Anthropology & Medicine

Routledge
Taylor & Francis Group

ISSN: 1364-8470 (Print) 1469-2910 (Online) Journal homepage: http://www.tandfonline.com/loi/canm20

Psychotherapy, psychoanalysis and urban poverty in Argentina

Maria Esther Epele

To cite this article: Maria Esther Epele (2016) Psychotherapy, psychoanalysis and urban poverty in Argentina, Anthropology & Medicine, 23:3, 244-258, DOI: 10.1080/13648470.2016.1180664

To link to this article: http://dx.doi.org/10.1080/13648470.2016.1180664

ANTHROPOLOGY & MEDICINE, 2016
VOL. 23, NO. 3, 244–258
http://dx.doi.org/10.1080/13648470.2016.1180664

Routledge
Taylor & Francis Group

Psychotherapy, psychoanalysis and urban poverty in Argentina

Maria Esther Epele

CONICET/University Buenos Aires, Instituto Gino Germani, Uriburu 950 P.6, ciudad Buenos Aires, Argentina

ABSTRACT

Based on ethnographic research carried out in the Buenos Aires Metropolitan Area, this paper examines the views of social actors on the psychoanalytically-oriented psychotherapy focused on marginalized populations. From Foucault's perspective on the forms of truth-telling, the aim of this paper is to analyze, as a preliminary research report, treatments according to the native ways of speaking and listening, which dominate the description of therapeutic experiences of patients who come to the treatment without any professional intermediation. The neoliberal transformations of the past decades in Argentina changed both the landscape of the public health system and the daily lives of marginalized people. Considering such changes, this paper examines the ways in which verbal actions (speaking and listening) take place in psychotherapy and mark the course not only of treatments but also the temporal rhythms of their development, and their various levels of efficacy. Finally, the discussion focuses on how ways of speaking and listening in treatments are modeled not only by institutional dynamics but also by the characteristics these verbal activities take in everyday life under the logics of power that prevail over them.

ARTICLE HISTORY
Received 24 March 2015
Accepted 8 January 2016

KEYWORDS
Medical anthropology; ethnography; Argentina

Introduction

The importance of psychoanalysis in Argentina has been the object of study of several disciplines (history, psychology, sociology and anthropology) (Vezzetti 1996; Plotkin 2003). While most studies focus on the middle classes, the characteristics of psychoanalytically-oriented psychotherapy in marginalized populations have scarcely been researched (Lakoff 2005). In order to analyze this neglected issue, an ethnographic study has been conducted in health centers and everyday life settings of dispossessed urban populations in Buenos Aires Metropolitan Area from early 2013 to the present. Its main objective is to understand the characteristics of psy therapeutic technologies aimed at these populations and their links to the changing map of discomforts, sufferings and illnesses in these settings due to rapid economic and political neoliberal reforms and the logics of power and government that prevail over them.

The neoliberal transformations of the past decades in Argentina have rapidly changed both the landscape of the public health system and the daily lives in shantytowns (Svampa

CONTACT Maria Esther Epele mariaepele33@gmail.com

2005; Epele 2010). The steady deterioration of the public health system has modified the institutional psy therapeutic dynamics and turned hospitals and health centers into a buffer zone where social problems are revealed, expressed and reproduced. Instead of focusing only on psychologizing and medicating practices as most anthropological studies do (Scheper-Hughes 1992; Biehl and Locke 2010), this paper opens verbal actions to scrutiny and analyzes the ways in which they model and are modeled by local treatments.

Based on the results of this ethnographic study, this paper describes and analyzes the perspectives of social actors themselves on the psychoanalytically-oriented psychotherapy that is aimed at marginalized populations. From Foucault's perspective on the forms of truth-telling (Foucault 2010, 2011), the aim of this paper is to analyze the treatments according to the native ways of speaking and listening, which dominate the therapeutic experience descriptions of patients who come to the treatment without any professional intermediation. The paper argues that psy treatments oriented towards marginalized populations mostly psychologized, medicated and translated into moral and individual terms the outcomes of neoliberal reforms (Biehl 2005; Fassin 2012). Nevertheless, as these psychotherapies privilege speech (Lakoff 2005), they also modify, normalize and are modified by the ways of speaking and listening not only in treatments but also in everyday life.

Psychoanalytically-oriented psychotherapies have had a complex evolution in Buenos Aires' Public Health System since the late 1960s (Visacovsky 2002; Dagfal 2009). Along with a changing categorizing process made by psy expert knowledge, residents who arrive at psychological treatment without any professional intermediation also express some difficulties regarding the actions of speaking and listening in the local setting, between words and silence, between popular and political discourses of others and their own words and expressions, the sounds and noises of everyday life (Das 2007; Han 2012). Finally, by understanding the ways of speaking and listening in treatments, this paper questions the way in which the governance of urban poverty and inequality includes multiple regulations and controls over daily verbal actions. Thus, this analysis enables one to place these treatments as a traditional technology, among many other power regulations on verbal actions in local settings.

