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**The Devil Made Her Do it: Understanding Suicide, Demonic Discourse, and the Social Construction of 'Health' in Yucatan, Mexico**

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**Abstract**

In the state of Yucatan, Mexico, the suicide rate more than doubles the Mexican national average. This article uses ethnographic data to argue that 1) local understandings of suicide in Yucatán reflect a logic of health among Yucatec Maya people hinging on the belief that spiritual, bodily, and spatial balance must be maintained in order to prevent “illness,” understood as bodily and spiritual suffering; and 2) that Yucatec Maya users of Mexico’s public health system readily adapt the biomedical model to existing paradigms that conjoin spiritual, mental, and bodily health due in great part to the inherent contradictions in both systems that simultaneously attribute responsibility for suicide and take it away. This apparent contradiction is thus a sympathetic template on which biomedical discourse and its imperfect application can map itself.

**Keywords:** suicide, demonic discourse, discourses of health, religion and biomedicine.

## **Introduction<sup>1</sup>**

On the evening of March 6, 2008, Ana<sup>2</sup>, a sixteen-year-old girl from Xulab, a village in the eastern part of the state of Yucatan, Mexico, played basketball with her girlfriends in the village square. She went home, got a drink from the family's refrigerator, and vanished into the bathroom. An hour later, her father discovered her lifeless body hanging from the shower head. Two months later, on April 26, the body of Ana's seventeen-year-old best friend, María, was discovered sitting in a cross-legged position in her bedroom, a hammock tightly wound around her neck.

These two deaths shook the small community to its core. Xulab, with a population of less than 400 people, usually saw one or two deaths in a given year. The deaths of Ana and María came as a devastating shock. Lidia, a community health technician, is trained by the state public health administration to administer over-the-counter medication, first aid, and address non-emergency health concerns. When the deaths took place, it was Lidia's responsibility to contact the physician in the nearest health clinic, located in a community a twenty minute car ride down a dirt road.

Soon after Ana's death, Lidia began to experience sudden anxiety. She startled easily, and became very afraid of being home alone or of sleeping in her hammock. She began to think obsessively about suicide. Her symptoms worsened after Maria's death.

**L:** As for me, when it had just happened, I was afraid of laying down in my hammock. God forbid the evil might make me do something like that. I was afraid for myself.

**BRF:** So, the evil leads you to do it?

**L:** Yes

**BRF:** How? How does evil lead people to commit suicide?

**L:** It was like I no longer enjoyed listening to music or hearing people talking. I felt very anxious, like I wanted to get out, to cry, to scream, I don't know. Go. I don't even know where, I just knew I wanted to go somewhere else. I felt like I couldn't go on anymore.

I felt like I was going crazy... I wondered, what did they feel? When they hung themselves. I thought about it so much and I got scared of doing the same thing. But with the help of the psychologist and my prayers, thank God, I feel that I am becoming calm again.

One could say that following Ana's and subsequently Maria's suicides, Lidia began exhibiting textbook symptoms of clinical depression and post-traumatic stress disorder or PTSD (American Psychiatric 2000). In a classical psychological narrative, Lidia's symptoms, appearing shortly after these traumatic events, would evidence a causal relationship between the suicides (the trauma) and the symptoms (the depression and PTSD). In fact, Lidia did seek professional psychological help, took medication, and, eventually, her symptoms began to improve. On the surface, the globalization of biomedicine and its discourse couldn't be clearer: Lidia, both through her particular symptomatology and by seeking help and complying with treatment despite serious obstacles such as basic transportation between Xulab and the nearest town, is displaying the sensibilities of a modern subject engaging in self-care (Foucault 1978). However, Lidia did not see her symptoms as the result of trauma. She did not consider herself to be suffering from trauma nor from any kind of mental illness. Instead, Lidia identified her symptoms as a demonic strategy to lure her into suicide, though she also recognized that treatment, combined with prayer, were an effective tactic of resistance. As such, Lidia's discourse is a fascinating example of yucatecan beliefs about spirituality and the etiology of suicide.

