CHAPTER 1

Land of Enchantment, Land of Pain

SCENES FROM THE FIELD

In late winter, as the New Mexican sunlight gleamed in the subfreezing wind chill, I (coauthor JHJ) first met Taciana at the Children's Psychiatric Center (CPC), in a small room that is part of the larger pueblo-style residential facility. Taciana had been admitted the previous week, and this was her first hospitalization. Slight and remarkably soft-spoken, she seemed younger than her stated age of fourteen years. She had agreed to meet to learn more about the research we were doing on how young people come to the hospital. After I explained our work and ensured she understood that we were not part of the treatment team, she gave her permission to be included in the study. Without hesitation, she plunged into a long and commanding narrative:

> I am Zuni. I come from the other side of the mountains. I come from Zuni. I came here because bad things happened to me and some people told me I could come here to rest. People could take care of me. This is my first time coming here, or in trying to commit suicide. I hate myself. Because I hear voices, like voices telling me what to do or "hang yourself, do it, become like one of us."

She explained that it seemed like hanging herself was "worth it" and tried it. She had no idea how long she had been hanging before her father found her. He told her that she needed help, so she went to her school counselor and told him that she was "having trouble dealing

with anger" and wanted help. The counselor told her that "there were some real nice people at a hospital who can help." Taciana continued her story about why she had come to the hospital:

T: For depression and I was dealing with a lot of things like my grandpa, when he passed away, I was sad because he meant a lot to me, and when he was gone, you know, I stopped going to school and I started smoking [marijuana] and I started ditching school, and I thought that was a really good thing to do, but when I talked to my brother, my oldest brother, who lives in [small town], he said I'm hanging around the wrong people and I don't have to do that. And he was getting, you know, angry because he hates seeing me following the wrong footsteps, and he told me, "You have to follow the light. You have to look for the light so you have to get out of your trouble." And I told him, "Well, I am going to a place where it is really going to help and I am volunteering to go." And I've been here at the hospital and it's really helping me . . . and I'm really glad I came.

J: Ah. So, you came to get help and to try to get away from the wrong crowd.

T: Yes. And my childhood was really bad back then because there was a lot going on, a lot of drinking in the family, and I didn't have enough time to sit down with somebody and talk with them about my problem. So, I've been dealing with it ever since I was five. When my grandpa died, I started seeing him and I thought I was going crazy, so I told my grandma about it, and she sat down with me and she said, "OK, let's talk." So I told her, "I'm seeing uncle, he's coming to me, asking me questions about whether I want to live or die. And I told uncle I wanted to live, I want to move on with my life." And back then I was moved from my mom and my father, and two social workers came to my house and told me that I needed to be removed from their house, because I wasn't getting the help that I needed at home, and there wasn't enough support, like, um, enough food at the house, or money that we needed. So they told me that there was a family where you could be loved and that I was going to go there. So, I said, "OK, that sounds nice. I'll go."

At the time she moved into this foster home, she was five years old. She told me how she was removed from her family home:

> Because my mom wasn't taking care of me like a parent should. She was leaving me outside when they were drinking, and there was a lot of fights going on, and when they were fighting, you know, the fighting would just get worse and worse. And I would get involved like Mom telling me to go outside, and I would be outside for a long time, so there was a neighbor that called the social workers, and they came to the house, picked me up, and we went to a home [foster family], and I was there for about two years . . . from [that] home I went back to the other foster home. That home I didn't like because I was abused.

Sexual violence and ravaging of her bodily and psychic integrity had occurred three times in Taciana's young life. Narrating these events, she paused to wonder: "I was saying, 'Why *me?* Why does it have to be me?' Because I'm the youngest? Is it because I'm the youngest [that] I have to be raped all the time?" The first rape occurred when she was ten years old, during a family party in her neighborhood. She decided to go back home to her trailer to get her sweater, but when she turned around to leave she encountered a young male by the door. She began to scream, but he grabbed her mouth and threw her down on the bed. Taciana continued to try to scream but, she told me, she had no idea what was going on. The young man raped her as she continued to try to scream. After he left, she wanted to go to urinate but could not because her "private was hurting, [so] I just took a nap and I was sleeping." Her foster mother entered the trailer and, seeing Taciana, asked why she didn't want to return to the party. She replied that she just wanted to take a nap. She narrated that she was scared to tell what had happened because she was afraid that the perpetrator, Taciana's foster mother's grandson, would lie and say nothing had happened to her.

