

The Psychologization of Worry

“How much of my job is teaching people how to feel?” Kim, a forty-eight-year-old Vietnamese Australian psychotherapist, asked me in correct anticipation of my next interview question. “One hundred percent.” She was joking, but the punch line is worth further consideration. Kim finds that her Vietnamese clients tended to be either completely closed to their emotions or entirely beholden to them. Her mission is to guide them toward a middle ground. The psychotherapeutic process is oriented toward the simultaneous cultivation of an awareness of one’s own emotions and the means to discipline them. “It’s about emotional regulation,” Kim said. Teaching people how to feel “is basically what a counselor is.”

Vietnam’s age of anxiety has been good for business at Ho Chi Minh City’s psychotherapy centers. According to Aaron, an American director of one center, anxiety brings 60–70 percent of clients to his office door. Once there, people are taught a variety of techniques to manage their worries. In doing so, they also learn to reconceptualize their worries in an emotive register as a matter of self-understanding (*hiếu mình* or *xem mình*, lit. observing or considering the self). While doctors at the psychiatric hospital expend most of their efforts on ensuring adherence to medication prescriptions and pay little attention to patients’ models of selfhood, psychotherapists often target the self directly in their treatments for anxiety. This process reflects the psychologization of distress, in which the psy-disciplines are marshalled to analyze conditions that are simultaneously psychological, social, and material. Psychotherapy is largely premised on Western, especially North American, notions of the person that valorize individualism, self-fulfillment, and emotional expressiveness, where a richly articulated and layered sense of inner self is evidence of self-coherence (Jenkins and Barrett 2004; Kirmayer and Raikhel 2009; Kirmayer 2007). Thus, going to therapy in Vietnam is about much more than the alleviation of emotional pain. Kim and Aaron’s clients may not learn to feel for the first time, but they are taught that some ways of feeling are better than others.

Hailing from Vietnam, the West, and the Vietnamese diaspora in the West, Ho Chi Minh City's psy-experts form an expanding professional network of clinical psychologists, counselors, social workers, applied behavioral analysts, speech and language pathologists, and special education teachers, among others. As such, their interactions with each other can be marked by tensions and disagreements, but what unites them is a shared mission to address a long-ignored treatment gap. Their perspectives on their work and the current state of feeling in Vietnam reflect and reproduce Western discourses of the self that people use to manage themselves in the global economy. Yet many of them are aware of, and conflicted about, the Western bias of their treatments. (Ironically, the Westerners stated more concerns about cultural competence than their Vietnamese counterparts.) Thus, mental health experts cannot be reduced to vectors of self-responsibility. Unlike the psychiatrists and their patients in chapter 4, psychotherapists and their clients increasingly share similar ideals of selfhood if not the same ideas on how to achieve them. Indeed, many of the therapists I spoke with were once clients themselves. They were inspired to their vocation because psychology gave them new ways to understand themselves and others. Ngọc Bình, the popular therapist influencer on TikTok, notes that his training made him more empathetic, so when people share their problems with him, he listens carefully rather than resorting to clichéd words of support (Chi Mai 2021). Many of the people in this book, including Anh (chapter 1), Hoa (chapter 2), and Trâm and Hải (chapter 6), were dissatisfied with the well-meaning but ultimately cold comfort they got from friends and family. Had they consulted with a skilled psychotherapist, they likely would have gained new insights about themselves. However, the impulse to treat therapy as a panacea for so many problems in the world stems from a growing emotionalization of society that assesses crisis primarily by its emotional impacts (Lerner and Rivkin-Fish 2021).

Operating as a global emotion pedagogy that frames the emotions as “teachable skill bundles” (Wilce and Fenigsen 2016, 83), cognitive behavioral therapy (CBT) has become by far the most common form of psychotherapy in the world. However, it has been analytically overlooked in the medical social sciences and humanities.¹ Compared to psychoanalysis (Obeyesekere 1990), family constellations therapy (Pritzker and Duncan 2019), or indigenous and hybrid forms of psychotherapy (Yang 2017), CBT can seem relatively bureaucratic and mechanistic, due to a narrow focus on modifying problematic behaviors. It is explicitly not designed to be exploratory. Yet CBT also rests on a theory of an integrated and egocentric self that must be in place for the treatment to be productively implemented. While CBT's customizable focus on specific issues may be more accessible for Vietnamese clients than the more comprehensive approach of psychoanalysis, the very work of self-compartmentalization requires a broader questioning of personal and cultural identity as therapists and clients alike negotiate the cultural forms that assist and resist the acceptance of psychotherapeutic principles. As the

emotions increasingly stand in for some core aspect of people's most authentic self among Ho Chi Minh City's middle class (see chapter 3), discovering the self and controlling it become inextricable. Neoliberal discourses of emotion frame the self as simultaneously capable of self-empowerment and vulnerable to emotional excess (Duncan 2017). A therapeutic monitoring of one's feelings is no longer reserved for disordered minds.

