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Introduction

Reflections on the anthropology of public psychiatry: The potential and limitations of transdisciplinary work

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Transcultural psychiatry and anthropology have long championed the comparative study of emotional distress to better understand how people experience, interpret, and manage extraordinary mental events and emotional quandaries around the globe. This special issue brings together practitioners, scholars, and experts from both disciplines working at the intersections of the community and the clinic, the personal and the social, the local and the global, to ask: where does this effort currently stand? We hope this collection of articles will serve as a bellwether selection of provocations and future directions for transdisciplinary research in psychiatric anthropology.

Much research on the mental health system in the US, at least, skirts the sprawling, fragmented, poorly mapped terrain of "de facto" services—a motley array of institutional arrangements claiming to offer custody and care, such as jails, prisons, detention facilities, residential institutions for teenagers, homeless shelters, and a variety of quasi-institutions for the deaf, blind, and elderly. Rather than avoiding these settings, the researchers contributing to this issue reflect on the challenging work of engaging intimately with interlocutors living with these conditions. We use the term "public psychiatry" to refer to this ad hoc, patch-worked, and ill-monitored system. Unlike "public health," as we use the term here, public psychiatry encompasses not populations but structures: state, private, and informal configurations of care, the surrogates of care and the default options offered when care is unavailing. Understood in this way, we can reflect on both public psychiatry in

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the US and the global variations of public psychiatry familiar to readers of this journal. Transcultural psychiatric research, both clinical and anthropological, has been less constrained by institutional boundaries and professional blinders and has often taken a look at public forms of health services (e.g., institutions, circuits of care), but further research is needed and has been provided in this issue.

The genesis of the papers in this issue of *Transcultural Psychiatry* was a working conference convened in March 21–24, 2013, funded by the Center for Advanced Studies in the Behavioral Sciences at Stanford University, thanks to Tanya Luhrmann's backstage *impresaria* work. The conference, titled "Whither Public Psychiatry?" aimed to increase dialogue and collaboration among researchers with a vested interest in public psychiatry. The goals were to take stock of knowledge, develop research initiatives that could help us to understand what was needed to advance knowledge in this field, and build collaborations to address pressing issues that have so far resisted resolution (or even clear formulation). Over the past decade in the US, for example, we have seen a virtual evangelizing of the importance of promoting recovery in mental health care. But what has actually changed at the level of everyday practice? Have the new initiatives reckoned with the substantial organizational culture change needed to accommodate a seemingly "new," recovery-oriented agenda? If so, what does that culture change look like and how has it been accomplished? If not, what wellsprings of institutional inertia stand in the way? What rules, roles, and relationships are needed for such initiatives to succeed, what kinds of alternatives need to surface, and what might be their chances of survival? Such questions defy easy distinctions between structural and cultural, let alone a clearly bounded domain of "mental health." They attract researchers with similarly overlapping areas of expertise and interest.

Even so, entrenched professional habits continue to stymie collaborations. Anthropologists, clinical investigators, and services researchers have little contact with one another, are wedded to different methods and modes of analysis, have different scholarly goals, and associate with distinctly bounded tribes. Their varying styles of inquiry can be divisive. Anthropologists tend to write in ways that health services researchers may struggle to read as relevant or see as likely to produce a fundable project. Those who do reach out to anthropologists often do so after their research is well under way as a "qualitative add-on" and the value of input at the formulation and design stages is already foregone. There is little appreciation of the need for early and sustained engagement if the anthropologist's skills are to be put to full use.

Moreover, health services researchers prefer to work in teams to apply for funding, collect and analyze data, and publish, while anthropologists (with the exception of archaeologists) tend to work on their own, placing great value in doing the ethnographic work from which their "data" and interpretive efforts issue, and publishing solo. Anthropologists also tend to challenge and deconstruct received constructs; mental health services researchers are trained to be problem-based and

solution-oriented, focused on generating evidence that can be "translated"—ideally, if optimistically—into policy, practice, and service design.

Not surprisingly, distinctive research cultures and requirements for promotion have meant that collaborative possibilities between these research tribes are infrequent and require extra effort to rise above disciplinary norms. As a result, scholars with a common commitment to interrogating and improving what passes for "good enough" in public mental health services tend to write past and ignore each other, and the opportunity for innovative, groundbreaking research is lost.