T: So, I told her I just wanted to stay in the trailer. [My sister was there and said,] "You *have* to go down there." I told her, "I don't want to." And then she slapped me, and every little thing I did wrong she would hit me with her hand, or with a washcloth, and I would always cry. I was depressed at that home. And that day we had a meeting with the social worker. I was scared to tell her, but I just said, "I *have* to tell her." So, I was brave enough to tell her what had happened.

J: I'm glad you are here [at the hospital], that you could stay. You must be a very strong person to have gone through all these terrible, terrible things, and to have the strength, and the goodness to be

able to sit here with me, and to share your story, because I feel very much just how difficult this is. So, it is a great honor to be able to talk to you.

T: Yes. You are welcome.

At this point in our encounter, the end of the first ethnographic interview, my mind raced with thoughts of what had happened to Taciana and what would happen next. I began to imagine how I would rearrange one of the bedrooms of my home so she could stay with my family. As an ethnographer with training in psychiatry and working in the field of mental health for over two decades, I felt flustered. Nothing like this had ever crossed my mind, even though, in my fieldwork in the homes of poor families, I had had innumerable encounters marked by pain, anguish, and uncertainty about the future. I thought of all the practical and ethical reasons why taking in this young girl could not possibly work. Why was I even thinking like this? Then, as I was leaving the hospital, I stopped dead in my tracks in the snow, frozen with the full-blown realization that ethnographic counter-transference had been activated: at the time, my own daughter was also fourteen years old.

Five months later, I (coauthor TJC) met Taciana at a residential treatment facility where she had been living for three months following her discharge from CPC. This was not a first-rate university hospital but a for-profit residential facility with poor management, supervision, and quality of care. A number of our interlocutors had been placed in this facility at one point or another in their trajectory as patients. They typically compared it with CPC and said they experienced this residential center as harsh, as a place of blame, punishment, and stigmatization. Taciana's experience (further described in chapter 5) was that the facility was neither supportive nor therapeutic. In fact, several years following Taciana's stay, the number of assault and battery calls at this treatment center had risen dramatically, with reports of teens smoking marijuana, getting into fights, or having sex. The New Mexico Children, Youth, and Families Department determined that the facility could no longer keep children safe or provide an adequate level of treatment, and it was permanently closed in April 2019.

Familiar with Taciana's first interview and the way in which JHJ had been compelled by her situation and her engaging personal presentation, I was eager to get to know her. Rather than leading with her Zuni identity and background, however, by this time Taciana's narrative was in an entirely different cultural idiom of misogynistic victim-blaming,

neoliberal individual responsibility, a medicalized discourse of diagnosis, and a constricted pragmatics of therapeutic working, processing, and coping:

> I'm here [at the residential facility] because I fucked up my life. I did it to myself. I can't really do anything right. I need to use my coping skills. . . . Right now, I'm working on my depression, my anger, my hallucinations, and my self-harming. I have [processed] with a lot of stuff and I do coping skills and I also call my mom if I need help.

Her mom in this narrative is her caregiver in treatment foster care. Taciana was eager to be discharged to the caregiver's family and was looking forward to their visit on the following day. Meanwhile she was having difficulty with the peer environment after an internal move to a different unit: "I was there for about two months and I started messing up. A lot of girls started hating me and they started lying about things and I started getting mad. And I started cutting and I started banging my head, and I started trying to hang myself again." She defined banging her head against a concrete wall of the facility as a "coping skill" she had learned by watching others do it at the facility.

Taciana's initial cultural and personal narrative was framed by "being Zuni" and being a person who had had a series of "bad things" happen *to* her. Now, it had been radically transformed into a narrative of the silencing and erasure of violation, shaped by the neoliberal discourse of individual responsibility whereby she was a girl who "fucked up my life." Nevertheless, she retained attachment to Zuni culture and her Zuni family, keeping a wooden prayer stick, a dried corncob, and cornmeal to protect her in moments of crisis and prevent her from lashing out at others. She proudly described the Zuni dancing deities as well as her own fluency in the Zuni language and knowledge of Zuni songs. My encounter with Taciana, like my coauthor's, produced a compelling moment, but this one had to do with a self-discovered practice that symbolically bridged the world of Zuni traditional healing and secular therapeutics. She had a stress ball that she sometimes squeezed, and on one particularly fraught day she found herself holding it in one hand while she held her ritual corncob in the other: "I had this feeling. Like I'd gotten lifted up or something. I got this feeling, went down my body, like something good touched me. I just squeezed them, [and felt] something touching me. So that's why I do it every morning before I wake up. It just gives me a better day every day."