Without a doubt, present-day yucatecan attitudes and beliefs about suicide contain great ambivalence. Suicide is, on the one hand, completely nonagentive: the *suicida* is a victim of a demonic power over which he or she has no control. On the other hand, Catholicism and newer protestant theologies prohibit suicide. Personal responsibility is at

once attributed to and taken away from the *suicida*. These views inform not only the ways in which people affected by suicide process the suicide of others, but, as extensive work with survivors of highly lethal suicide attempts shows, the motivations of people who attempt suicide as well.

In this article, I argue that 1) local understandings of suicide in Yucatán reflect a logic of health among Yucatec Maya people hinging on the belief that spiritual, bodily, and spatial balance must be maintained in order to prevent “illness,” understood as bodily and spiritual suffering; and 2) that Yucatec Maya users of Mexico’s public health system readily adapt the biomedical model to existing paradigms that coningle spiritual, mental, and bodily health due in great part to inherent contradictions in both systems that simultaneously attribute responsibility and take it away. Discourse about suicide in Yucatán contains an apparent contradiction informed by an unbounded personhood that results in profound social ambivalence regarding the spiritual causes, and consequences, of voluntary death. This apparent contradiction is thus a sympathetic template on which biomedical discourse and its imperfect application can map itself.

Suicide in Yucatan reflects a local etiology of health that is simultaneously spiritual and physical. This initial separation of the physical from the spiritual, however, should be understood as a false Cartesian separation of body and soul. Within the large body of work considering ritual from an anthropological perspective (cf. Asad, 1993; Bell, 1992; Boremanse, 1993; Chao, 1999; Csordas, 1997; Hanks, 1984; Huntingon & Metcalf, 1979), the work of Talal Asad (1993, 2003) has drawn critical connections between ritual, disposition, and the body. Building on Mauss’ (1973) original concept of

*habitus*, Asad argues that bodily ritual has a profound effect on disposition, thus drawing attention to the centrality of the body in religious practice.

Religious practice is embedded in everyday in communities throughout Yucatan: all homes have altars, usually in shared communal spaces. *Rosarios* and *Novenas*, the gathering of groups of people in the community for rosary and novena prayer, is a central part of social life. In any given community, people gather for rosary prayers at least once, usually more, times a week. Maya communities have vibrant religious lives. Protestant Mayas, who generally practice charismatic forms of Christian fundamentalism, also engage in frequent bodily religious practice. Whether religion as physical engagement predates Catholicism or not, the connection drawn by subjects on the ground between physical and spiritual health falls within local logic and is further strengthened by everyday ritual practice.

The research that forms the basis of this study was conducted throughout the year 2008 in the Mexican state of Yucatán. Research for this study was based on six months of ethnographic in the area around and within the city of Valladolid (pop. 70,000) as well as six months of institutional ethnography and in-depth interviews in the city of Merida (pop. 1,000,000). Because my research was focused on users of Mexico's government-run public health system, my research subjects were primarily poor and of Yucatec Maya descent. Research methods included participant observation within and outside clinical settings, structured and unstructured interviews with users of mental health services provided by the Mexican government, and archival research.

### **Background: Suicide in Yucatán Past and Present**

Although suicide captured the attention of sociologists and anthropologists (Durkheim 1951, Bohannan 1960, Giddens 1964), anthropological literature on suicide is relatively scant. Recent years, however, have seen a resurgence in the topic, particularly in the form of a special issue devoted to the topic in *Culture, Medicine, and Psychiatry* (2012) and a Max Planck Institute Workshop situated around the role of suicide and agency. As a subject of study, suicide's potential lies in its simultaneous universality and particularity: although self-inflicted death happens in every society, how the act of ending one's life is interpreted and understood is highly variable. Staples and Widger (2012) argue that suicide should be understood as a "kind of sociality... through which people create meaning in their own lives" (183). At the risk of reifying problematic binaries of individual vs. society, one can make the argument that suicide is a useful tool for considering not only how people make meaning in their own lives through a sociality facilitated by suicide, but how this sociality is experienced and leads to meaning-making on a collective level. In societies where the concept of the person is inherently diffused through the extension of the self into space, as is the case among Yucatec Maya people, the collective experience of suicide becomes particularly relevant.