To begin with, this paper presents the characteristics of these psychotherapies in the light of the historical and anthropological perspectives and neoliberal transformations of the public health system and everyday life in shantytowns. Secondly, this paper describes and analyzes why residents go to treatment and the ways in which they narrate their discomforts and hardships in terms of their daily life. Thirdly, taking into account that psychoanalytically-oriented psychotherapies focus on speech, it describes the native ways of speaking and listening in treatments, as well as their distinctive features in marginalized populations through the lens of the very social actors. Finally, the conclusion examines how the ways of truth-telling are modeled in treatments not only by institutional dynamics but also by the changing characteristics of urban poverty and the logics of power that target these populations.

Psychotherapeutic treatments and urban poverty

Over the last decades, research on psychoanalysis in Latin America and Argentina has focused mostly on middle classes and urban elites (Plotkin 2003; Damousi and Plotkin 2009, Dias Duarte 1986). While psychotherapy aimed at impoverished populations was

implemented in Buenos Aires during the first decades of the 20th century, psychoanalytically-oriented psychotherapy spread through the public health system as a progressive therapeutic approach during the late 1960s (Visacovsky 2002; Dagfal 2009). Psychoanalysis has had a complex, discontinuous and historically revised trajectory in Buenos Aires' public health systems modeled not only by changing transnational psy frameworks but also by local economic and political regimes (Damousi and Plotkin 2009). However, current psychoanalytically-oriented psychotherapy aimed at marginalized populations has scarcely been addressed (Visacovsky 2002, Lakoff 2005).

The economic and political neoliberal reforms in Argentina have led to a rise in poverty, unemployment and marginalization (Fassin 1996; Svampa 2005). The Metropolitan Region of Buenos Aires' shantytowns has experienced rapid changing social mobility, population growth, development of informal and illegal economies, fragmentation of local social networks, changing territorial surveillance, increasing violence in local settings, multiplication of public assistance policies, a fast increase in drug consumption and in the number of violent deaths (Epele 2010). Along with these structural and policy changes, there has been a continuing deterioration of the public health system: privatization of certain services, lack of supplies, flexibilization of professional labor, the institutionalization of pro-bono work for psychologists, longer patient waiting lists, and an increasing number of impoverished middle class patients (Escudero 2003; Iriart and Waitzking 2006).

Considering the pace of these transformations, categories, symptoms and diagnoses in the psy field have experienced several revisions driven by changes in shantytowns' everyday life and the characteristics and types of discomforts in Buenos Aires' marginalized populations (e.g., domestic violence, abuses, addictions, suicides, anxiety, fear and panic) (Ortiz Hernández et al. 2007; Fernandez 2014). Almost all psychologists who work in these social settings acknowledge psychoanalysis as their main background, which is expressed in their focus on speech (*la palabra*) and their understanding of psy treatments as a talk therapy (Lakoff 2005). However, psychoanalytical theories and techniques are subjected to a continuous revision with the aim of responding to new ways of suffering under the particular characteristics psy treatments have in the public health system (chronic hospitalization, ER emergencies, 'judicialization' of social problems, psychopharmacological treatments, etc.). In addition, certain perspectives and techniques used in other approaches, specifically regarding 'the social' as the causes of different social sufferings (e.g., collective health, intercultural health, etc.), have progressively been included in these psychotherapies (Onoko Campos et al. 2008; Stolkiner 2013).

As several studies in Anthropology have pointed out, some social problems are transformed into individual suffering trajectories by psy experts' language (Kleinman, Das and Lock 1997), while others are translated into moral language that turns inequality into exclusion, domination into misfortune, injustice into trauma (Fassin 2012), whose outcomes can be addressed by different psy technologies. Nevertheless, in certain mental health services of this geographical area, local versions of well-known social sciences' critical arguments on psychotherapy and poverty (psychologization, individualization, medicating practices of social issues, etc.), have been progressively included in professional backgrounds and reflexivity. Reflexivity about clinical process focuses mostly on dubious therapeutic efficacy in specific cases and possible side-effects engendered by their own activity (Fernandez 2014).

Instead of analyzing the psychological and psychoanalytic theories and their connection to the changing therapeutic techniques applied in urban poor populations (Fassin 2012), the objective of this paper is to describe and analyze the view of psychologists and patients on the ways of speaking and listening in these treatments. Along with some discomforts and hardships, residents who arrive at psychological treatment without any professional intermediation, also express some uneasiness and difficulties regarding the actions of speaking and listening in the local social networks and settings. Together with the changing characteristics of urban poverty and marginalization under the neoliberal regime, residents describe the multiplication of regulations in verbal activities, in terms of what can and/or should be said, when and where to say it and to whom, linked to changing logics of power over these populations (Das 2007).

Ways of speaking and governance

According to Foucault, the acts of truth-telling include not only the courage to speak about what one believes to be true – that is to say, a sort of deal with oneself – but these verbal activities also involve other people and include political dimensions (Foucault 2010, 2011). In addition, these practices of speaking are ways of being or ways of life, as they are 'subjectifying' through specific forms of care of the self and governing one's own behavior and that of others (Lock and Nguyen 2010). In line with Foucault, psy treatments are activities with another person, 'a practice of two' (Foucault 2011, 5). The presence of the other person in psy therapies, who is essential in the game of truth-telling about oneself in modern times, adopts a normalized institutional form and a guaranteed qualification for the psychological, psychiatric and psychoanalytic knowledge (Rose 1998).