Taciana's agency, identity, and reflectiveness in dealing with extraordinary conditions are critical to understanding her lived experience and

her hope for a better day, as well as the possibility of her having a life beyond the hospital and the world of treatment. Overall, and as we develop further below, we will not represent her experiences—nor those of our other interlocutors—either as reducible to "bad parenting" (as one psychiatric colleague said) or as summarily "tragic," "sad," or "depressing" (as some anthropology graduate students have said). Such characterizations only invite us to turn away and are not responsible characterizations of these young people, as troubled as they may be, nor are they apt for the intricate life experiences we explore in this book.

CONCEPTUAL ORIENTATIONS: LIVED EXPERIENCE, INEQUALITY, AND ENGAGED STRUGGLE

Our challenge in this book is to engage the lived experience of adolescents who have been inpatients in a psychiatric hospital, their trajectories through the mental health treatment system, and their hopes for having a life in the face of extraordinary conditions of precarity and affliction. Our theoretical framework is grounded in the interrelations among lived experience, power and inequality, and engaged struggle that concurrently structure subjectivity, sites of care, and sites of harm. "Lived experience" is central to our concern with immediacy and intersubjectivity as wellsprings of meaning and plays an important role in contemporary phenomenological anthropology (Jackson 1996; Csordas 2008, 2013; Katz and Csordas 2003; Duranti 2010; Kirmayer 2008; Desjarlais and Throop 2011; Jenkins 2015a; Ram and Houston 2015). It is a powerful yet redundant phrase, for isn't all experience lived? In fact, the apparent redundancy is itself a reminder that all experience is first and foremost "lived," whether it is mundane or remarkable, in dreams or in everyday life. And in any case, are we as anthropologists even interested in any kind of experience that is not lived? There are three reasons that we choose to foreground lived experience.

First is our long-standing theoretical commitment to the primacy of experience as the starting point of ethnographic investigation (Martin 2009, 2010; Biehl 2013; Jenkins 2015a; Csordas 2002, 2015; Haas 2017; Csordas and Jenkins 2018), rooted in the fields of psychological and medical anthropology. This could not be clearer than in the argument by Arthur and Joan Kleinman that made explicit the theoretical prerequisite for medicine and anthropology to foreground experience qua experience: "What is lost in biomedical renditions—the complexity, uncertainty and ordinariness of some man or woman's unified world

of experience—is also missing when illness is reinterpreted [by anthropologists] as social role, social strategy, or social symbol . . . anything *but* human experience" (Kleinman and Kleinman 1991: 276, emphasis added). To be of value, this approach demands attention to the *interpretation* of experience in contextual specificity without losing sight of the *immediacy* of experience in its bodily specificity.

Second, empirical attention trained on lived experience inevitably involves the workings of power and thus provides a window onto critical points of intersection. This line of thinking stems from a theoretical framework developed for the reciprocal production of subjectivity on the one hand and structural-institutional inequalities on the other. To be more precise, concentrated into this formulation are "extraordinary conditions" (Jenkins 2015a) that are constituted by personal experiences of bodily alteration that, in the present case, are culturally diagnosed as forms of mental illness on the one hand, and as sociopolitical and institutional conditions and forms of violence and adversity—including poverty, misogyny, racism, and abuse or neglect—on the other. These dual sets of conditions are reciprocally produced as interlocking sets of extraordinary conditions. The former set of conditions can be defined as illnesses, syndromes, or disorders; the latter set of conditions can be defined as forces of structural violence as formulated by Paul Farmer (2004a). Both kinds of conditions might come to feel "ordinary" in the sense of becoming routinized, recurrent, or expectable. However, as experiential modes of suffering and conditions of social pathology, they are not properly regarded as either unusual or normative conditions but rather as matters of well-being and social justice that can best be addressed by development of critical sites for engaged listening, care, and social change.