I was originally drawn to study suicide in Yucatán when I found out that Yucatán's suicide rate more than doubles the Mexican national average. During preliminary fieldwork, I repeatedly came across newspapers featuring pictures of suicides on their front covers with flashy headlines such "He followed the funereal steps of Ixtab" (González 2008) or "He worshipped Ixtab" (2008). As a Mayanist, I was drawn to the enigma of suicide and the repeated newspaper mentions of Ix Tab (cf .Reyes-Foster 2012, 2013), the "goddess of the gallows" described in Diego de Landa's colonial manuscript

*Relación de las Cosas de Yucatán* (de Landa 1978). Preliminary research showed some compelling evidence of high suicide rates and quite a bit of public interest in the topic (manifested through the many newspaper reports and depictions of suicide as well as a weekly column and radio show devoted to the topic of prevention). Moreover, suicide attempts seemed common throughout the peninsula. Regardless of who I spoke to or where I traveled, in every village, town, and city I encountered people whose lives had been affected by suicide and suicide attempts. These early experiential encounters encouraged me to address the topic in a systematic manner.

In 2008, just as it had in previous years (and since), the suicide rate in Yucatán more than doubled the national average of Mexico (INEGI 2008). As a cultural anthropologist, my original research question focused on the possibilities of a social construction of suicide. As I began to spend more and more time interviewing people who had attempted suicide, noticed that the discourse people used to talk about suicide was heavily laden with religious and spiritual references, and that these references were embedded within their discourses about body and mind.

Many of these spiritual references and the discourses they index can be traced back to the Spanish Colonial Period. According to Diego de Landa (de Landa 1978), the people inhabiting the Yucatán Peninsula at the time of the conquest

said and held it as absolutely certain that those who hanged themselves went to this heaven of theirs; and on this account, there were many persons who on slight occasions of sorrows, troubles, or sicknesses, hanged themselves in order to escape these things and to go and rest in their heaven, where they said that the goddess of the gallows, whom they called Ix Tab, came to fetch them (Tozzer 1941:132).

Alfred Tozzer (1941) believes that Landa probably wrote his *Relación* in Spain around 1566. Nearly 50 years later, in 1613, Pedro Sánchez de Aguilar would bemoan the



Indian propensity for suicide. In his *Informe Contra Idolores Cultores* (Sánchez de Aguilar 1996), written to demonstrate the failures of the “spiritual conquest” of Yucatán, Sánchez de Aguilar recommends the creation of a new position, a *fiscal*, within individual Yucatecan churches. Among the fiscal’s duties would be the administration of *bien morir*, the good death:

This *fiscal*, knowing how to read, and write, should help the ill to die well [*bien morir*], giving form to the ritual... and talking to him to encourage him and revive his faith and hope. *Because, without this consolation and comfort, [the dying] despair, and are strongly tempted by the Devil to hang themselves* [my emphasis].

This colonial text is strong evidence of a prevalence of suicide in the colonial period. It also first introduces the idea of demonic intervention in suicide. However, my own ethnographic research –and that of other ethnographers of suicide in the Maya area (cf Baquedano 2009, Hernandez Ruiz 2010, Imberton 2012)—did not uncover any contemporary mentions of Ix Tab or of a goddess of suicide in Maya communities. Overwhelmingly, motifs in suicide discourse in Maya communities in Yucatan center on discourses and theories of demonic intervention as the underlying cause of suicide.<sup>3</sup>

### **Self, Community, and Space**

In Xulab, Lidia, the community health technician, framed her experiences following the suicides of Ana and Maria as demonic attacks. “Evil” or *el Mal*, as it is commonly called in Spanish, is another name for the Devil. The role of the demonic in suicides in Yucatan repeatedly appeared in my work and has also been documented by Baquedano-Lopez (2009) and Hernandez Ruiz (2010). Gracia Imberton’s (2012) work among the Chol Maya of Chiapas also uncovered demonic intervention as a common cause of suicide. Many previous studies of the demonic in Latin America treat the Devil as a

character of folk narrative or as a metaphor for class and gender oppression (Edelman 1994; Nash 1997; Sanabria 2007; Taussig 1980). In Yucatán, however, there is nothing metaphorical, allegorical, or figurative about the demonic and its role in suicide.