Critics charge that the rise of therapeutic governance in the West indicates a dystopian seizure of people's hearts and minds by the state (Rose 2006; Szasz 2001). Such sweeping claims, however, overlook the negotiations that characterize the spread of the psy-disciplines in the Global South. Focusing on the diverse array of techniques, expertise, and values that produce political subjects outside of the West sheds insight on why certain technologies of the self may be accepted, adapted, or rejected. Thus, rather than frame the globalization of psychotherapy as a simple clash between the traditional and the modern, the rising popularity of psychotherapy in Vietnam and elsewhere suggests an ambivalent terrain upon which people experience the transition to a market economy (Zhang 2017; Matza 2018). While Ho Chi Minh City residents work toward what their psychotherapists view as a modern mindset by engaging with neoliberal discourses of the self, this process does not yield uniform results. For many clients, the motivation to seek treatment stems from desires to reduce intra-family conflict and to retrench relational forms of selfhood instead of replacing them. Thus, psychotherapeutic practices are part of an increasingly diverse set of technologies of the self available to people as they adopt multiple regimes of selfhood. While they certainly differ, such configurations of the self do not necessarily compete against each other. Rather, they are cumulative, expanding the repertoire of possible selves for Ho Chi Minh City residents. Therapeutic selfhood can be simultaneously social and reflexive, private and public, and neoliberal and socialist (Zhang 2018, 2020).

PSYCHO-BOOM-TIMES

That psychotherapy centers even exist in Ho Chi Minh City is notable in a country where Western psychological and behavioral sciences have been contested for much of the twentieth century. During the early colonial period, psychological theories from the West found a receptive audience among the cosmopolitan elites in urban Vietnam, but after World War I, leading Vietnamese intellectuals agitating for national independence favored the political philosophies of Locke, Rousseau, Marx, and Engels (Marr 2000). Meanwhile, French psychiatrists—and, eventually, their Vietnamese counterparts in the colonial asylums—pioneered several therapeutic approaches that became widespread, not just in other colonial holdings in Southeast Asia but in the metropole as well (Edington 2019). For example, bridging the divide between the asylum and its surrounds, racialized notions of labor therapy were designed to prepare patients for life after discharge and instill self-discipline by having them perform agricultural labor. The

contemporary psycho-boom is also notable because it contrasts so starkly with the socialist critique of academic psychology as an interest of the self-obsessed bourgeoisie. Throughout the socialist world, psychiatry was generally reserved for addressing psychotic episodes, and mental illness was blamed on erroneous political convictions that were to be treated through “thought work” (cf. Zhang 2018; Huang 2014, 2015). However, in twenty-first-century Vietnam, conversations with foreign discourses of society, civilization, and selfhood have taken a decidedly psychological turn.

Early therapeutic interventions under *đổi mới* more closely resembled life coaching or training than the psychotherapy typical in the West. This stemmed from many therapists’ inclination to provide quick and pragmatic solutions and clients’ demands for direct answers to their issues. Members of the first generation of counselors in Vietnam are notorious among the younger therapists I spoke with for only dispensing advice, instead of listening to their clients. As part of their work at an international NGO, Julien and Sylvie, two recently graduated psychotherapists, treated patients and provided training and consulting in psychotherapy at several public hospitals throughout Ho Chi Minh City. They found that the most challenging aspect of their work was in getting Vietnamese mental health specialists to reflect on their own emotional reactions to their patients (i.e., countertransference), beyond whether or not they liked the patients. One counselor at the Ho Chi Minh City Psychiatric Hospital was surprised when Julien criticized her for offering too much advice to a patient and, indeed, for talking more than her patients during their sessions. Instead, like the psychiatrists, these psychologists preferred to focus on helping clients with concrete advice.

Tâm, a sixty-five-year-old woman, founded one of Ho Chi Minh City’s first counseling centers in 1997 to apply the insights of psychotherapy and educational psychology to people’s sentimental lives (*đời sống tình cảm*). Her center’s primary work revolved around resolving conflicts within marriages, families, and friendships and addressing “social problems” related to domestic violence, gender inequality, and sex and sexuality. Additionally, she was regularly invited to student assemblies at universities to discuss and answer questions related to sexual and reproductive health. Counseling services took place in a spacious room with several desks and folding chairs, cordoned off with paneled room dividers. Most of the clients phoned in for services, so privacy was usually not a significant concern, but if multiple clients were in the center at the same time, an employee would simply open a window to allow the ambient traffic noise to drown out the consultation. A reexamination of the self was not a priority for Tâm and her employees. For example, if a client wanted a divorce from her husband, counselors would encourage them to sacrifice for their children. Their preference for concrete advice over abstract and ponderous self-exploration echoes the thought work promoted by the state to impart socialist ideology to citizens. Indeed, the center’s guiding philosophy was inspired by state discourses on proper morality and the “happy family” campaign (cf. Kwiatkowski 2016; Shohet 2017).