Based on Foucault's analysis of the forms of truth-telling (Foucault 2010, 2011), this paper examines how the ways in which these verbal actions (speaking and listening) take place in psychotherapy shape the course of treatments, the temporal rhythms of their development and the different types of effects acknowledged by social actors themselves. In addition, the analysis argues that the ways of speaking and listening in treatments are modeled not only by institutional dynamics but also by the characteristics these verbal activities take in daily life in shantytowns.

Even though several critical anthropological studies unveiled the translation of social problems into individualized diagnosis categories, this paper challenges the analysis of these psychotherapies through the exclusive lens of psychologization (Fassin 2012). In privileging the analysis of the forms of truth-telling in terms of actions of speaking and listening in treatments, it also becomes a study of the forms these verbal activities take in daily settings. Due to their focus on speech, these psychotherapies also modify, normalize and are modified by the ways of speaking and listening in everyday life.

The examination of the relationships between governmentality and therapeutic technologies, pastoral power and singularity, logics of power and diagnoses have shed light on the production and reproduction of suffering and subjectivities in specific social contexts (Foucault 2010; Fassin 2012; Biehl and Lock 2010, Garcia 2010). Taking the perspectives of the social actors themselves, the importance of speaking and listening in treatments is related to the ways in which these actions have become the central focus of different logics of power in these populations (public assistance programs, political clientelism, political

parties' discourses, local illegal economies, law enforcement surveillance, and changing tactics of populist governments).

However, instead of addressing this issue with a therapeutic governance approach only (Biehl and Lock 2010), this paper has situated psy treatments within a wider governance of urban inequality and poverty structured by a complex assemblage of multiple and contradictory power regulations on local verbal actions in daily settings (Ong and Collier 2005). Psychoanalytic psychotherapy is just one among various strategies and tactics. It is a traditional approach that even though it disguises social inequality as individualized suffering, is different from others which link speeches to the access to several basic rights, subsistence, and survival. Finally, while different studies structure the analysis of psy treatments by opposing the individual versus the collective, this paper opens to scrutiny how the logic of power acts through different means over daily verbal action in urban poverty settings, participates in the production and/or deepening of social inequality, causes marginalization and local social fragmentation, engenders a wide range of difficulties in organizing and engaging in collective actions, and also drives some residents to go and talk in treatments.

The research

In previous ethnographic studies on health issues in several shantytowns of the Buenos Aires Metropolitan Area, psychotherapies in local Health Centers emerged as one the most accessible resources among the very few available for these populations to deal with a wide spectrum of discomforts and sufferings. During those researches, however, shantytown dwellers expressed different and contradictory types of experiences, versions and relationships with local psychotherapies. This paper is part of an ethnographic research that has been carried out since early 2013 to the present. In order to fill the vacuum of knowledge about this issue, the aim of this study is to describe and analyze the characteristics of psy therapeutic technologies (knowledge and techniques) in local centers of the public health system placed in impoverished neighborhoods, and their link to the changing map of discomforts and hardships of marginalized populations in the Buenos Aires Metropolitan Area.

The theoretical-methodological approach articulates both anthropological ethnographic perspectives on psy treatments and Foucault's ways of truth-telling. Instead of placing his approach either in the epistemology or the history of science frames, Foucault's analysis focuses on the historical and cultural conditions of the existence of particular ways of truth-telling as a form of 'ontology of true discourses' (Foucault 2010, 2011). As his work is based on the analysis of ancient written texts, Foucault analyzes the modes of being linked to different kinds of truth-telling involving risks for the speaker and transformations of his/her ethos in the ongoing process (Foucault 2011). Taking psy treatments targeted at marginalized populations as the analytical focus, the ethnographic approach methodologically enables one to determine the historical, social, material and governance conditions in which psychoanalytically-oriented psychotherapies and their ways of truth-telling emerge. As the research did not involve participant-observation during the psychotherapeutic meetings, the ways of speaking and listening in treatments are analyzed by indirect means: what social actors themselves say about them. The changing analytical techniques from written texts to actual and ongoing statements about verbal acts were

addressed by a complex documenting approach. First, a follow up of cases was carried out during the research period. Second, each case included different ways in which patients describe the ongoing therapeutic process, changing professional reports about each patient, presentations of cases in psychological group meetings, and participant-observation in institutional settings. This information was documented not only in tape-recorded interviews but also in field notes. Instead of considering the ways of truth-telling in the restricted dyadic relationships, in this research and analysis the ways of speaking and listening in treatments include all the above-mentioned sources, in which participants mix literal references to speech actions in treatments with reflections about their verbal actions. In order to avoid self-justifying conclusions, I also carried out interviews and informal conversations in everyday settings not only with residents who had been in treatment and quit, but also with those that were not willing to go to treatments at all.

The fieldwork was performed in one of the typical neighborhoods of this geographic area, a destination of immigrants from the 19th century to today. In addition to some descendants of those European immigrants of the early 20th century, this neighborhood became the destination of immigrants mainly from the neighboring countries (Paraguay, Peru and others) and from Argentine provinces during the last decades of the 20th century and the early decades of the new millennium. The ethnography was carried out in this geographical area because it concentrates not only about one third of the country's population but also most urban poverty. Moreover, in growing shantytowns located in the Metropolitan Region of Buenos Aires, marginalization processes had deeper consequences: segregated and stigmatized territories, higher rates of violence (at homes, schools, hospitals, etc.), many labor experiences in the informal market, early school dropouts, increasing drug consumption, spread of infectious diseases (syphilis, tuberculosis, etc.), higher rates of youngsters' deaths in violent episodes, law enforcement surveillance and persecutions, etc.

