture needles, among others. All this, in a never-ending search to attain a well-being beyond the somatic and psychological, possibly a spiritual well-being freeing the faithful from the anxiety of living in a permanent state of emergency. In short, this represents a vast “market” where supply competes with demand for cures – a rich market, in its own way like the free market that now guides modern scientific medicine.

Part of this scenario includes Afro-Colombian healing rituals, resulting from the importation into the country in recent times of Afro-Cuban *santería* by important leaders of the drug trade. Their clientele is, again, formed by members of the professional sectors or by office workers from the middle classes in cities like Cali, Bogota, Medellin and Barranquilla. And here, once again, we have networks that link the Babalawo (“father of the mysteries”) and their disciples to the great Cuban masters of two of the *santería* specialties: the *palo*, and voodoo. In addition, most of these specialists do not, in the true sense, belong to the Afro-Colombian communities that come from the Pacific or the Caribbean.

The list of methods of healing offering their promises of happiness to the Colombian people, stricken down by pain and desperation, continues. For instance, we have those offered by a host of Catholic priests and neo-Pentecostal pastors, committed to celebrating their healing Masses, their prayers for the sick, their rituals to free those possessed by the Devil, their apparitions of the Virgin Mary, in their efforts to provide testimony of God’s power in the curing of cancer, diabetes, depression and Aids, amongst other diseases. Those anointed with the Holy Spirit’s charisma, promoters of miracles, cults and prayers, as well as networks of prayers for the sick, have proliferated. As before, a “medical” theme is always present in their cures. One of these priests, Álvaro de Jesús Puerta, referring to his holy sanctuary, claims that it represents “a great open-air hospital; a great hospital of the Lord,” and that the sick turn to him “because health care in this country is worthless.”

Patient or agent in a hyper-ritualized scenario

The statement made above by the Catholic priest, Álvaro de Jesús Puerta, at the shrine of Nuestra Señora de La Esperanza in the municipality of Soracá de Los Andes, is relevant to complete the argument raised in this essay (Uribe, 2009). The following remarks are presented in two sections. The first is inspired by the claim made by this priest, since the official health care system in the country promotes, in verifiable empirical forms, the expressive flowering of these other therapeutic possibilities. This profusion of alternative therapies is not simply due to the saturation of the official medical services, nor is it due to the bureaucratic barriers that

regular patients must face to gain access to certain services, especially the more expensive ones. For the “bureaucratic itineraries” patients follow in seeking medical assistance can become a veritable maze of waiting and despair (Abadía, Oviedo, 2009). It is possible to expand the list of reasons why patients end up being “expelled,” so to speak, from the official health care system. However, there is one reason, that is not usually mentioned in these debates and which I find very intriguing: it involves a definition that reflects the local image of an individual (explicit in the “patient” category), which illustrates the two aspects of the equation concerning the matter under discussion, namely the physicians and the patients.

I will illustrate my position based on psychiatry and the mismatch with the patients it looks after and treats. I appeal to psychiatry because the psychiatric field lends itself very well to the perception of an intermingling of ideas, such as normality, abnormality, pathology, madness, well-being, health etc. In the example that follows, which is trivial albeit representative, I will employ medical terminology.

This involves a clinical case.³ A psychiatrist attended a patient for a clinical consultation. This was a man called Pérez, a patient who carried in his hand the form that authorized his referral for psychiatric services issued by the private entity to which he is affiliated, in accordance with the law governing the Mandatory Healthcare Plan, or Programa Obrigatorio de Saude (POS). After undergoing a mental examination, the physician concluded that her patient, an urban middle-class employee with higher education, suffered from a psychotic disorder. It was characterized by the presence of a variety of visual and auditory hallucinations and self-referential persecution delusions – which, as the patient never tired of saying, made him feel he was being attacked daily by a female figure resembling a witch. Once she had made her diagnosis, the psychiatrist explained to her patient that his problem involved a cerebral neurotransmission of a molecule called dopamine. And, furthermore, that the medication that he would be prescribed, an antipsychotic, would correct this “problem.” Thus, if Mr. Pérez rigidly followed the prescribed pharmacological treatment, he would be able to go on to live a normal life.

The patient left the hospital with the prescription in his pocket. He was accompanied by his wife, who wore a smile of satisfaction on her face. They had just arrived home at their apartment, located in a residential complex in the capital – four blocks of buildings, each one with five 10-floor buildings and five apartments per floor – when the employee began his treatment. Three or four days later, he was already beginning to feel the effects of the medication in his body, together with the accompanying “extrapyramidal symptoms,” as the doctors say – though the patient had been warned beforehand that this could happen. Worried, the couple began to think about what they should do next. They decided to continue with the treatment since the dopamine could be a factor causing these problems. After all, modern neuroscience has advanced a great deal in its research into psychosis. In addition, the problem is in this employee’s brain, a “broken brain,” in particular in the neural pathways that transport the dopamine, and not in his “mind” or in his psychosocial profiles. Much less in conspiracies involving witches – as stated by the acclaimed North American psychiatrist Nancy C. Andreasen (1985), a worthy representative of this vast body of specialized medical literature that defends a biomedical reductionist approach to mental illness.