Today, psychotherapeutic concepts and techniques are no longer confined to clinical and academic settings. Instead, driven by market demands, they have been flexibly deployed across a wide variety of settings that Ho Chi Minh City's middle class deems in need of psychological intervention. Self-help books in English and in translation sit alongside financial advice books on local bookstore shelves. Schools and corporations incorporate psychotherapeutic techniques to manage their students and employees, and it is not uncommon to see people reading popular psychology books by themselves at cafés. (Ten years ago, it was rare even to see anyone by themselves at a café!) Organized by therapists to supplement their income, paid seminars with psychoeducational themes (stress management, emotional intelligence, introverts vs. extroverts, etc.) are increasingly popular among young professionals, especially those working in human resources, on the lookout for expertise and counsel for their personal and career ambitions as well as networking opportunities. The rise of the psychotherapeutic industry in Vietnam parallels trends elsewhere in the region. For example, China's national certification program in counseling psychology has licensed many within the new middle class (Zhang 2018). Few, however, intend to become mental health professionals. Rather, they are attracted to the courses by the potential to self-actualize an ideal of the good life.

Despite growing popular demand for psychotherapeutic services in Vietnam, thus far the state has offered little support. For example, the national labor code does not recognize psychotherapist as an official occupation, a bureaucratic headache for the growing number of psychotherapists. The lack of government support for and oversight of psychotherapy has led to an unregulated market of counseling services. Freelance counselors range from foreigners seeking to accrue experience for their credentials before returning to their home countries, to both Vietnamese and expatriates with limited training who promise unrealistic outcomes through unorthodox methods (e.g., curing autism with yoga), to a naive clientele largely unfamiliar with the conventions of the field. Kim's husband quipped to her that Westerners can "come to Vietnam and become doctors." By the time that clients or their families realize that such treatments may be more harmful than helpful, their conditions have often worsened to the point where emergency procedures are required. Medical evacuation to inpatient treatment facilities in Singapore or Hong Kong is not uncommon in cases that involve suicidal ideation or prescription drug abuse.

Over the past decade, however, what was once a cottage industry has developed a disciplinary identity with its own set of norms and standards, and the field's increased professionalization has routed out many of the more dubious practitioners. Ten years ago, my conversations with the staff at fledgling counseling centers in Ho Chi Minh City were marked by an undercurrent of embarrassment that someone was even paying attention to them and their work. They emphasized how new the concept of psychotherapy was to Vietnam, as if to apologize for the state of

their field. Today's generation of therapists, however, speak with much more assurance and conviction about their work and repeatedly stress the optimistic outlook of their profession. Many spoke of a "big market" for psychotherapy that remains untapped. Tuấn, a fifty-six-year-old clinical psychologist who trained in the United States, wanted to duplicate the success of Chinese private mental health treatment facilities that used a "properly American style" of care in Vietnam. As he told potential capital investors for his own center, "For sure we'll kill it. People are waiting."

COGNITIVE BEHAVIORAL THERAPY IN THEORY

Cognitive behavioral therapy refers to a set of psychotherapeutic approaches developed as an alternative to then-dominant psychoanalytic schools of thought that were increasingly under fire for being too nebulous and time-intensive. During the 1950s, early advocates of behavioral therapy in the United States emphasized scientifically validated techniques rooted in the classical and operant conditioning principles of behaviorism. By the 1970s, the rise of cognitivism and cognitive therapy emphasized the impact of mental phenomena such as thoughts, feelings, and internal reflection on human behavior. Integrating these two approaches as cognitive behavioral therapy focuses on an individual's thoughts and beliefs in order to reduce unwanted behaviors. Oriented toward concrete problems and solutions, CBT is based on the assumption that the development of new coping strategies and ways of processing information blunts the impact of maladaptive thinking, what are called "cognitive distortions." Examples of cognitive distortions include magnifying negative information, minimizing positive information, and catastrophic thinking. The goal of CBT is not so much to diagnose any given disorder but rather to examine specific problems in relation to an individual's life. CBT requires both client and therapist to be actively involved in identifying cognitive distortions and some of the patient's most problematic cognitive and behavioral patterns, as well as developing a strategy to resolve them.

CBT's pragmatic and supposedly atheoretical orientation has contributed to its wide-ranging appeal. Its current prevalence is additionally driven by a user-friendly design with clearly defined techniques that require less extensive training than psychoanalysis. Because the process is driven by concrete strategies, CBT is also fairly easy to standardize in training manuals and commoditize in self-help books. This standardization allows CBT to be tested in efficacy experiments, and its association with evidence-based practices and the scientific method gives CBT the presumption of being value neutral and a seemingly universal applicability.