The participant observation was done not only at healthcare centers, where psychotherapies are carried out. It also included soup kitchens, homes, streets and other places (parks, cultural centers, coffee stores) where everyday life takes place. The first year of fieldwork was carried out in the local health center with patients and psychologists. After contacting residents who were in treatment, the participant-observation was also conducted at their homes, as well as at their relatives' and neighbors' homes. Even though the research continued at the health center, the second year focused mostly on interviews, informal conversations and participant observation in everyday settings. The interviews involved 30 psychologists (24 women and 6 men) and 30 patients (21 women and 9 men) over 18. The study was approved by the ethics committee and the participants signed an informed consent form.

Patients come to the treatment through several channels (referrals from other institutions and/or professionals, they are taken by family members, or they come 'spontaneously through available information'). Most people who become patients earn low incomes and are near the poverty line. Those who have a job work as housemaids, cleaning or non-professional staff at schools, craftsmen, cleaning staff at companies or government agencies. Also, most of them are granted some government aid subsidy. The lack of reliable official statistics makes the quantitative description of socio-economic indicators very inaccurate.

Regarding their level of education, only a few (three) of those who grew up in extreme poverty conditions were able to finish higher education studies (nursing school, teacher's training programs, etc.). Very few (two) of those who have a stable job in government agencies and have health insurance went to the community Health Center because they know the health professionals, the quality of the service and/or its convenient location. In this paper, I will only include in the description and analysis those patients who arrive without any professional intermediation (medical, psychological, judicial, etc.). This selection is based on those cases considered strategic to establish certain links between the psy treatments and the daily lives of these populations.

The interview protocol and the analysis methods include the following topics and categories: demographic and personal data; characteristics of income generating strategies; public assistance programs; characteristics of social networks; characteristics and variations of verbal actions in different everyday settings; personal, family and neighboring psy treatment trajectories; native categories and types of discomforts, ailments and hardships; changing experiences and categories of discomforts during the last generations (three decades); modes of access to (and end of) psy treatments; difficulties and obstacles in accessing and continuing treatments; local reasons and motives to go to treatment; patients' descriptions of psychotherapeutic experiences, local categorization of their effects; psychotropic medication and consumption practices; psychologists' backgrounds, theories and techniques regarding urban poor populations; specific psy notions and techniques for marginalized populations; distinct features of these treatments; professional ways to understand treatment variable processes; links of local psychotherapies with juridical and legal issues; conflicts and tensions during ongoing treatments.

Go and talk

Residents who come to the appointment without any professional intermediation (medical, judicial, etc.) describe different ailments and hardships using ordinary language and/or words, expressions and/or diagnoses of expert knowledge. These include: sleeping disorders or insomnia, fear of going out, panic attacks, distress over problems with their children, not knowing what to do with family members addicted to drugs, aggression and violence, stories of abuse, etc.

However, all the cases recorded also mentioned different problems associated with the actions of speaking and listening in everyday life, which motivated them to start a treatment. Some of the statements include: 'I can't speak'; 'there are things I can't tell just anybody'; 'I have no one to talk to'; 'there are things you can't say, because it's dangerous'; 'no one listens to you'; 'I'm afraid of speaking'; 'they lend an ear but they don't understand a thing'; 'everybody's got issues, I can't go around telling them mine'; 'I don't trust people, they like to gossip'; 'it's hard to listen to other people's problems'; 'I feel overwhelmed, and it's worse to overwhelm others'; 'in my family, when I talk I feel like I'm talking to a brick wall'; 'I'm stunned, confused.'

With these expressions, residents revealed some disturbances between speaking and listening, words and silence, sounds and noise, which caused different ailments and hardships in their daily lives. Whether in a dissociated form or in combination with a collection of complaints categorized as 'reasons for consultation,' the ailments and hardships linked to the verbal activities in their daily lives became the entrance to gain

intelligibility over their treatment. Not only the patients, but also the professionals, describe and talk about the treatments, their characteristics, progress and efficacies in terms of actions of speaking and listening.

> I have trouble… hmm… saying stuff… I have a lot of trouble… saying stuff. This year I kind of started here [at the health center]… to… Well, last year I kind of started to talk… clearly about stuff. After that, things also changed at work… (Raúl, 27 years old)

Some characteristics of verbal activities were recorded among those residents who came to the appointment in the community. Most patients live in old multi-family houses, in poor building conditions. In addition to the fear of eviction, one can hear loud noises, extremely loud music, arguments and fights between family members and neighbors. Living in this environment even has an impact on a simple conversation. Some residents talk about the absence of silence in overcrowded conditions, i.e. any conversation can be heard by others. Besides, the growth of several illegal activities (prostitution, drug-trafficking, theft) in the neighborhood has multiplied the tension and mistrust in the local social networks. The most frequent problems include: an increase in theft among neighbors, drug use, domestic violence, police raids and violence, prostitution networks, armed conflicts among criminal gangs, unsolved murders.