However, after a few days, the couple agreed to seek other methods to deal with the patient's suffering. What upset them most was the nature of these "witch" attacks. A medium who "works" with the Venezuelan physician, "San" José Gregorio Hernández, had told them, during a consultation, when the symptoms of this psychosis first began to appear, that a woman had contracted a witch to "cast a spell" on Mr. Pérez. The medium said that this was an act of revenge because he had not continued an adulterous affair with this woman. Everything seemed to point to the secretary who worked in the husband's office. These uncomfortable, or "dirty" episodes, as his wife described them, had affected this man's mind. It was as if he was "paying for his sins" and jealousy and envy were "responsible" for the witchcraft that disrupted his mind. As a result, Pérez could not sleep and began to see these strange apparitions, hear voices and to "see in his head" the witch who threatened to drive him mad. When he returned home after this revealing meeting with the medium, this timid employee had to confess to his wife that he had had a brief affair with the secretary, but that "nothing really happened." Amid his feeling of regret, guilt and weeping, he asked his wife for forgiveness and promised that, from now on, he would remain truly faithful to her.

Our employee then began to visit various specialists; he sometimes went alone and at other times was accompanied by his wife. There began a "therapeutic itinerary" (Uribe, Vásquez Rojas, 2008), the first step being a private appointment with a bioenergetics physician, who had been highly recommended by his mother-in-law, who always used Alternative and Complementary medicines. Things began to improve a little. The patient continued to take his antipsychotic medication, even though the new therapist had recommended that he replaced this with his own homeopathic prescription. After a serious relapse, our employee decided to visit a center for transcendental meditation to remove the unsettling thoughts involving witchcraft that were tormenting his mind. Someone at the center told him that a powerful indigenous *taita* from Putumayo, a shaman, would soon be visiting town and would offer his services during the following weekend at a rural farm located nearby. As this involved a healing ritual using *ayahuasca*, which would include a *temazcal* on Sunday, and would be open to all willing to participate paying a modest fee of COL\$ 100.000 (around US\$ 50), the employee decided to go. He went alone because his wife "wanted nothing to do with anything involving an Indian."

And so, after several downturns, which took him from one therapeutic network to another, this healing itinerary finally took Pérez and his wife to Soracá, in Boyacá. There they attended the healing Masses of Father Puerta, which were always held on the first Saturday of each month. Since they wanted to do things properly, the couple decided to take part in the complete cycle: confession with the priest on Wednesday; the laying on of hands on Thursday, and, more importantly, the prayer of liberation offered by the priest on Friday. After their pilgrimage to the Sanctuary of Our Lady of Hope (Nuestra Señora de La Esperanza), Pérez and his wife highlighted two incidents that had occurred during these religious celebrations. The first relates to the liberation, when the priest exorcised the devil who attacked Mr. Pérez because of the curse cast on him because of his infidelity. The second incident was the promise they both made to be good Catholic believers, after becoming overcome with emotion, to the point of shedding tears, during the sermon given by the priest on Saturday – a long speech in which the priest bluntly attacked witches, the indigenous healers who

deceived the unwary, and the false Venezuelan saint, José Gregorio Hernández. Today, Mr. and Mrs. Pérez have an exemplary marriage. For several months now, Mr. Pérez no longer takes haloperidol. Both have become affiliated to a cult of the Virgin Mary, and belong to the Catholic Charismatic Renewal Movement (Movimento de Reinvoice Carismática Católica) and every month go to Soracá, to accompany Father Puerta. Both are members of the “ministry of music,” which joins Father Puerta, with their songs and music, in his healing Masses held every Saturday. Every so often, Mr. Pérez again sees the apparitions and hears voices. So, he fasts and redoubles his efforts to participate in the circle of prayer dedicated to the Virgin Mary.

Final considerations

This tale can be analyzed from many angles. I have chosen one that I would like to stress. We can begin by stating that the initial meeting between physician and patient was marked, in truth, by a mismatch. Two viewpoints, one expressed by the physician and the other by the layman, confronted one another during the clinical consultation. The outcome of this was the primacy of the physician’s opinion, which encapsulated the entire issue of Pérez’s suffering in terms of natural science, in particular neuroscience. The patient, on the other hand, who partakes in this “medical culture,” to some extent accepts the naturalization of his distress. Nevertheless, when confronted with excessive doubts and questions (signifiers, as it were), begins to feel overwhelmed by the number answers (signifiers) which enable him to conceptually “domesticate” his own suffering. This, in turn, triggers off a conflict between different viewpoints about what psychiatry calls “psychosis” (Kleinman et al., 2006). This conflict of interpretations prompts Mr. Pérez to seek other forms of treatment, while the psychiatrist aims to ensure, as she says, that the patient “perseveres” with his treatment. Thus, we can proceed with an analysis in terms, shall we say, of Foucault and start to use the categories of biopolitics that all this entails. We may also use the concepts of Foucault’s disciple, Nikolas Rose, and talk about the “psychologizing” or not of Mr. Pérez’s subjectivity or his governability (Rose, 2007; Rose, Abi-Rached, 2013). All this is relevant: we are undoubtedly in the presence of a conflict of powers. Furthermore, although this involves a banal conflict of interpretations, these questions are not resolved either by the physician nor by the patient, for the questions are above argumentation after a certain point in the therapeutic encounter is reached.