With the waning popularity of psychodynamic approaches, CBT has become easily the most common evidence-based psychosocial therapeutic practice. Perhaps more critical to CBT's success than its theoretical innovation, however, is its methodological and procedural one. While psychodynamically oriented talk therapy typically requires weekly or biweekly sessions for one to two years

to surface the unconscious problems that patients continually stumble on, CBT is short term and goal oriented. Individuals come in once every two or three weeks for four to seven months, for an average of twelve to twenty sessions. As part of the co-construction of the psychotherapeutic practice, therapists and patients devise an action plan, with the patients assigned “homework”—frequently a recording of their thoughts, feelings, and actions to be brought in and analyzed with the therapist.

However, with its therapeutic emphasis on cognition, verbal skills, and rational (however *rational* is defined) thinking, CBT is as value-laden as any form of psychotherapy. Indeed, Euro-American ideals of self and personhood are reflected in a therapeutic emphasis on assertiveness over indirectness and subtlety in social interaction, change over patience and acceptance, personal independence over interdependence, and open self-disclosure over protection of family reputation (Hays 2009). For example, the goal of changing aspects of the inner self assumes that people will assume control over problems such as disturbing thoughts or maladaptive and self-defeating behaviors if they recognize their cognitive distortions and change them to be more helpful, positive, and realistic. However, CBT’s individualism and internal locus of control may come into conflict with social and familial hierarchies found throughout East and Southeast Asia (Iwamasa, Hsia, and Hinton 2019). Thus, multicultural psychologists warn CBT practitioners against attributing environmentally based problems to some kind of deficiency in the individual (Hays 2009). As an alternative, Hwang et al. (2006) advise psychotherapists working with minority populations to “acknowledge the discrepancies in cultural expectations and reframe the goals of treatment to developing ‘adaptation skills’ that are necessary for a healthy life” in order to allow clients to “play out their bicultural selves” (298). According to them, CBT should be adapted—or at least framed differently—for the client. However, when CBT is deployed outside of its native context, a different sort of adaptation occurs.

COGNITIVE BEHAVIORAL THERAPY IN PRACTICE

The PsyCafe’s actual café generated little of its revenue. Its primary function was to serve as a cover for privacy-seeking individuals who would proceed upstairs for psychotherapy sessions. Each of the consultation rooms had only enough space for two armchairs, facilitating intimacy between therapist and client. The PsyCafe did have a large seminar room reserved for business meetings and training courses. Every few weeks, Bão, the fifty-three-year-old owner who was trained as a counselor in Thailand, and a group of five to ten students convened to discuss theory, methodology, and case studies; gather feedback and advise on the students’ own clients; and occasionally observe a session with one of Bão’s clients. Almost all the PsyCafe students I met during my research were women. This reflects gender roles that assign women more expectations of care and emotional sensitivity

but less pressure to be financially successful, which allows them to pursue their own career interests, so long as they do not interfere with domestic responsibilities.² The students range from current and recently graduated college students who want to enhance their training to working professionals who want to maintain their professional and personal ties to each other. Classes typically started with a recap and discussion of the core theoretical tenets of counseling psychology, especially CBT, and workshopping of various cases the students had taken on. Students often referred to CBT simply as *điều trị hành vi* (behavioral therapy), and Bảo had to remind them that the cognitive and behavioral components of the therapy must be linked.

One of the students, a thirty-one-year-old school counselor named Vi, told her classmates about the case of an ethnic Chinese man who consulted her because of his son's frequent disobedience. Corporal punishment is regularly used to discipline boys in Vietnam (Rydström 2006a), but because the son had epilepsy, his parents agreed to never hit him, for fear of triggering a seizure. The central issue that Vi wanted to discuss, however, was not the child but the father.³ When she asked him to clarify why he wanted his son to be more obedient (*ngoan*), he only repeated that he wanted his son to be similar to a neighbor's more docile child. Regarded as the "pillars" of the Vietnamese family, fathers tend to have an authoritative parenting style, and the man told Vi that a father's commands to his son should be carried out without question or justification. When Vi probed her client about his emotions (*cảm xúc*) regarding the situation, he responded, "What's a feeling?" To this, the rest of the students laughed knowingly at one another. According to Vi, the man did not know if he was sad or not and could only repeat his desire for a more obedient child. One of the students floated the idea that he did not understand the word *cảm xúc* because he is Chinese, but Vi noted that he was born and raised in Vietnam and did not speak Vietnamese with a foreign accent. Others wondered if he simply lacked the habit of talking about his emotions or even lacked any emotions. The lack of emotional awareness already presents a difficult challenge for psychotherapists, but where do Vi and her classmates begin for clients who apparently are not even aware of the concept of emotion?