In suicide discourse, the *suicida* is a victim of demonic intervention. Interlocutors will often go so far as to state that the Devil physically places the rope around the suicida's neck. However, these same interlocutors will also say that suicide is in fact an agentive act and the *suicida* does have to face the consequences of the sin of suicide. In the same conversation I had with Lidia about suicide as a demonic attack on an innocent, Lidia's discourse reflected a view of suicide that was simultaneously agentive and non-agentive:

My father was very upset that they buried [Ana] with a normal Catholic ceremony. He said her family should have stuck wooden horns in her ears to drive out the evil, and verbally harassed the corpse, telling her what she did was a bad thing, telling her to leave, to get out of here... then when [María] died, some elders said the same thing, that they needed hammer wooden horns in her head, and circle her head with 12 needles to keep her from taking another... When Ana died, I told my sister, you know, this girl, her family didn't go to church, she didn't have a religion, maybe, to save her own soul, she'll take someone who is close to God. When my sister came by to visit the other day I reminded her. I told her, "see? Remember I told you she might take someone close to God?"

In this excerpt, Lidia describes the ideal mortuary treatment for a suicide that is quite different from Catholic burial rituals, which do not differentiate between suicidal vs. non-suicidal deaths. The corpse is disfigured and verbally abused as it is taken for burial. In this sense, the corpse, the material remains of the person, is punished. Furthermore, Lidia notes that she believed, even before Maria's death, that Ana would "take one close to God to save her own soul." This in and of itself is a fascinating statement: if Ana was a victim, why would she be able to "save her soul" after death?

Why does her soul need saving if she in fact was forced by the Devil to commit suicide?  
If her Maria is an innocent victim, why is she condemned to hell?

Lidia also spoke about the consequences of suicide for the deceased, stating that “[the soul of a suicide] does not enjoy the gates of Heaven, they go to Hell, because they belong to the Devil.” However, when I asked her whether those who commit suicide are called back during Hanal Pixan, the annual return of the dead to the world of the living that coincides with the Mexican Day of the Dead, she responded in the affirmative. “We hold Mass and rosary prayers for them, and welcome them back for the feast of the dead, but, as the say, doing these things just lowers down the flames of Hell for a little while. When the prayers are over the heat turns back on.” During our conversation, Lidia repeatedly stated that “what they [Ana and Maria] did was bad,” while at the same time emphasizing that each was a victim of demonic intervention. This anecdote illustrates the contradiction and ambivalence in discourse about suicide in Yucatán regarding the causes and consequences of voluntary death.

Lack of consensus and balance in community life is locally understood as a source of illness. People in Xulab interpreted Ana and María’s suicides as physical manifestations of a disease afflicting the entire town. Figuratively speaking, a deep social illness –rooted in ongoing conflicts between various factions inside the community—had “opened” the village and made it vulnerable to the unwelcome demonic entrance. “There was a time,” Lidia explains, “when we had a fight at every community meeting. The women couldn’t even set eyes on one another... sometimes, the meeting would have to get broken up because of the fighting... our village didn’t use to be like this. People still aren’t speaking to one another.”