The Stanford conference assembled representatives from these different fields to contest the disciplinary boundaries and explore the possibility of real collaboration. Researchers, policymakers, academics, and clinicians—from practice-axis heirs of Bourdieu (1977) to theory-weary pragmatists in the employ of the state—all were tasked to debate the pressing issues faced by both a public anthropology and a public psychiatry. Old alliances and long-simmering suspicions stalked the opening presentation. The conference began with reflections by Mike Hogan, former commissioner of Mental Health in New York State and architect of the President's New Freedom Commission on Mental Health (2003), which officially endorsed "recovery-oriented care" for the US. Other participants included academics with long-term experience in securing funding from the National Science Foundation and the National Institute of Health, as well as younger scholars. All are active players on the research front and explored challenging questions including: What exactly is it that anthropologists have to offer to psychiatrists (and vice versa)? What fresh ideas or novel framings have been ventured regarding the social and biological causes of schizophrenia? (And what sort of epistemological cautions ought to shadow the term schizophrenia?) How does addiction treatment fit into contemporary mental health services—and how do lay and religious practitioners figure, if at all, in that arrangement? Does our thinking about recovery change as we learn about mental health, multicultural approaches to healing, and outcomes in indigenous communities?

The papers in this issue offer a sample of the issues raised at the conference. Anthropologists and psychiatrists have long shared an interest in the ways that the dissemination, implementation, and practice of mental health care vary across social contexts. Looking at psychiatry from a transcultural perspective alerts us to the complex ways that culture shapes mental health and its care and treatment, and can make us better informed skeptics on the home front, by promoting constructive criticism of psychiatry's theory and practice. A critical comparative perspective also reminds us how deeply public mental health is entwined with politics. The result is an intertwined assemblage of empirical research, pointed commentary, and critique—leavened with irony, irreverence, and speculation—that can fulfil what Rudolph Virchow (1821–1902), the physician and anthropologist, saw as the job of the "practical anthropologist": to take the "theoretical solutions" of "medicine as a social science" and "*find the means for their actual solution* [emphasis added]" (Virchow, 1848, in his weekly newspaper Die Medizinische Reform 2, quoted in Merrick, 2013, pg. 1).

From the user or "demand" side of mental health care policy and practice, the papers in this issue foreground anthropology's case for reviving the goals of an earlier "public psychiatry" that aimed to bring mental health care to people outside of asylum walls, in their local, everyday contexts (Mollica, 1983). Public psychiatry in the US since the late 1970s, however, has come to stand for the state-sanctioned provision of mental health services throughout the institutional structures of everyday life: a massive, fragmented, poorly mapped terrain of custody, management, and treatment activities. This "de facto" system—like the serial service landscape in the addiction world that Jacqueline Wiseman (1979) once referred to as "stations of the lost"—includes police encounters, jails, prisons, schools, shelters, ERs, detox facilities, family homes, and a variety of such quasi-institutions. Relay outposts on this institutional circuit are much in evidence in the articles here, from the Mexican *anexos* to nerve-wracked primary care doctors and freshly deployed "crisis respites" in New York City.

Makeshift treatment for mental health and addiction disorders in such venues may at times align itself with biomedical models of serious emotional distress (as in Mendoza, Rivera-Cabrero, & Hansen's [2016] piece on the hegemony of neurochemical approaches in American opiate addiction treatment). Alternatively, as Garcia and Anderson (2016) show, they take the form of hybrid (and, occasionally, abusive) treatment regimens when biomedical variants are not available. In each case, the absence of flexibly configured alternatives is keenly felt despite huge differences in cultural context and resource wealth. Competing agendas, uneven standards of care, and a view of patients as "resistant" challenge the lives of people with addictions and serious psychiatric disability. These differences in context make considerations of politics unavoidable. For example, Garcia and Anderson rightly question the ability of the *anexos* to address the larger transnational context of addiction. Their study context is a region saturated with drugs en route to the United States, whose "War on Drugs" has led to structural devastation, violence, poverty, and chronic unemployment in neighboring Mexican communities. Meanwhile, in middle-class Staten Island, New York, biomedicine may reign, but its collateral damage is formidable: prescriber abuse (the now-incarcerated doctor whose office lawn was littered with empty Oxycontin bottles); overregulation of "maintenance therapies" making doctors leery of prescribing drugs such as buprenorphine); and defensive medicine that has led to a tragic rise in illicit heroin use in the region. Both sets of authors ask us to consider the complicated social conditions surrounding addiction and its treatment. Here, public psychiatry becomes indistinguishable from public health.