According to the residents, life in the community does not particularly oppose state organizations, political parties and the government. Some places (such as soup kitchens, community centers, client and social networks, schools, and social movements and organizations) became anchor points for aid programs granted by the government's political party, and other parties as well. In those cases, the ways of speaking and listening, the words and speeches, all participate in the systems of local exchanges whether informal and of food and housing programs, etc. However, different people, communities and neighborhood networks carry out protests, organize themselves and fight for their cause (housing, justice for unsolved murders, etc.), finding a way for their fight not to fall prey to some political discourse and agenda. Therefore, as expressed by those residents who become patients, the wide variations in the actions of speaking and listening in everyday life, not only at home but also in public spaces, have progressively turned into the focus of regulation and of different logics of power (informal, formal, legal and illegal, family, community).

Ways of speaking and listening in treatments

'Treat' and 'work with the speech (la palabra)' are native terms used by most psychologists who do psychotherapies targeted at the residents of these neighborhoods. These expressions mark a distinction within the different perspectives of the psy field: the sense of belonging to the psychoanalytical genealogy. Besides, some of them also have a background in the collective health approach, Latin American social medicine notions, and even in intercultural perspectives. Latin American perspectives on 'psychic suffering' provide psychologists with a set of theoretical notions (vulnerability, marginalization, neglect, abandonment, labor exploitation, abuse, stigma, criminalization, etc.) by which they are able to fill the vacuum of knowledge about urban poverty's everyday life. However, most psychologists speak in terms of *speech,* and refer to Freud and Lacan as the more important sources for current theories and techniques. Unlike private practice, these treatments

administered in the public health care system are modeled by institutional rules: no choice of professionals, strikes, vacations, assistance during work hours, shorter sessions and treatments. In turn, treatments and the ways of speaking in them gain some characteristics linked to the relationship these populations have with government agencies and the public health system (previous therapeutic experiences, waiting conditions for assistance, 'judicialization' of social problems, etc.).

The arrival of the individual to the health care centers and the start of the psychotherapeutic treatment do not take place simultaneously. Through the so-called admission interview, professionals assess the 'seriousness' and/or 'urgency' of each case. Due to the restrictions in the number of professionals and offices for psychological assistance, with this interview patients are selected for immediate care or for a place in the waiting list.

According to patients, to start the treatment, 'you need to really talk,' said Juan. 'Really talk,' 'try to say everything,' 'open up,' 'say what you feel,' 'tell the truth' are some of the recurrent expressions that patients use to describe the way of speaking in psychotherapy. Instead of speaking in terms of the speech as most psychologists do, residents refer to treatments in terms of verbal actions (talk, say, tell, speak, listen, etc.). These expressions show certain differences with other ways of speaking (with family members, friends, at work, etc.):

> You need to open up, or nothing happens. That's how you start: speaking. I have trouble doing that, that's why I come here. I have close people, but you can't go around telling what's wrong with you. There are many problems here and you can't trust others, because you never know. […] You bottle it up, again and again, it's bad for you. I have to open up and talk. You need to have the guts to speak. But to continue, you need to feel that the other person is listening. (Laura, 28 years old)

Like Laura, most patients indicate that in order to be able to speak and continue the treatment, it is necessary for another person, the psychologist, to listen. The professional's active listening becomes evident to the patient through different actions: looking, saying something appropriate, asking and remembering something said in the past.

> You realize if they are listening, how they look at you, talk to you, at the right time, how they say things, it's not that I start speaking behind closed doors and that happens. It's necessary that… they make you… ask yourself the right question. (Patricio, 31 years old)
> And she [the psychologist] remembers word for word, well, not just the words, that's the least important, right?, but what I said, the essence of what we were speaking about weeks ago, and that makes me feel good, you see… and go on. (Raúl, 32 years old).

According to psychologists, however, listening is considered one of the main therapeutic techniques to work with speech. Besides studying the theory and clinical cases, the listening skill is acquired by 'listening,' 'speaking' and 'being listened to by others,' whether it is as a professional, at the supervision or as a patient, i.e., during the three phases of the analyst's training. As with any knowhow, the professionals themselves cannot describe or explain their listening skill extensively, consistently and completely.

> You don't learn to listen, you are trained to do so. It's something constant, continuous, it never ends. […] To be able to listen to another person, you need to empty words of their common sense. When you listen that there's someone who… is suffering, they're having a hard time, common sense can't be applied. (Carla, 41 years old)

In order for this way of listening to take place, it is important to differentiate it from other ways of listening (e.g. clinicians) and other strategies of approach (e.g. social work). Those psychologists who work with marginalized populations say that they have some additional work to do: to avoid receiving the complex cases referred by other professionals. Some institutional practices refer to psychological treatment a large number of patients who have diverse social problems (having many children, addictions, violence, etc.). In most cases, they are told: 'go talk to the psychologist,' without considering if the person wants to start a treatment, or if there are more appropriate ways to solve the problem (legal counseling, programs for young people at risk, housing NGOs, etc.).

Moreover, the listening technique implies not questioning in terms of referential truth, that is, whether the experiences told by patients have been lived or not. Starting from the differentiation of the psychic reality and the physical reality, everything said has a (psychic) reality status, that is, it is real for the patient and it is considered as such by the professional. Any other position in the listening that questions the reality of what has been said may interrupt the treatment: it can cause the patient to stop talking, not say certain things, leave the treatment, etc.