Third is the human capacity for struggle as a fundamental human process of vigorously engaging possibility, a capacity shared by children and adolescents, as well as by those who are living with conditions diagnosed as mental illness. "Recognition of struggle goes beyond the useful and increasingly prominent notion of individual resilience in the face of affliction. When we analytically elevate the study of struggle, we see beyond the usual conceptual categories of analysis and see instead a fundamental human process that comes to light as a product of an anthropological approach trained on lived experience" (Jenkins 2015a: 2). How do people with serious mental illness struggle, and how do children and adolescents struggle, particularly those living with disorienting and disturbing features of illness experience? Such people do in fact struggle, and however disabling their affliction, it is seldom the case

"that the human capacity for striving is eclipsed" (Jenkins 2015a: 94–95).

Guided by these conceptual orientations, we have three primary aims in this book. First is to contribute to a corpus of ethnography grounded in experiential specificity and to a body of anthropological thinking on subjectivity[1] understood as a relatively enduring but circumstantially transformable structure of experience (Jenkins 2015a; Csordas and Jenkins 2018; see also Biehl, Good, and Kleinman 2007). A second goal is to produce knowledge of value to clinicians who treat troubled youth or who are responsible for developing treatment programs, whether in outpatient or residential care settings. A third goal is to present ethnographic and empirical documentation of potential value for those who design, implement, and assess health policy. Though policy is not our area of expertise, we feel there is potential value in examining what is happening on the ground as policies and institutional arrangements play out in the daily lives of our interlocutors. Restrictive cutbacks in funding for mental health services, which we witnessed over the course of this study, have only been exacerbated by an ever-increasing constriction of health care for the poor and disadvantaged.

In the next sections of this chapter, we first consider the concept of "adolescence" in relation to mental health. We then provide an overview of the ethnographic setting and state of New Mexico, including the clinical setting from which we launched our work. Finally, we describe our study and introduce descriptive characteristics of the youth, their kin, and their households.

ADOLESCENCE AS CULTURAL AND HISTORICAL NOTION

The category of adolescence has not been universally recognized across cultural contexts and historical periods. It is a cultural rather than a natural category, though based partially on biosocial characteristics of development. That is, though puberty is a biological event marked in part by the onset of the capability to reproduce, it is ritually marked in many societies by a ceremony that meets a criterion of a sacrament as defined by anthropologist Robert R. Marett (1933), namely the cultural consecration of a culturally perceived "natural" process. What comes before and after puberty is widely variable across and within cultural settings and historical periods, but social adolescence is often conceptualized in relation to reproductive capacity and includes preparation for

a wide range of marital arrangements across cultures (Schlegel and Barry 1991). As is the case with adolescence, mental health and illness are categories as much cultural as natural and are not easily defined, especially since so much is at stake in terms of social stigma placed upon those diagnosed. Clinicians are often rightly hesitant to impose diagnoses on children or teens, due to developmental fluctuations as well as the instability of psychiatric diagnostic categories within and across cultural contexts. Recognizing that our work on adolescent mental health takes place at the intersection of these not entirely stable categories introduces an inherent element of caution and critique, and requires us to consider what we mean by adolescence in relation to mental health and illness.

Philippe Ariès (1996) provides a European history of the family over the past six hundred years, claiming that in medieval times the "ages of life" included a period of adolescence lasting from the age when a person can beget children until one is no longer able to reproduce. In France, the only words available were those referring to childhood, youth, and old age, leaving no room for adolescence, which was conflated with childhood at least in linguistic usage (1996: 23); and in the seventeenth century both English and French were lacking words to distinguish little children from bigger ones (1996: 25). Ariès writes that "even when a vocabulary relating to infancy appeared and expanded, an ambiguity remained between childhood and adolescence on the one hand and the category known as youth on the other. People had no idea of what we call adolescence, and the idea was a long time in taking shape" (1996: 27). The "first typical adolescent of modern times" was a type which appeared in France in the years around 1900. By this time the notion of youth was collapsing into adolescence, and by the end of the First World War there was a clear sense of generational opposition between the younger troops at the front and the older generations in the rear: "From that point, adolescence expanded: it encroached upon childhood in one direction, maturity in the other. . . . Thus, our society has passed from a period which was ignorant of adolescence to a period in which adolescence is the favourite age. We now want it to come early and linger in it as long as possible" (1996: 28). In wealthy countries adolescence became the "privileged age" of the twentieth century, an era which "recognized itself in its adolescents" (1996: 29).