When asked to account for the relative success of CBT in comparison to other forms of psychotherapy in Vietnam, most mental health experts argued that the appeal lies in both its matter-of-factness and its emphasis on external behavior instead of inner feelings. First, clients often came to treatment with clear goals and direct requests to eliminate their symptoms or change their children's behavior in two weeks. Nguyễn, a thirty-year-old counselor at a call-in center in Ho Chi Minh City, observed that his clients' expectation that a single session will yield the advice that will resolve their problems follows a medical model. The explanation that CBT is popular because of a focus on specific problems and quick results is certainly not limited to Vietnam.⁴ The specific therapeutic strategies of

CBT reflect the punctuated timeline of late capitalism (Craciun 2016), and the fast pace that many Ho Chi Minh City residents regard as emblematic of a modern lifestyle leaves precious little time for oneself or others.⁵ Kim promotes short-term strategies because so many of her clients tend to disappear after a few visits. Her rationale for doing so is that some small adjustments (e.g., doing breathing exercises five times per day) to the clients' lives would be better than nothing. In some ways, she noted, current trends in psychology, such as the growing popularity of online listicles with titles like "5-Things-To-Do-To-Not-Be-Depressed," jibes with a Vietnamese context, especially in regard to a distinct orientation to behavior.

Second, CBT's perceived emphasis on observable behavior accords with a widespread belief among clients that actions speak louder than words. Ho Chi Minh City residents often noted to me that a person's most authentic self would be revealed in their behaviors. That is, one should not trust what people say but watch what they do. In general, I found most of the people I encountered during my fieldwork to be careful watchers of other people's behaviors, since anticipating others' needs and desires indicates one's own degree of care. Indeed, other people are often regarded as better judges of one's character than one's own self. Moreover, when people recount a story, they tend to describe in detail people's actions, rather than their perceived emotional states. This reflects a perspective on selfhood that emphasizes how one is perceived by others over how one perceives one's own self. Indeed, this greater comfort with behavior is common among many mental health workers as well. According to Julien, CBT has a pragmatically American character that especially appeals to Vietnamese mental health professionals. Hằng, a twenty-nine-year-old applied behavioral analyst who specializes in autism treatment, said that modifying behavior was simply more real. According to her, everything else was "just advice." To effect substantive change in people's lives, an action plan must be applied. Many cognitive-behavioral therapists bristle at the common parlance for a psychotherapist, *bác sĩ tâm lý* (head doctor, lit. psychological doctor), because it evokes notions not dissimilar to the English pejorative *shrink*. Unsurprisingly, they generally disregard psychoanalytically rooted practice, and they also differentiate themselves from other, similarly behaviorally focused mental health experts, such as the applied behavioral analysts. Usually trained in a single narrow specialization, applied behavioral analysts are more akin to technicians and lack the artistry of more broadly trained psychotherapists who can resort to other psychotherapies, even psychoanalysis, when appropriate.

Although familiarity with analyzing observable behaviors, as opposed to subjective experiences, may bring people to the door of the psychotherapy center, it is also what makes the job of a CBT practitioner so difficult. Focusing on behavioral adjustments seems like a convenient way to avoid the difficult work of self-reflection and articulation of interior conflicts. Like the psychiatric patients who only want a drug prescription to treat their anxieties, many clients undergo psychotherapy for instructions on improving their lives or fixing behavioral problems that disrupt family harmony. This echoes a Confucian morality with clearly

defined familial roles and the heavy hand of the Vietnamese Communist Party's directions on how to be a good socialist (e.g., remember the fatherland, have no more than two children). However, the neoliberal imperative to be free directs individuals to determine their own path to authentic selfhood without any explicit instructions. Clients are attracted to the medical model of psychiatry because it seems black-and-white to them, but psychotherapy is about, in Julien's words, the complexity of the gray area.

The apparent lack of emotional awareness among many Vietnamese is at the root of both the appeal and the mission of CBT in Vietnam. While emotion is not the primary focus of cognitive-behavioral therapy, CBT theory holds that some degree of emotional reflexivity is necessary so that clients can recognize, if not the psychodynamic roots of their problems, then at least how their problems manifest. Kim says that she "completely understand[s] where they're coming from." She tells her clients that she grew up in Vietnam like them but is upfront about her Western training and methods. She also specifies that they can pick and choose what techniques work or do not work for them, "based on their culture." According to Kim, in the West, therapy is a process of learning, growing, and self-discovery, but in Vietnam people are more problem- and solution-oriented. When her clients ask her point-blank questions on how to solve their problems, they want a prescription in terms of both pharmaceutical and psychosocial treatments.

For example, when Kim explained the symptoms of PTSD to a woman in her twenties who suffered from trauma-induced nightmares and panic attacks, the client asked, "Can I just forget this?" Whereas Kim's clients in Australia sought to process their trauma and earn something from it, this patient effectively wanted to learn how to walk away from it without confronting it directly. According to Kim, Westerners are more indulgent in their suffering and want to "dump it out on someone else" in order to work through it. This client, conversely, would rather not burden anyone with her problems, echoing the gendered notions of endurance discussed in chapter 2. Kim described herself as initially lost with this client yet insists that she does not need to adapt the CBT techniques themselves to a Vietnamese clientele. Rather, she only modifies her approach to them. For example, Kim explicitly states the therapeutic goals to her Western clients but tries to get her Vietnamese ones to realize what those goals are on their own, because she does not want to shame them for not knowing. What gets adapted in this cross-cultural therapeutic encounter, then, is not the CBT techniques but the clients.