Christine Kray's (2005) work on tranquility in Dzitnup, a town in the same region as Xulab, shows a similar expressed desire for consensus. Kray alludes to the kind of disagreements created by religious and political differences, noting that in Dzitnup "tranquility indicates the ideal state of affairs, one in which everyone is in agreement, everything of value is evenly distributed, and respect and respectability characterize human relationships" (340). When the balance is broken, the community becomes vulnerable to illness, broadly defined as both spiritual and physical. People in Dzitnup take pride in the tranquility of their town. In Xulab, people despaired from the lack of it. The responsibility of Ana and María's suicide was carried by everyone in the community: the Devil may have been the proximal culprit in the girls' deaths, but the community was to a great extent responsible for allowing the Devil in when the social equilibrium was lost.

The concept of person in Yucatán is characterized by a certain fluidity of boundaries. This fluidity has profound historical roots, not only in pre-Colombian Maya culture (Gillespie 2001; McAnany 1995) but in the mystical Catholicism practiced by those in charge of Yucatán's so-called "Spiritual Conquest" (Lizana 1995). Javier Hirose's (2008) work on the body in the Chenes region of Campeche focuses on relationship between body and space, emphasizing the possibility of occupying several physical spaces at once, and linking a necessary equilibrium in the relationship between person and space to health:

"According to the ideas of a traditional doctor from the state of Campeche regarding the body and its relationship with the universe, the spaces occupied by the human being in the cosmos —the home, the *solar*, the *milpa*, the town, and the world—constitute extensions of the body, while

the spatial-temporal location of the human being in relationship with these spaces determines the condition of illness or health” (1).

Timoteo Rodríguez and Juan Castillo Cocom (2010) document a similar concept of person and space which they term *iknal*. Echoing Hirose’s discussion space and time, Rodríguez and Castillo Cocom state, “Our presence is forged within a proximity to our memories. The bond of one’s sensibility to selfhood and to those memories gauges a ratio of presence –a moving ratio of presence coalescing through the recent past and near future. This bond is a spatial presence understood as one’s *iknal*” (9). This bond gives meaning to place, and turns physical space into extensions of the self.

In his doctoral dissertation, Hirose carefully and exhaustively catalogues the myriad of Yucatec names and terms for various body parts including internal organs, bones, and external characteristics as well as biological states such as pregnancy. Hirose notes that the Maya person is a single entity that expresses five elements (earth, water, fire, wind, and light) that are projected in a sort of corporeal aura. The actual body is but a “wrapping” (*kukut*) for the spirit, made up of the *pixan* (*soul*) and the *ool* (*breath of life*). The *pixan* inhabits the entire body, the *ool* is primarily located in the blood (Redfield and Villa Rojas 1933). Subsequently, he explains the ontological understanding of the body as *yaan* (right side, male, translates to “there is”) and *yuum* (left side, female, translates to “lord”) together forming a single concept: *yaan yuum*, “there is the Lord”.

Hirose argues that the natural equilibrium forming the concept *yaan yuum* is in fact a state of health, in other words, that not only can the cure of illness be found in a Creator, but that the Creator itself can be found within the human body in proper equilibrium. This sense of equilibrium extends beyond the individual body to the body

social because the self itself extends into physical space. If the key to bodily and spiritual health lies in a harmonic relationship between these physical extensions of the self and the individual “wrapping” represented by the human body, as described by Hirose, it follows, then, and every person can extend into every other person that occupies the same place.

Thus, the self is not merely one part of the community; rather, the entire community is a system of selves connected in space and time. A lack of consensus, or “tranquility,” to borrow Kray’s term, is dangerous to the physical and spiritual health of everyone in the village. Clearly, this is not to say that in every village and town there are no breaks in tranquility, consensus, or harmony. In fact, squabbles over political party, religion, and other scandals are commonplace everywhere in the Yucatán. These, however, are seen as extremely negative events. Community harmony is thus paramount: the health of an entire community depends on this equilibrium because everyone is linked in a metaphorical and physical way. More importantly, the presence of this equilibrium implies the presence of the divine, the antithesis of evil.