In the United States, the concept of adolescence received an influential formulation in the two-volume work published in 1904 by the psychologist G. Stanley Hall. Hall wrote about biological and social development,

promulgating racist evolutionary views in his description of the variations among puberty initiation ceremonies in savage tribes, classical civilizations, medieval knighthood, and Christian confirmation. He devoted considerable attention to negative features of adolescence in chapters on "Diseases of Body and Mind" and "Juvenile Faults, Immoralities, and Crimes," which included statements like "Again with children as with savages, truth depends largely upon personal likes and dislikes" (Hall 1904, vol. 1: 351). The attitudes of this influential psychologist most certainly penetrated popular consciousness, though by midcentury a major compendium on *The Adolescent* (Seidman 1953) made no explicit reference to Hall's specious and by then outmoded work.

One lasting element of Hall's legacy is his characterization of adolescence as a period of *Sturm und Drang,* a phrase borrowed from the early German Romantic movement's emphasis on emotional intensity and turbulence. When Sigmund Freud visited the United States on Hall's invitation, he was teaching about the power of an inherent conflict between opposing instinctual forces of sexuality and aggression on the one hand and social needs to live together on the other. Based on this, Anna Freud elaborated the idea of adolescence as a period of internal disharmony between these forces and needs (Adams 2005: 4). Anthropologists suggested caution in generalizing this conclusion about adolescence too far. Margaret Mead (1928) pointed out that emotional turmoil was not inevitable in adolescence, offering the counterexample of a relatively relaxed and carefree adolescence in Samoa. For her this argument supported the possibility of critically examining aspects of our own culture supported by taken-for-granted categories presumed to be universal and/or biologically invariant. Ruth Benedict (1938) explained that in our society adolescent turmoil could be accounted for as part of a specific cultural configuration in which there is a discontinuity of expectations when behavior interdicted among children becomes expected of young people as they mature. Unlike in some other societies, our cultural institutions do not adequately support young people undergoing such role transition, and in fact they are negatively sanctioned if they cannot manifest the new behavior spontaneously or, on the contrary, manifest it too belligerently. Nevertheless, this notion is so ingrained in North American society that such behavior appears naturalized, expected of adolescents who often conform to expectation. The teenager in turmoil, trapped between childhood and adulthood, reappears in popular culture over the decades in figures of the rebel without a cause, stranger in a strange land, girl interrupted, failure to launch.

We are uncertain even whether to refer to this period as adolescence, the teenage years, the second decade of life, youth, or emerging adulthood.

In contemporary anthropology the concept of adolescence has received a notable amount of attention as a stage in the life course at which identity is consolidated and people approach full cultural membership (LeVine 2007; Lowe 2003; Suárez-Orozco and Suárez-Orozco 1995; Csordas 2009), but which is also fraught with challenges to well-being that anthropology can contribute to understanding in a way relevant to mental health policy and practice (Burton 1997; Dole and Csordas 2003; Lester 2011; Meyers 2013; Jenkins and Haas 2015; Duncan 2015, 2018). This literature is too voluminous to fully cite here,[2] but we can capture its flavor by considering two special issues of the journal *Ethos* devoted to adolescence. The first, edited by Alice Schlegel (1995), included work from two major anthropological predecessors of our project, the Adolescent Socialization Project and the Harvard Adolescence Project. This collection was organized around the questions, considered across cultures, of the overall movement from childhood dependency to adult autonomy and responsibility; the "naturalness" of adolescent revolt against authority and the question of continuity or discontinuity between generations; the management of adolescent sexuality and, in particular, the recent claims of adolescent girls to control their reproductive lives; delinquency or conformity and the relative influence of peers, lovers, and parents; and the social roles of adolescents, including training for adult occupations and a sense of competence in life. The second collection, edited by Eileen Anderson-Fye and Jill Korbin, explored adolescence as a developmental period of becoming more aware of and engaged in the surrounding social world in the context of the contemporary historical period of unprecedented social change and globalization that constitute a significant challenge for young people (Anderson-Fye and Korbin 2011; Korbin and Anderson-Fye 2011). Contributors observe that the concept of adolescence as a time of storm and stress has been supplanted by talk of the dangers and risks in youthful social behavior. Notably, the majority of contributions are based on ethnographic work in the United States.