The ways in which the actions of speaking and listening are interlaced in the treatment also involve different types of interventions by the professionals. According to psychologists, such interventions consist of looking, saying certain words, asking questions, being silent, making gestures, interrupting the session, and changing the frequency of the sessions, which are among the most important. Unlike traditional psychoanalysis with a couch, the treatment at health care centers includes a face-to-face relationship. 'We have to be able to work with the look. You can avoid looking or put on a "poker" face so that the other can speak.' With a look you can also 'support,' 'intervene,' 'make gestures,' 'reinforce,' 'be open.' The expression and the gestures, the look in general, are resources that will vary according to the patient's singularity.

Therefore, the actions of speaking, listening, saying, being silent, looking and being looked at are all intertwined in a special way in treatments carried out for marginalized populations. That is, those treatments have specific characteristics and challenges which are modeled by – and model – the forms of the verbal activities in daily contexts.

Distinctive features in contexts of urban poverty

Besides the characteristics of the treatments already mentioned at state health centers, both patients and psychologists describe problems that make it possible to identify certain features that differentiate the psychotherapeutic treatments in these populations from others carried out in other social contexts. On the one hand, the fact that these professionals work for these state institutions regulates (restricts, stops, sanctions, promotes, reproduces) their ways of speaking, listening and intervening. On the other hand, according to those participating in these treatments, the social differences (education, income, housing, nationality and birthplace, etc.) between professionals and patients add more problems to those that therapeutic work already poses. Among these issues, we can highlight three.

First, some common experiences (different types of abuse, threats, violence, knowledge of and/or conduct of illegal activities, etc.) are frequent in the treatments administered to these populations. However, some patients say that when they talk about these problems with the psychologist, there are things that are left unsaid, because they think the

psychologist will not understand them, believe in them or trust them. In turn, patients know that these professionals work for state institutions that could bring about different consequences (judicial, social services for the protection of women and children, etc.).

> There are things that, if you tell them here,… you have to be careful. My youngest son has drug issues. He leaves home and when he comes back, he's not well, he's aggressive. I ask the psychologist what to do, but I don't tell her what's going on, who he hangs out with, it's dangerous to be in this neighborhood if they find out that you talk about them with the psychologist… and also for her. (Carmen, 39 years old)

Secondly, there is the problem of the professionals' listening in relation to chronic issues or extreme experiences in which they cannot intervene directly or as urgently as required. Most professionals make reference to different experiences about patients that are hard to listen to and have had several effects on their (the professionals') lives their wellbeing and/or health.

> Hmm… and if a person lives with… practically… hmm… with rats… and if they sleep like that and a rat bites them at night… I don't know. There's a socio-economic… housing… reality… and if you're like that… it's because you're in a really bad place, let's say… People live in very bad conditions, they don't have a job… and that has a sure effect… on how you live, on how you can support your family, your children…

However, other psychologists said they had trouble listening to stories that imply extreme suffering, specifically at the start of their professional career. Some psychologists pointed out that when they listen to 'harsh stories' from some patients, 'they can't stop thinking about it for days,' 'and can't sleep at night,' 'it leads them to accidents,' 'and to drink more alcohol.' In those cases, the problems are discussed and analyzed in work teams, supervised and referred to other professionals. As Fassin stated, through their treatment process, the listening centers in France translate inequality, domination and injustice into the moral language of exclusion, misfortune and trauma. In his study, most psychologists who work with marginalized populations also showed many disturbances and discomforts as side effects of their listening (Fassin 2012).

However, some psychologists said that to listen in an effective manner means not only to receive but also to make interventions in order to give relief and to encourage actions that can alleviate at least some of their suffering.

> Nora's life had been hard, so awful… She had suffered a great deal, terribly. When she came to the treatment, it was because she had been scammed!! She lived in a dump and she had been scammed when she was trying to buy a little house, something she had been working at for a long time. I couldn't change her life, but when she felt a bit better, we were able to connect her, through the social worker, to the public advocate and other housing movements, and she was able to recover what she had lost. At least, she could have confidence again…

In the third place, psychotherapeutic treatments in these populations demonstrate the two faces of their discomforts. That is, these populations' hardships show both chronic and acute characteristics, both continuous and urgent. Generally speaking, patients and psychologists challenge the mismatch (imbalance, delay, etc.) between the times of treatments, the times of listening and speaking, and the pace of everyday life.

Summing up, the 'forms of truth telling' and 'opening up to speak' about what they go through, how they feel and think in the therapeutic framework include the tensions that the problems described here exert in the treatments' development.

Ways of speaking, times and therapeutic effects

Certain aspects of verbal activities in everyday life, specifically linked to the problems analyzed above, are brought by the patients themselves and their psychologists as part of the progress made in their psychotherapies. Some key points are also considered so as to understand their distinctive features, duration and acknowledged effects by the very own participants. Focusing on the patients' perspective, and taking into account these specific ways of speaking, it is possible to recognize three main points of progress and therapeutic effects.