Why take the demonic “seriously”? In considering the interplay of Western mental health services and locally generated worldviews, I kept running into a single question: Given what I knew about Maya understandings of personhood, spirit, and space, why did Maya people appear to readily embrace the biomedical model of psychiatry to explain suicide? I soon realized that pre-existing ideas about suicide, its etiology and its prevention continued to thrive—including the ever-central role of the demonic—and biomedicine was simply adopted into an existing, locally generated discourse of health. This conclusion brought about yet another question: what was it about Yucatecan culture

that allowed two seemingly conflicting and irreconcilable worldviews to coexist in such a harmonious way?

### *Hospital Psiquiátrico Yucatán*

Hospital Psiquiátrico Yucatán (HPY) is located almost 100 miles and a world away from Xulab. It is an in-patient psychiatric facility that accommodates 160 beds. Its operation follows a biomedical approach: patients are treated with a combination of psychiatric drugs and individual and group counseling. Although Mexican psychology has early roots in European psychology, psychiatry, and psychoanalysis, as of the mid-twentieth century American psychiatric and psychological models have dominated Mexican psychological and psychiatric practice (Galindo 2004). The Health and Wellness Department is charged with operating HPY, the only psychiatric facility in the peninsula. Patients who enter the hospital are funneled to it from every other health care system in Yucatan and other nearby states such as Campeche, Quintana Roo, Chiapas, and Tabasco. Usually, patients are only referred to HPY if they are showing symptoms so severe that 1) they are posing a danger to themselves or others, 2) their families are unable to care for them and they are unable to care for themselves, 3) they have received outpatient psychiatric treatment and have not responded, or 4) they have had repeated and increasingly lethal suicide attempts. Patients who arrive at HPY have usually been undergoing some sort of psychological or psychiatric treatment for some time.

Within the facility, Programa Integral de Atención al Suicidio (PIAS), a suicide prevention program, has taken a holistic approach to treatment. Its founder, psychiatrist Gaspar Baquedano Lopez, holds a Master's degree in anthropology. Having studied

suicide for over 25 years, he advocates for a prevention approach that focuses on improving patients' quality of life and involving family, friends, and neighbors in the effort. "We never tell people not to kill themselves," he explains, "we ask them why they want to die. Most of them have never been asked that question."

PIAS was reinitiated in the fall of 2007 after seven years on hiatus by Dr. Gaspar Baquedano Lopez.<sup>4</sup> As its website states,

[PIAS' stated goal] is to offer through an interdisciplinary approach the institutional resources and strategies in order to detect and psychiatrically, psychologically, and socially treat people with suicidal risk and their families. In this way we seek a rapid biological, psychological, and social recovery of the user.

Dr. Baquedano's vision for PIAS is a program that seeks holistic psychiatric treatment for people who had attempted suicide and their families. Typically, a patient is admitted due to a suicide attempt at the psychiatric hospital when the attempt is particularly lethal or is the latest in a series of multiple attempts. Patients are referred from public hospitals in the region once their injuries have been stabilized and remain at HPY on average about three weeks (Yucatán), although in my time there I saw several patients stay for longer than a month. During their stay, patients are introduced to the PIAS program, where they attend small, in-patient group therapy sessions twice a week and a weekly group meeting. Once the patients are released, they are invited to continue attending the weekly meeting with their families. In six months of ethnographic research, most of the patients I worked with who entered the hospital for in-patient treatment returned to at least a few sessions while others became regular attendees.



Patients also continue using the psychiatric hospital's other services, usually seeing a non-PIAS affiliated psychiatrist as well as attending weekly PIAS meetings. Because the hospital is the only psychiatric hospital in the region, it serves people of all walks of life, though PIAS patients are predominantly indigenous, poor, and female. Ironically, although a majority of PIAS participants are women, the group is dominated by the male members, who tend to speak and direct meetings more than the female members. This ease of leadership on the part of men can be related to expectations of male dominance of public space as well as male group members' familiarity and participation in 12-step recovery groups, which function in Mexico as spaces for the creation and reiteration of masculinity (Brandes 2002).