We are convinced that these two sets of works do not represent simply two different sets of interests but demonstrate a shift in emphasis, within anthropology over this fifteen-year period, from concern with socialization and development to concern with health and well-being. In general, we can say that if anthropology lagged behind psychology and sociology in addressing adolescence, within the anthropological literature on

adolescence there has been a lag in addressing mental health in particular. An important contribution by Fabrega and Miller (1995a) is an exception that proves the rule. Writing at the same time as the volume by Schlegel that we have just considered, they likewise emphasize the biocultural basis of adolescence, and also endorse the idea that the contemporary form of adolescence is a product of capitalist industrialization and market development, the stresses and strains of which generate "adolescent psychopathology." They apply a historical and comparative perspective to anorexia nervosa, dissociation disorders, and social aggression among adolescents and argue for the importance of the interactions among historical and structural forces, experiential meaning, and psychobiological/biomedical changes. Late or not, the turn by anthropologists to adolescent mental health in terms of how social conditions create a precarious situation for contemporary youth constitutes a recognition of the urgency of the situation.

ADOLESCENT MENTAL HEALTH

The fields of child psychiatry and psychology have not been immune to changes over this period. In this arena as well, two prominent reference works on adolescent mental health in the United States can serve as a touchstone for our ethnographic departure. The volume edited by Van Hasselt and Hersen (1995) is framed as the first thorough treatment of the subject against a background of more general books on adolescent development and adjustment. It opens with a chapter recognizing the cross-cultural and historical variation in the concepts of adolescence and mental health, and that the fields of adolescent psychiatry and psychology are "recent creations of Western biomedicine" (Fabrega and Miller 1995b: 4). Fully half of the book is devoted to themes of biological and intellectual development, social interaction and family environment, diagnosis and assessment. The chapters on specific disorders are organized according to a format that includes description of the disorder, historical background, clinical picture, course and prognosis, complications, epidemiology, familial pattern, differential diagnosis, and clinical management. Appearing ten years later, a volume by Gullotta and Adams (2005) is framed in terms of a development since the middle of the twentieth century, when the influence of psychoanalysis was waning. Over the course of several decades the orienting "buzzwords" became family and social justice, giving way in the 1990s to genes and the decade of the brain, and in the opening of the twenty-first

century to biopsychosocial theory and evidence-based practice (2005: xvii). The editors accept this development without critique or consideration of its consequences, and the chapters on individual disorders are organized around the idea that clinical treatment should be directly based on evidence derived from research studies. Authors discuss each disorder in terms of risk and resiliency factors, and examine treatment and prevention strategies in terms of research evidence about what works, what might work, and what does not work.

Changing clinical concerns over this relatively brief span of time can be seen in the disorders that receive chapter-length treatment in the two books. The 1995 volume includes gender identity and impulse control disorders, which are excluded from the later work; the 2005 volume includes pediatric bipolar disorder and obesity, neither of which had achieved diagnostic currency at the time of the earlier work. However, perhaps the most consequential change across the two volumes, acknowledged by Gullotta and Adams to be due to the influence of bureaucratically managed health care, is the overall reconceptualization of concern with mental health as concern with *behavioral health* (2005: xvii). This is evident in the 2005 volume's relative emphasis on cognitive behavioral therapy and psychopharmacology. It is also evident in a dual perspective that results in separate sections, one with chapters on diagnostic entities such as depression, post-traumatic stress disorder, and conduct disorder, and another with chapters on behavioral categories such as violence and delinquency, substance abuse, sexual offenses, and gang behavior. Indeed, whereas in the 1995 volume suicide and sexuality are the only "special topics" to receive separate chapters, the 2005 volume includes chapters on ten separate problematic behaviors. Finally, it is worth noting that in the earlier book substance abuse is treated as a disorder while in the later book it is a behavior; and in the earlier book suicide is included as a special topic while in the later book it is a disorder.

From our standpoint, one advantage of the shift within the health sciences toward the "behavioral" is a relative decentering of exclusive focus on psychiatric disorders and the highlighting of features of the social environment and what can be described as problems of living. The disadvantage is that behavior is construed in such a way as to exclude attention to experience. Thus, for example, emphasis is placed on the external or surface features of violent behavior without analysis of the immediate circumstances and meaning of violence, on the management of anger without nuanced examination of the experience of anger, on the recommended forms of treatment without description of

how patients experience that treatment, and on promulgation of coping skills without appreciation of what it is like for troubled adolescents to "cope" on a daily basis. Moreover, because available evidence focuses on discrete disorders and behaviors, Gullotta and Adams recognize that "little attention has been given either to bridging the experience of young people from the residential to the community setting" or to discussing co-occurring disorders (2005: 631).