In the first place, some residents leave their treatment after a few sessions: one or two or three. For some patients, the experience of undergoing treatment is explained as going and talking about what happened 'outside' the therapeutic settings, usually emotions, without expecting anything from the psychologist, except for him or her to listen. Others said that they quit their treatment at the beginning due to the uneasiness or difficulty in talking to a stranger: 'I wasn't comfortable,' 'It made me feel strange,' 'I couldn't stand the silence.' Considering the different experiences, however, the main characteristic in this group is that psychotherapies are considered by these patients as a discontinuous environment detached from everyday life, which does not meet the necessary conditions to encourage speaking (there is a lack of trust, feeling odd, uselessness of the words of somebody who is different, etc.). However, most say that this 'liberating experience' has felt like a relief, even if it is just for a moment, while daily life continues. Most interviewed patients referred to this kind of therapeutic experience.

Second, for other patients who continue their treatment for months, their progress includes 'talking,' 'opening up,' 'liberating', with certain interruptions and discontinuations, which are adapted to the pace of daily life. However, in these cases, the dynamics of the actions of speaking, listening, being looked at, and looking, according to patients, produces a 'mirror effect.'

> I mean, she listens to me, she listens… I see that later. I come out saying: 'Oh, yes.' Something I could have seen before, but… I wasn't able to take it in. A kind of mirror. It's like… let's say, I'm talking to you in the mirror, and after that I tell myself… but you've already said that… For example, she says it… and I see it.

This mirror effect, as actors describe it, enables people to listen to and see themselves talking to another person, who listens and sometimes points out, through different interventions (words, gestures, questions, etc.), what the patient says. According to patients, these dynamics make it possible to continue the treatment for a long time. Moreover, a certain progressive differentiation occurs between the therapeutic dynamics and space and daily life, and the changes in the actions of speaking and listening that take place in the session are translated into changes in the actions of speaking and listening in daily life.

Lastly, there is a third group of patients, just a few, who continue their treatment for over a year. These patients already have previous experiences of psychotherapeutic treatments, usually in public health systems.

> For me, it's really a therapy, if you really see something, you really see it…, you really get to a point… Yes, I think that changes everything. There has to be somebody… who can help me… see things. Because there are things I have inside and I don't see them. And the professional makes me see them […] And when I talked, I realized how I had burdened my son… .

> I had burdened him with a lot of things that were not right… . Seeing yourself do that makes you change…

Through speaking, listening and being listened to, this way of speaking results in 'seeing' oneself, regarding speaking, acting, feeling and thinking. This process of self-recognition requires a radical differentiation between treatment and daily life, the objectification of the latter through expert-therapeutic speaking, and the differential subjectification between the self and others.

Conclusion

Psychotherapies aimed at marginalized populations in the Buenos Aires Metropolitan Area are described and understood by participants in terms of the actions of speaking and listening. The logics of growing marginalization (political, economic, coming from illegal activities, party factions in community organizations, conflicts among local groups, law enforcement surveillance, territorial control and persecutions, etc.) have changed the characteristics of verbal activities in everyday settings, breaking the traditional balance between the discourse of others, silence, and people's own speeches in local social networks. These logics also regulate those activities in state institutions due to the risks of triggering different government interventions (judicial, child protection, etc.).

The distinctive features of these psychotherapies are not only their psychoanalytical scope. If we consider those cases in which patients go to treatment without any previous professional intermediation, the intriguing question that arises – given the patients' everyday living conditions – is why do they just go to talk therapy. How do they understand their continuity over time? In the first place, based on Foucault's perspective on truth-telling, this paper analyzed the perspectives of participants, both patients and psychologists, regarding the ways of telling their own truths, the actions of speaking and listening, looking and being looked at, and seeing. As they privilege speech, these treatments modify, normalize and are modeled by daily verbal actions. Thus, it is possible to conclude that for those who continue with their psychotherapies over time, these treatments modify the activities of truth-telling, the characteristics and boundaries between what is within oneself and what is not, and between therapeutic space and daily life. However, by situating this therapy in the complex logics and tactics by which the governance of urban poverty takes place nowadays in marginalized settings, it is also possible to reach a wider historically-situated conclusion.

Psychologization and individualization take place not only through psychotherapies. They are also carried out by a variety of expert and lay discourses that are appropriated and reproduced by the very own populations in their daily speeches. Besides, as Fassin (2012) pointed out, moral languages have progressively invaded different social policies and programs by translating social inequality, injustice and urban poverty into social and psychic sufferings, whose outcomes can be addressed by different kinds of psy treatments. The great significance of speaking and listening practices for participants in speech therapies also makes it possible to situate these treatments within a wider governance logic of urban inequality and poverty structured by a complex assemblage of multiple and contradictory power regulations on local verbal actions in a daily setting. Taking into account the above-mentioned results, these treatments can be understood as a traditional

approach that modifies verbal actions relying on the promise of expressing and putting people's suffering into words under this therapeutic regime. Nevertheless, it is the long-standing technology among many other logics and tactics of power on verbal actions that have colonized the everyday lives of these populations linked to the access to basic rights, subsistence and survival. However, people, networks and local groups carry out protests, organize themselves and fight for their causes (housing, justice for unsolved murders, etc.). Governance of social inequality and urban poverty includes the assemblage of these contradictory logics and tactics engendered by multiple sources of power and local fragile organizations, in which state psychotherapeutic treatments are the only ones that, from time to time, enable someone at least to say – and sometimes to do – something about them.