Every Thursday morning at HPY, a group of people gathers at the Sigmund Freud room for a group therapy session that resembles a twelve-step meeting more than any Western psychotherapeutic model. Anywhere between thirty to sixty men and women fill the room and for the next hour and half the patients, who are called "*usuarios*" or "users" in hospital lingo, share their experiences with pain, despair and hopelessness. Usually one will stand and show the rest of the group the scars on her wrists or the deep, red indentation created by a rope during a hanging attempt and relate her story. These sessions offered tremendous insight into the ways in which survivors of suicide attempts make sense of their lives, and also about how the relationships between users and hospital staff and volunteers is manifested in the group. Six months of ethnographic research at HPY with the PIAS suicide prevention group revealed much

about the ways in which this program functions to both transform and reiterate patients' relationships with the medical establishment, each other, and their own bodies.

The trope of suicide as a symptom of disease effectively *making* the user attempt suicide represents the medicalization of the demonic in suicide discourse. Instead of it being the devil that ties the knot around a *suicida's* neck, the *enfermedad*, the illness, takes on this role. However, the association of the demonic to suicide is by no means replaced by a physiological understanding of mental illness rooted in brain chemistry. To quote Gaspar Baquedano, “Mental illness and suicide are considered as having an evil origin. It is a manifestation of the devil under the disguise of a medical disorder, even if it is treated with medicine, in the end it is connected to the supernatural world” (Baquedano 2009:79). The Devil, then remains the underlying cause of the suicide, while the mental illness becomes the means by which the Devil achieves his objective.

This viewpoint was discernible at every PIAS meeting I attended, where phrases such as “*no le demos derecho al Diablo*, “let us not give the Devil the right”, *que no nos gane la mente*, “let us not let our mind ‘win’”, *con la ayuda de Dios*, “with the help of God” were frequently used. Patients who had survived suicide attempts never explained their experiences as rationally made decisions. Moreover, the vast majority of cases described the events leading up to their suicide attempts as otherworldly experiences. Patients described visions, dreams, and demonic presences and voices in experiences immediately preceding their attempt. In patient discourse at HPY, the idea of “fighting the devil” frequently recurred.

In my weekly observations of the PIAS group therapy sessions, I found that PIAS meetings often echoed a long-established and widely successful recovery model: the 12

step Alcoholics Anonymous (AA) model. The existence of 12-step recovery programs like Alcoholics Anonymous has created a beneficial environment for the flourishing of the PIAS program. First, the cornerstone of Alcoholics Anonymous is the iteration of alcoholism as a physical disease. However, the treatment of this disease, the Twelve Steps themselves, is spiritual (Anonymous 1981). As such, the Twelve Steps of Alcoholics Anonymous posit a spiritual cure to a physical affliction, blurring the boundaries of body and spirit in a way that is not only compatible with local understandings of the person, but sets the stage for a similar view of other forms of *enfermedad*. The blending of spiritual and organic elements in the etiology of alcoholism speaks to a deeper level of cosmological coherency that allows for the adaptation of biomedicine into local etiologies of health.

Biomedicine was often considered an effective tool in battling the demonic entities that cause suicide. Although PIAS does not actively engage with the demonic narratives shared by the vast majority of its members, the discourse of agency is absorbed into the demonic narratives. While patients still attribute their suicidal ideation to demonic intervention, they articulate a newfound ability to resist these attacks on their spiritual health. Like Lidia, the community health technician from Xulab, PIAS patients at HPY can fight the Devil with medicine and psychotherapy as well as by relying on belonging to a strong, healthy community and renewed spirituality.

## **Conclusion**

In his chapter of the *Oxford Textbook of Suicidology and Suicide Prevention* (2009), Gaspar Baquedano-López frequently uses two words in his analysis of suicide in Yucatán: religion and ambivalence. In my own research, these two words became a

frequent presence in my field notes and interview analyses. For a Yucatecan to attribute suicide to the devil and condemn the *suicida* in a single utterance was as common as it was for a psychiatric patient to discuss the efficacy of psychotherapy and medication in staving off the devil's advances. Unlike Binswanger's Ellen West (Binswanger 1958), nearly every person I spoke to who had attempted suicide expressed a desire for life. Every person I spoke to used a similar narrative of spiritual struggle in describing their suicide attempt. Individual agency was not as important as finding the right equilibrium within a self conceived of as body, spirit, and space. Biomedicine, with a language that emphasizes finding equilibrium in brain chemistry, is one way of achieving it that can be combined with others.