My proposal, instead, is to put forward an argument using a theory of action to resolve critical life events, such as, for example, an acute psychotic crisis. It must be said, firstly, that this is only one example of this sort of situation of rupture, in a country that is in a state of “permanent emergence” such as Colombia. This approach, which nowadays is usually referred to as “enactive” or “enaction,” attempts to accompany the practical implementation, or rather, the praxis of an action — in this case, the attempts made to find a cure by real, concrete individuals like Mr. and Mrs. Pérez, imprisoned in their own webs of social relationships (Mol, 2002). The Pérez couple “act” or “enact” their tormented, uncertain and troubled lives during these ritual therapeutic transitions, which include the psychiatric appointment itself. This is the reason I chose to emphasize the therapeutic itinerary of the Pérez couple. That which physicians refer to as a “patient” is, really, an “agent,” namely a person who has the capacity

to act – even though many of his/her actions may not appear to us as being very rational and the result of the malfunctioning of their central nervous system. Ultimately, it is these “agents” who control every medical act, every healing event; for they are involved in the pursuit of happiness and certainties, or at the very least some transcendental or “spiritual” certainties. These “agents” bring with them all their personal histories as individuals, simultaneously as private individuals persons and collective individuals, embedded in culture. Or, rather, in a private culture.

Indeed, we can now go further in our understanding of the hyper-ritualization that Colombia is experiencing. This hyper-ritualization is related to a certain trend involving excessive rituals in response to the chronic transitions that disrupt individual and collective life in the country. “Madness” is one of these transitions that erupt as confusion and chaos in the life of those caught up in it, and in the lives of their inner circle of family and friends. On a collective level, violent, accidental or premediated death, homicide, massacre, or riot, and the like, in the protracted irregular warfare that went on in the country also raises this “theatralization of excess” (Blair, 2004). This is a consequence of the fact that the concentrated terror of ritual healing confronts the generalized terror of violence; furthermore, in the face of terror and its consequences, namely, the unresolved traumas both at the individual and the collective levels, there follows the naturalizing of the ritualization of daily life. This way it may be possible to better illustrate a widespread history of ritualization which came, in the first place, with the arrival of the Counter-Reformation to these lands, interlocked with its ritual and baroque undertakings.

I now present the conclusion I wish to put forward for this essay: modern individuals, in our countries, never became “disenchanted,” in the sense of Max Weber, nor did they become “re-enchanted,” in the sense proposed by some post-modern authors. It is necessary to examine in what way the program of secularization, psychologization, reflexivity, or the autonomous decisions regarding the destiny of one’s genes, and other attributes of modern individuals, proclaimed in unison by Northern theorists, failed to be achieved in full in these parts. Conversely, modern individuals around here have always been “sacralized.” Despite this, people here have become “secularized” at different levels, even though they have always been tied to ritual, following the counter-reformist imprinting of these lands. It may be that all this only applies in the case of Colombia. At any rate, our modern individual does not seem to be this Calvinistic-type of European Protestant ascetic, who so enchanted Weber, and continues to enchant his theorist followers in late modernity – even though, in the final analysis, this Calvinist-Weberian person is only the result of an idealization, an ideological and essentialist construction. On the contrary, the Latin-American individual has been “post-modern” since time immemorial. The “post-modern” epithet is not ideal, but shows how nowadays it is possible for us, Latin Americans, to be – to a great extent – hybrid beings (García Canclini, 1989). Even so, the monist and materialist reductionism of biomedical psychiatry clearly fails to understand its “patient.”

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NOTES

¹ In order to illustrate the close relationship between Colombian psychiatry and the biomedical psychiatry of the Anglo-Saxon world, it is also necessary to examine the connections that exist between the Colombian Association of Psychiatry, the university departments of psychiatry and the multinational pharmaceutical industry – a tripod that also operates in the case of psychiatry in the United States (Whitaker, 2002, 2010; Luhrmann, 2001; Martin, 2007; Conrad, 2007; Dumit, 2012). With regards to Argentina, see the similarities with the case of Colombia in the works of Lakoff (2005, 2007), although we encountered a marked presence of psychoanalysis there (Plotkin, 2001; Dagfal, 2009). With respect to the globalization of psychiatry, see also Petryna, Kleinman (2007) and Healy (2007).

² The experimental model of scientific psychology became the dominant model after the “conflict of paradigms” with psychoanalysis during the 1970s (Ardila, 2013, p.83).

³ Although based on real clinical documentation, this case is totally fictitious.

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