Ethical approval

The study was approved by the ethics committee of Comite de Etica del Instituto Gino Germani, Facultad de Ciencias Sociales, Universidad de Buenos Aires and the participants signed an informed consent form.

Disclosure statement

No potential conflict of interest was reported by the author.

Funding

This research was carried out by the financial support of National Council of Scientific Research (CONICET-PIP-2014-2016) and University of Buenos Aires UBACYT- (2014-2017).

References

Biehl, Joao .2005. *Vita. Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

Biehl, Joao, and Peter Locke. 2010. "Deleuze and the Anthropology of Becoming." *Current Anthropology* 51 (3): 317–351.

Dagfal, Alejandro. 2009. *Entre París y Buenos Aires. La invención del psicólogo (1942–1966)*. Buenos Aires: Paidós.

Damousi, Joy, and Mariano Plotkin. 2009. *The Transnational Unconscious. Essays in the History of Psychoanalysis and Transnationalism*. New York: Palgrave Mc Millan.

Das, Veena. 2007. *Life and Words. Violence and the descent into the ordinary*. Berkeley: University of California Press.

Dias Duarte, Luiz. 1986. *Da vida nervosa nas classes trabalhadoras urbanas*. Río de Janeiro: Zahar.

Epele, María. 2010 *Sujetar por la Herida. Una Etnografía sobre Drogas, Pobreza y Salud*. Buenos Aires: Paidós.

Escudero, José. 2003. "The Health Crisis in Argentina." *International Journal of Health Services* 33 (1): 129–136.

Fassin, Didier. 1996. "Exclusion, Underclass and Marginality. Figures Contemporaines de la Pauvreté Urbaine en France, aux États Unis et en Amérique Latine." *Reveu Francaise de Sociologie* 37 (1): 37–75.

Fassin, Didier. 2012. *The Humanitarian Reason. The moral history of the present*. Berkeley: University of California Press.

Fernandez, Ana. 2014. "Crítica y Clínica. Desafíos Psicoanalíticos frente a subjetividades actuales." *Revista Subjetividades. Psicoanálisis de las configuraciones vinculares*, tomo XXXVI, Número $^{1}/_{2}$.
Foucault, Michel. 2010. *The Government of Self and Others. Lectures of College de France*. New York: Palgrave, Mc Millan.
Foucault, Michel. 2011. *The Courage of Truth. The Government of Self and Others II. Lectures at the College de France*. New York: Palgrave, MacMillan.
Garcia, Angela. 2010. *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande*. Berkeley: University of California Press.
Han, Clara.2012. *Life in debt. Time of Care and Violence in Neoliberal Chile*. Berkeley: University of California Press.
Iriart, Celia, and Howard Waitzkin. 2006. "Argentina: No lesson learned." *International Journal of Health Services* 36 (1): 177−196.
Kleinman, Arthur, Veena Das, and Margaret Lock eds. 1997. *Social Suffering*. Berkeley: University of California Press.
Lakoff, Andrew. 2005. *The Pharmaceutical Reason. Knowledge and Value in Global Psychiatry*. Cambridge: Cambridge University Press.
Lock, Margaret, and Kim Nguyen. 2010. *An Anthropology of Biomedicine*. Oxford: Wiley-Blackwell.
Ong, Aihwa, and Stephen Collier, eds. 2005. *Global Assembleges. Technologies, Politics, and Ethics as Anthropological Problems*. Maklen: Blackwell Publishing.
Onocko Campos, Rosana, Adriano Massuda, Iris Valle, Gustavo Castaño and Oscar Pellegrini. 2008. "Salud Colectiva y Psicoanálisis: entrecruzando conceptos en busca de políticas públicas potentes". *Salud Colectiva* 4: 172−185.
Ortiz- Hernández, Luis, Sergio López Moreno, and Guilherme Borges. 2007. "Desigualdad económica y salud mental: revisión de la literatura latinoamericana." *Cad. Saúde Publica* 23 (6): 1255−1272.
Plotkin, Mariano. 2003. *Freud en las Pampas*. Buenos Aires: Editorial Sudamericana.
Rose, Nikolas. 1998. *Inventing ourselves. Psychology, Power and Personhood*. Cambridge: Cambridge University Press.
Scheper Hughes, Nancy. 1992. *Death without weeping. The violence of everyday life in Brazil*. Berkeley: Berkeley University Press.
Stolkiner, Alicia. 2013. "¿Qué es escuchar un niño?: Escucha y hospitalidad en el cuidado en salud". In *La Patologización de la Infancia (III)*, edited by G. Dueñas, E. Kahansky, and R. Silver, 71−84. Buenos Aires: Noveduc.
Svampa, Maristella. 2005. *La Sociedad Excluyente. La Argentina bajo el signo del Neoliberalismo*. Buenos Aires: Taurus.
Vezzetti, Hugo. 1996. *Freud en Buenos Aires*. Quilmes: Universidad Nacional de Quilmes.
Visacovsky, Sergio. 2002. *El Lanús. Memoria y Política en la Construcción de una Tradición Psiquiátrica y psicoanalítica argentina*. Buenos Aires: Alianza Editorial.