TEACHING PEOPLE HOW TO FEEL

Tuấn had ambitions for how psychotherapy could help people not just one-on-one, in individual therapy sessions, but through a series of programming across print and online media platforms: self-help books, a blog, and a YouTube channel. This was less of a public health measure than an entrepreneurial effort to develop a brand—perhaps even a psychotherapeutic empire. Technology transfers inspire

Tuấn's business model. For example, he tells clients that the brain is a piece of hardware that sometimes gets a virus, and he provides the software that deletes the virus. Tuấn transfers these technologies of the self through psychoeducation, the process of providing information on mental health concerns to clients and, when appropriate, their caregivers. A central component of many psychotherapies, it rests on the assumption that understanding one's emotional challenges and how to cope with them leads to greater self-efficacy. Within the global mental health movement, the promotion of psychoeducation encourages emotional self-control, stress management, and maintaining social relationships in order to foster a general sense of wellness and produce social and economic benefits (Duncan 2017; Rose 2019).

An increasingly prominent feature of psy-globalization (Duncan 2018), lists of emotions are designed to help people label and articulate them in culturally intelligible forms (Pritzker 2016; Wilce and Fenigsen 2016). For example, Kim often shows both adult and child clients an emotions reference sheet with cartoon drawings of exaggerated facial expressions. Clients are tasked with labeling the feelings depicted in each figure in order to practice, recognize, and discuss their own emotions. When Kim asks them how they felt about some event that bothers them, many often respond by saying something such as "I didn't like it," "I thought it was stupid," or "I just walked out." Indeed, in my own research, I noticed that when Ho Chi Minh City residents recount a story, they tend to describe in detail people's actions, where an American like myself might expect a description of a perceived emotional state. In the West, emotion charts are often used for clients with alexithymia, the inability to recognize and articulate emotions in the self. While people with alexithymia may experience emotions, they can only describe them in terms of physical symptoms or externalized behavior. Typically used for subclinical conditions, here the emotions reference sheet is used to "treat" Vietnamese narrative conventions because CBT is unproductive if clients are not sufficiently descriptive of their own emotions. According to Kim, people have to feel more than "bad," because "bad" is not a feeling. Clients expand their emotional vocabulary in session and at home with various "homework" assignments like thought records or diaries. Thus, clients are not taught to feel for the first time, as Vi and some of her classmates might surmise. Rather, as one of the first steps in their treatment, they learn to impose categories of emotions on their lives.

While specific emotions may be supported in some cultural contexts (e.g., anger among the Ilongot; Rosaldo 1983) but avoided in others (e.g., anger among the Inuit; Briggs 1970), cultivating an awareness and receptiveness to a broad range of emotions is increasingly valorized in neoliberalizing contexts. After all, Kim wants to teach people how to feel, not what to feel. Some refer to the general category of emotions through the term *nỗi niềm*, which is a combination of the classifier for both negative (*nỗi*, as in *nỗi buồn*, or sorrow) and positive (*niềm*, as in *niềm vui*, or joy) emotions. Such inclusive valuation of emotional range facilitates the

emotional labor, flexible subjectivities, and acceptance of others' emotional reactions that are characteristic of late capitalism (Urciuoli 2008). Through the explicit use of talking about one's thoughts, feelings, and relationships, clients learn to center themselves within their own narratives (Kirmayer 2006).

Clients also learn to disentangle themselves from the rhythms of everyday life. For example, one stress management exercise is to ask people to recall the last time they were stressed. For Tuấn, that people usually cannot remember is evidence of a lack of emotional intelligence. At his stress management workshops, he asks participants how a person in Ho Chi Minh City, where just going outside entails bumping up against ten million other people, goes a single day without stress. The goal of the stress management workshops is to increase attendees' awareness of potential triggers so that they can be more conscious of their own frustrations and manage them in ways that do not harm others. Đức, a forty-five-year-old clinical psychologist at an international hospital in Ho Chi Minh City, explains the concept of "taking it out on others" to his Vietnamese clients with the expression "*giận cá chém thớt*" (so angry at the fish that you slash through the cutting board). The imposition of a medico-scientific model of psychic distress—which is to say, redrawing the line between self and society—does not necessarily flatten people's emotional lives so much as frame the everyday as an arena for emotional experience. Unlike some of his peers in Ho Chi Minh City, Tuấn believed that Vietnamese people were already too emotional. As such, they need emotional intelligence to observe their own feelings and, thus, to be more aware of and subsequently manage themselves. This particular type of self-awareness distinguishes the core of the self from the circumstances, so that one is able to separate the two.