The work we present in this book is focused precisely on the experience rather than the behavior of children with co-occurring problems as they move along a trajectory into and out of residential treatment and inpatient care. Our dual concern with lived experience and with equitable access to treatment is exemplified in two complementary intellectual undertakings in which anthropology has a critical stake. First, the contemporary anthropological approach to childhood, influenced by *child standpoint theory,* aims at an account of society from where children are socially positioned and in which they are not passive social "others" but agentive participants in social life, hence co-constructors of knowledge and, by extension, of knowledge generated by research (Alanen 2005; Fattore, Mason, and Watson 2016; Hunner-Kreisel and Kuhn 2010; James 2007; Mayall 2002; Wells 2015). In particular, anthropologists have taken up the idea that "children have agency and manifest social competency" (Panter-Brick 2002: 156; see also Bluebond-Langner and Korbin 2007: 243). This is put to the test in the case of severely troubled youth under conditions defined as structural violence (Farmer 2004a; Jenkins 2015b), but by no means is it canceled out by their troubles.

The second relevant intellectual undertaking is addressing the inequality of exposure to adversity that threatens the mental health of children and youth. As a matter of social justice, this inequality is a central concern of this book. To take but one factor that affected many of our interlocutors—food insecurity—there is empirical evidence for relationship among hunger, poverty, and the mental health of adolescents. A large national survey of youth thirteen to seventeen years old found that "the association between food insecurity and mood disorders was strongest in adolescents living in families with a low household income and high relative deprivation" (McLaughlin et al. 2012: 2). The World Health Organization (2013) reports that with respect to the global prevalence of mental disorders among adults, at least 50 percent of disorders are developing by age fourteen. As we will see, that is precisely the mean age of those in the present study. Taken together, understanding how youth make sense of and engage in their illness, and understanding the

intergenerational effects of socioeconomic disadvantage and structural violence on mental well-being, are essential to describing the lived experience of struggle (Jenkins 2015a, b).

Accordingly, we are concerned with equitable access to services and treatment as advocated by the movement for global mental health (Patel 2005; Becker and Kleinman 2013; Opakpu 2014; Kohrt and Mendenhall 2015; Kirmayer et al. 2015; White et al. 2017). This interdisciplinary field is only in the initial stages of being extended to children and adolescents, both with respect to scholarship and with respect to actual funds committed for relevant programs (Patel et al. 2007a, b; Lu, Li, and Patel 2018; Kieling et al. 2011; Kohrt et al. 2008, 2010; Floersch et al. 2009; Jenkins 2015b; Jenkins and Stone 2017; Jenkins, Sanchez, and Olivas-Hernández 2019). Yet recent reports suggest that serious mental health difficulties are common among children and adolescents, with approximately 20 percent being affected worldwide (World Health Organization 2005, 2012: 6; Bird 1996; Verhulst 1995; Ford, Goodman, and Meltzer 2003; Kessler et al. 2005). Working toward global health equity in adolescent mental health and well-being requires continued input from anthropologists focused on the lived experience of youth in treatment such as we present in this book. This is true not only from a methodological standpoint, but also in the pragmatic sense that the United States contains under-resourced regions like New Mexico, regions currently posing challenges of inequity and offering inadequate services that are no less of a concern for global mental health than in what are often classified as "low- and middle-income countries" (cf. Jenkins and Kozelka 2017).

THE ETHNOGRAPHIC SETTING

New Mexicans call their state the Land of Enchantment (map 1 and figure 1). It is a land of historical depth where the ancient ruins at Chaco Canyon lie close to the lands of the Jicarilla Apache people, and the sheer cliff dwellings of Bandelier National Monument lie close to the government's Los Alamos National Laboratory. It is a land that inspires an awe of nature (figure 2), home to the massive grandeur of Mount Taylor, the sacred southern mountain of the Diné people; the startlingly jagged peaks that serve as a badge of identity for Las Cruces; and the Sandia Mountains that preside over Albuquerque so loomingly close that an airliner once crashed into them near the site of the present-day tramway to the park near their summit. The tree-lined Rio Grande is a ribbon-like oasis flowing hundreds of miles as it bisects the state