But patients are not just passive targets or testing grounds for treatment schedules and regulatory schemes. They are, as several authors remind us in quite different ways, *moral agents* with active, world-constructing imaginations. Thus, Jones, Kelly, and Shatell (2016) deploy the permissive epistemology of "postsecular" doubt to explore remarkably protean explanatory models fashioned by people grappling with the uncanny world of psychosis. As Ellen Corin and colleagues (Corin, Thara, & Padmavati, 2004) and others (Estroff, 2004; Lovell, 1997; Myers & Ziv, in press)

have noted, the difficulties of voice and identity at issue here are formidable: Who is allowed to speak for whom, on what authority, and with what level of authenticity is continually challenged and negotiated, as is the kind of story a person with psychosis is able to tell. In this instance, Jones, Kelly, and Shattell have repurposed conventional tools of inquiry for a revealing take on the usually hidden (even actively denied) work of alternative sense-making. They show how porous the boundaries can be between seemingly incompatible registers of knowing—or, better, how easy it is to shuttle (or "migrate") between multiple ways of knowing in the interest of coherence. Variants of the real and delusional come to denote not sealed chambers of perception and explanation but alternative bids for plausibility, to be weighed, tested, tweaked, and blended as needed to meet specific "situational demands." Their paper is a mischievous piece of work, borrowing the tools of a once-rejecting public to reveal the multitude of worlds within it. As Luhrmann (1989) suggested some time ago in her wry assessment of contemporary witchcraft in England, the everyday turns out to be a very unusual place indeed.

For Myers (2016), as was true for Norma Ware et al. (Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007), being recognized as a moral agent—someone capable of action and accountable for its consequences—is critical to the work of recovery. Here, she presents three variants on that work, spanning a wide range of success. For the most part, these are self-directed, informally supported projects and, not surprisingly, their track record is mixed. One of her striking suggestions is that formal public psychiatry programs should be held to account on a metric of moral agency. If truly "recovery-informed," that is, they should supply social situations (and institutional legitimacy) that can be mined for self-respect, as well as resources that can be turned into "autobiographical power" and "peopled opportunities." Alternative communities (religious and/or peer-based) will surely play a role, but coordinating their "work" with treatment and/or rehabilitation-oriented programs will be challenging. How certain missing pieces—such as educational achievement—can be corrected or compensated for remains an especially tough problem.

Finally, Pope, Cubellis, and Hopper (2016) argue the case for an embedded ethnography that contributes to implementation research. The arrangement they characterize as "dirty work" involves a monitor-and-report-back operation in public mental health. "Parachute NYC" enlisted these anthropologists as active agents of a new, family-based, crisis intervention program positioned to detect mishaps, miscommunication, simple lapses, or routine errors in ways that might inform and direct corrective action. In exchange for brokered access, a research team effectively "signed on" as active participants in the deployment of the new program. Pope and her colleagues are wise to the difficulties of working (one might say) as double agents, but hope to be able eventually to produce "an honest story, honestly told" (Geertz, 1988, p. 9). Their lens has a narrow aperture and great depth of field, but their ability finally to attend to untended-to structural constraints remains to be seen.

The concept of a "global public psychiatry" widens the field of inquiry, extending its breadth. Unsettling the assumptions of Western practice, enables us to investigate how mental health care is supplied across cultures, and whether or

not interventions meet local needs (Kirmayer & Pedersen, 2014). Distressing experiences and extraordinary lives take shape and are responded to in a variety of ways in different social and cultural contexts. These "local moral worlds" (Kleinman, 1999) and their institutional counterparts organize the "de facto" field of public psychiatry. A good faith form of mental health care that acknowledges and incorporates local perspectives and needs is desperately needed—locally and globally. We hope this issue of *Transcultural Psychiatry* advances the conversation about the kinds of services that are needed for diverse conditions, including schizophrenia and addictions, by gathering together the perspectives of anthropologists, sociologists, psychiatrists, psychologists, and mental health services users and researchers in one issue focused on the supply and demand of mental health services in a variety of settings. The contributors, who have benefited greatly from our transdisciplinary dialogue, pose crucial questions for future work in anthropology and psychiatry: What aspects of social context should be taken into account to supply care that meets the needs of individuals? If access to culturally informed care is to be enhanced—as some locally embedded researchers insist—to what end? And how, in the long run, might we productively extend these ongoing conversations and provisional collaborations among social scientists, clinical researchers, clinicians, and the publics they seek to serve?

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