The use of CBT to cultivate an emotive self submerged in the demands of everyday life in Vietnam may be surprising to many CBT practitioners in the United States, where one of the most popular psychotherapeutic trends of late is mindfulness-based cognitive therapy (MBCT). This modified version of CBT incorporates mindfulness meditation, which was most popularized in the West by the Vietnamese Buddhist monk Thích Nhất Hạnh. According to MBCT theory, feelings come and go and do not represent who one is, so one should not attach one's identity to how one feels at any given moment. Thus, by observing their thoughts and withholding any judgment about them, clients disengage from both everyday life and their feelings. Mindfulness-based practices are also gaining traction in Vietnam, but not just within psychotherapeutic circles. Ho Chi Minh City's corporate culture has embraced meditation in the secular pursuit of people's professional ambitions, with seemingly little attention to the Buddhist warnings about attachment and striving (Nguyen 2020).

Teaching people "how to feel" is less about the production of affective states than the cultivation of an emotive self. While CBT may reconfigure people's models of the self to align them with the rational behaviors that the state and market economy encourage, it can also provide inspiration in rethinking the relationship

between self and others. Working on the self may be done to repair social relationships, not sever them (Pritzker and Duncan 2019). Participants at Tuấn's stress management workshops learn to identify and cope with stress in more productive ways. For example, Tuấn suggests going to the gym or getting a drink with friends before going home from a particularly stressful day at the office. While taking some time for oneself can be interpreted as a typically neoliberal form of self-care, in this case it is done to avoid taking the stress home, where it might create conflict. This becomes a way to renegotiate, as opposed to escape, relationships in the context of radical social transformations (Duncan 2018). Thus, the realms of the individual and the social are not necessarily in opposition to one another but instead are mutually contingent (Yates-Doerr 2015). Rather than establishing a monolithic form of selfhood, psychoeducation contributes to "meta-emotional diversity" (Wilce and Fenigsen 2016, 83). Psychotherapy has become an arena in which people can experiment with alternative and hybrid identities in the context of rapid social change.

THE POLITICIZATION OF PSYCHOLOGIZATION

Because psychotherapeutic practices frame individual interiority and autonomy as a matter of personal growth, counseling privileges clients' subjective experiences over their political-economic circumstances. As a result, therapeutic practices encourage people to mine and then manifest their inner selves to achieve their personal goals instead of questioning their sociopolitical circumstances. For example, in post-Maoist China, the state integration of psychotherapeutic measures and techniques in police, military, and labor matters renders political-economic quandaries in emotive terms (Yang 2014; Zhang 2017, 2020). Drawing on psychological expertise to understand political problems obviates the neglected and unmet responsibilities of the state by focusing on individuals for their inability to adapt to their new economic circumstances. From this perspective, psychotherapy becomes a means to induct people into the state's therapeutic ethos and to cloak its deficiencies by distracting them from growing inequalities.

While some aspects of these criticisms certainly resonate in Vietnam, psychotherapeutic discourses have also been mobilized as a form of social critique of Vietnam's political past and present. Indeed, the state of the country's mental health burden has long been viewed as an indictment against the existing social order. In the early twentieth century, Vietnam's academic, popular, and literary press became the site of intense debate over and experimentation with the role of the self in public and family life. For example, citing Émile Durkheim, Vietnamese scholars argued that rising rates of mental illness and suicide were the byproducts of modernization, not a deficiency in traditional culture (Edington 2019). Between World Wars I and II, the Vietnamese intelligentsia resisted colonial

rule by drawing on Western scientific knowledge and medicine that the French believed were too advanced for Vietnamese to appreciate (Nguyễn-Võ 2008).

While mental-health-related critiques from the colonial era swirled around debates about whether or not the Vietnamese had the intellectual capacity to govern themselves, today they center on emotional maturity, specifically the development of the emotional intelligence necessary to rise to the challenges of a fast-paced market economy. Psychotherapists' assessments of the national state of feeling offer implicit critiques of the state. For example, their explanations for the current interest in emotion and mental health concerns typically attribute its emergence to social changes introduced by *đổi mới*—era globalization or modernization. Emotional intelligence is simultaneously understood as a universal feature of humanity and a product of the country's recent economic growth, which many Ho Chi Minh City residents attribute not to effective strategic measures on the part of the state but rather to its withdrawal from the public sphere. In Ho Chi Minh City, the ruling Communist Party is often considered an interruption not only in people's lives but also in the city's cultural and economic identity as the primary engine of Vietnam's economic growth. In this timeline of progress, the entrepreneurialism of the southern Vietnamese is a matter of instinct (Leshkovich 2014a).