Within classic psychiatric biomedical discourse, this point would be irrelevant. In the words of Dr. Baquedano-López, who has been pioneering efforts to incorporate anthropological and social scientific perspectives to the treatment of psychiatric patients in Yucatan, to most psychiatrists and psychologists, the culturally specific discourses of patients ultimately boil down to *puras pendejadas*, utter nonsense. As Charlotte Blease has argued in her analysis against the Culturally Bound Syndromes (CBS) category in the DSM-IV, "folk theories" are simply nonscientific explanations for existing, scientifically proven illness categories (Blease 2010). The assumption of the DSM-IV is that all human beings essentially think the same way and experience the same mental illnesses regardless of where they are. Through biomedical discourse, mental illness—and suicide as a result of mental illness—is reduced to a series of organic occurrences in the brain. How these organic occurrences may manifest differently cross-culturally has had the attention of anthropologists as well as psychologists engaged in the well-established field

of cross-cultural psychology, but as of 2008 had not translated into organized local applications of “culturally competent” psychology in Yucatecan clinical practice. That said, biomedicine’s success in Yucatan is perhaps not indicative of a transformation in the subject population, but rather indexes the ways in which this worldview has been subsumed into local etiologies of health.

Lidia, Xulab’s community health technician, never had to visit HPY. She never attempted suicide. However, when she began to experience what she believed was a demonic assault on her sanity, she did not hesitate to seek help from a mental health professional. As a community health technician, she understood local health resources and used them. The same logic that facilitates PIAS’ success at HPY informed her use of local psychological and psychiatric resources to treat a spiritual ailment. In the same way that prayer protected her spirit, therapy protected her mind, and medication tended to her body. Like prayer, therapy and medication were simply part of her religious arsenal for fighting the Devil. In many ways, this logic reveals what an early reviewer of this piece called a “deeper level of cosmological coherency” that was visible in the in the words, actions, and interactions of the research subjects profiled in this article, a coherency that can be found by looking beyond the internal contradictions visible at first glance. As I stated at the outset of this article, the contradictory nature of the Yucatecan attitude toward suicide is a sympathetic template upon which biomedical discourse can map itself. But, like a transparent film placed over a map, the elaborate geography beneath it remains.

## **Endnotes**

1. This research was supported by a Fulbright-Hays Doctoral Dissertation Research Abroad grant and was approved by the University of California Berkeley Office for the Protection of Human Subjects Institutional Review Board (OPHS-IRB).
2. All names of people, living and dead (with the exception of Dr. Gaspar Baquedano, who is a recognized scholar in the field) have been changed to protect their identities. The name and geographical location of Xulab has been changed. However, it would have been impractical to attempt to change or disguise the name of Merida, the capital of the state of Yucatán, or of the field site, Hospital Psiquiátrico Yucatán.
3. Baquedano (2009) presents a compelling argument whereby a pre-existing ethos possibly accepting of suicide was transformed but not eradicated through the colonial process.
4. The existence of many social programs at Yucatecan public hospitals is highly dependent on political affiliation and alliance. PIAS went on a seven-year hiatus because of a change in the state government political affiliation.
5. Moreover, “Western” as an ontological category bears further scrutiny: the term is laden with a multiplicity of meanings. Due to constraints of space, an in-depth discussion of the problems of “Western” and its application to long-term postcolonial societies like those in Latin America is not possible here.

6. The complexity of identity in Yucatan has been addressed elsewhere by others (Castañeda 1996; 2004; Castañeda and Fallaw 2004; Castillo Cocom 2000; 2005; Castillo Cocom and Ríos Luviano 2012) and myself (2012).

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