Most of the blame for the current state of feeling, however, is reserved for Vietnamese neo-Confucianism because it stands for the traditions that prevent people from adopting a modern mindset. For example, Kim argued that strict parenting styles and heavy school and household workloads prevent Vietnamese teenagers from a phase of rebellious self-expression. In Vietnam's patrilocal residence pattern, individuals rarely leave their family homes until they establish a family of their own. Because most people only move from one family into another, they are too focused on pleasing others to discover how to meet their own desires. For example, Hoa and Khuyên (from chapter 2) defined their emotional maturity in terms of care, sentiment, and sacrifice. Khuyên's mother told her she was mature for her age because Khuyên never made her sad. Conversely, Kim advised a female client in her twenties who had just broken up with her boyfriend, with whom she had been cohabitating, to keep her apartment but remain single for a while so that she could learn what satisfies her.

Unlike Kim, Tuấn did not place the blame for people's emotional woes on Confucianism itself so much as on the contrast between tradition and modernity—or, as he phrased it, “rice (*lúa*) culture slamming up against high tech.” Rapid but uneven socioeconomic transformation is testing the Vietnamese mentality. According to him, cities change at a breakneck pace, but the countryside (where most current Ho Chi Minh City residents grew up) has remained the same for the past century. It is a tumultuous time for the Vietnamese, but they do not even know it because they are distracted by the lure of modernity's shiny surfaces. This

was perhaps best illustrated by a specific subject of Tuấn's ire: people with iPhones who arrive late to meetings because they got lost. According to him, they do not know how to use the maps function on their phones, which they use only to take selfies and to show off their latest status symbol. Instead of using new technologies to better their lives, people are too focused on their own vanity because they care so much about what others think of them. People are so stuck in a village mentality that they do not look beyond their immediate horizons, let alone the screens of their smartphones. Tuấn also blamed Buddhist notions of fate (*số mệnh*) for encouraging passivity and preventing people from taking responsibility for their own actions. "Good luck taking on scientific values," he said, "because that is the future."

Thus, when CBT practitioners describe the challenges of providing care in Vietnam, they are careful not to blame their clients for some deficiency of individuality or personal responsibility, among others. Instead, the blame gets shifted onto Vietnamese culture and politics. CBT's intense focus on the inner self often comes at the expense of social and cultural factors that restrict people's ability to implement changes for themselves. Any factors stemming from so-called cultural traditions that deviate from CBT's presumed ideal of personhood are presented as detrimental or even as quasi-pathological or pathogenic. Psychotherapists link the nation's changing tides with the minds of its citizens, and many of them stated that psychology is the most important field for the country's future. In their argument, addressing Vietnam's mental health crisis is essential to modernizing the country, as if "modernity" and its trappings were not part of the problem to begin with.

CONCLUSION

Taken together, pharmaceutical and psychotherapeutic treatments for anxiety reveal the breadth of ways in which selfhood has been adapted to meet people's needs in post-reform Vietnam. Because pharmaceutical approaches in Vietnam directly focus on the physical symptoms of anxiety, patients are largely able to accommodate them into their existing understandings of worry, illness, and selfhood. Doctors' entreaties to reexamine patients' personal lives, if even bothered with, went largely ignored. Psychotherapeutic treatments, conversely, target and challenge clients' sense of self, not just their symptoms. Almost in spite of itself, CBT has become a critical means of self-discovery in Vietnam. If, as I have argued, models of selfhood are inextricable from different forms of anxiety, new configurations of the self—even those designed to ease troubled minds—may elicit different forms of anxiety. Ho Chi Minh City residents seeking relief from their worries may get more than they bargained for in their sessions.

"What's the difference between psychology and anthropology?" Trâm asked me. She apologized for still being unclear about my profession even after years of friendship, but she could hardly be blamed. Psychotherapy sessions and the

person-centered ethnographic interviews that Trâm had participated in share common attributes, including an exploration of the significance of one's feelings, relative anonymity—at least from the clients and interviewees' social networks—and the mutual construction of empathy.⁶ However, as I told Trâm, anthropological research typically does not have the therapeutic goal of changing people's behavior. Instead, it aims to contextualize their experiences in political and economic institutions. At any rate, I knew her well enough to know that her next question—"You studied psychology in school, right?"—had an ulterior motive. Trâm suggested that she could tell her story (*kể chuyện*) and I could then explain her own psyche to her. I insisted that I was no substitute for a therapist but could listen as a friend. I also offered to put her in contact with some of the psychotherapists I knew, but she said she could not afford it anyway. Her proposal reflects both the growing interest in psychotherapy throughout Ho Chi Minh City and how out-of-reach it is for many. Regardless, Trâm had long experimented, to varying degrees of success, with the emotive discourses of the self that Ho Chi Minh City's mental health workers promote. The next chapter examines some of these attempts, from several years prior to this conversation, and how psychotherapeutic ideals of emotion and selfhood operate outside of the clinic.