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Permalink

https://escholarship.org/uc/item/34p3499w

Journal

Medical Anthropology Quarterly, 29(1)

ISSN

0745-5194

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Publication Date

2015-03-01

DOI

10.1111/maq.12104

Peer reviewed

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Straining Psychic and Social Sinew: Trauma among Adolescent Psychiatric Patients in New Mexico

Drawing on data from a longitudinal study of 47 adolescents of diverse ethnic backgrounds hospitalized for psychiatric disorder in New Mexico, the article critically examines the relevance of post-traumatic stress disorder (PTSD) to address anthropological questions of how to define the problem. Factors include the utility/limitation of psychiatric diagnostic categories, the lived experience of severe distress, the socioeconomic and political conditions of suffering, and reciprocal relations between immediate and remote social institutions. I discuss the mental health care system for adolescents and present two case studies of young inpatients, emphasizing the need for dual specification of the conditions of trauma and the structure of experience. I argue for understanding patterns of abandonment that shape the raw existence of young people at both the personal and collective levels to apprehend their depth and durability. [adolescent mental health, trauma, PTSD, New Mexico, lived experience]

Over the last two decades, attention to the mental and behavioral health of children and adolescents has intensified globally (Anderson-Fye and Lin 2009; Carpenter-Song 2009a, 2009b; Csordas 2013; Hoagwood and Olin 2002; World Health Organization 2005). Anthropological accounts of adolescent mental health are needed to determine the cultural contours and situational specificity of the lives and health status of contemporary youths afflicted with mental illness. Such accounts are a vital complement to descriptions in clinical diagnostic terms, on the one hand, and critiques of medicalization, on the other. Ethnographic data are likewise needed as a corrective to rhetoric and practice that seek either to minimize problems as nothing more than normative struggles or blame them on unruly youthful provocateurs. These are the data of palpable suffering in the form of suicide and self-injury, pain, and rage over the constriction of life-sustaining possibilities and collective betrayal by the state, communities, and kin who do not meet basic needs for care and protection. On a global scale, they are among the many aspects of turbulent lives that may be manifested in a variety of forms that are as socially serious as they are symptomatically severe (Merikangas et al. 2010).

In this article, I take initial steps toward an anthropological study of psychic trauma among youths at personal and collective levels. The primary goal of the analysis, derived from a larger research project, is to examine the phenomenological, social, and situational features of trauma as lived experienced of children and adolescents.[1] While adaptation in the aftermath of warfare is intricate, we know far less about the process of defense and adaptation of children who are repetitively exposed to traumatic events as everyday condition of their lives.

For the cases of trauma in the present study, there is a patterning of conditions of abandonment and neglect that make events of trauma all but routine. The conditions provide the occasion for regular violation of the dignity and integrity of vulnerable teenagers. Comprehending this problem, in my view, requires a clear recognition of this social historical pattern as a type of structural violence (see Farmer 2004) that conduces to a reciprocal shaping of subjective experience and social structural relations. Although such levels of analysis entail what may arguably appear as intangibles in the abstract, particular forms of their convergence can create inarguably tangible forms of mental anguish and psychic suffering as a matter of lived experience.

The WHO (2005:7) reports an overall 20% prevalence rate of mental disorders for children/adolescents. Community studies are greatly needed, but a summary of available epidemiological studies by Patel and colleagues (2007) provide transnational data for overall prevalence of mental illness that indicate a range of 8–29%, with rates of 13% in Brazil and India, 18% in Ethiopia, and 27% in Australia. Recent reports of mental illness from the United States among teenagers between the ages of 13 and 18 are 21% overall; the comparable figure for the adult population is reported as 26.2% reporting symptoms of a diagnosable mental disorder in any given year (NIMH 2012).

Southwest Youth Experience of Psychiatric Treatment (SWYEPT Study)

This article draws on data collected from an interdisciplinary research project on adolescent mental health carried out from 2005–2011 and funded by the National Institute of Mental Health.[2] The study (Southwest Youth and the Experience of Psychiatric Treatments [SWYEPT]) was based in the Albuquerque metropolitan area, but for practical reasons—there is a high degree of residential mobility among the youths studied—the research was carried out across the State of New Mexico. Conducting a study of persons and institutions in motion does not resemble the more traditional anthropological approach of staying put in one locale or neighborhood as the site of culture and place (Gupta and Ferguson 1997).

During the course of this six-year study, the research team ventured out across the state largely as "road warriors," given the great distances traveled to get to wherever the adolescents resided following their discharge from the hospital. Not infrequently, these sites were unstable by virtue of changes of family residence or aftercare clinical placements. In this respect, the research was conducted as mobile anthropology, now common for work in mental health and global medicine (Desjarlais et al. 1996; Good et al. 2006; Ward 2003).

Members of the research team were positioned in relation to study participants as recruitment encounters and initial interviews often took place in the inpatient

setting. The research rather than the clinical function of team members was reinforced by our subsequent following of patients and families beyond the hospital over several visits to their homes and across other clinical facilities. The collaborative nature of the research was emphasized for both participants and researchers by the fact that different team members conducted different interviews at different times (ethnographic, clinical/diagnostic), so that participants often inquired about team members they had met previously, and team members consulted with one another about aspects of their respective encounters with participants.

We were able to visit homes and residential facilities to conduct ongoing interviews and observations for an average of 13 months, but the range was between three months and two years.[3] The research team would meet with the adolescent and his or her family (separately, usually) in the home setting, although in some cases we met in coffee shops or the homes of other relatives where the adolescents were not residing. The homes were typically low-income housing, with few amenities and little space (apartments, trailers, small homes).

The types of mental health problems with which people grappled were by no means minor. Problems far exceeded Attention Deficit Hyperactivity Disorder (ADHD), depression, or any one type of problem. Diagnoses included a full range of serious and usually multiple problems of anxiety disorders, eating disorders, and psychoses. An abbreviated examination of trauma in relation to post-traumatic stress disorder (PTSD) as a diagnostic category is discussed below, but more extended discussion of the fuller clinical picture along with the utility and limitation of psychiatric diagnostic categories is beyond the scope of this article.

Overall, during the course of our fieldwork, we were struck by the palpable personal anguish and the cultural, social, and economic particularities that seemed implicated in their creation. Notable for many individuals was a constant instability of social settings, including hospitals and clinics, kin-based households, foster homes, hospitals, schools, and neighborhoods. Beyond the more circumscribed situations of trauma examined here, we are attempting to understand these youths' lives in terms of what Korsgaard (1996) has developed as a model of practical identity defined in terms of valuing oneself, action, and life as worthwhile. In situations of exposure to repetitive or sustained traumatic events and conditions, persons might be expected to fundamentally call into question an existential description of life worth living (Nietzsche 1967). Indeed, in this study many of the admitting incidents were suicide attempts.

Trauma and Trouble in the Land of Enchantment

The wide geographic swath of the state of New Mexico, self-described as the "Land of Enchantment,"[4] is well known as a multicultural mélange of Hispanic, Native American, and Anglo-American populations. Through the 1980s, Hendren and Berlin (1991) provided an excellent account of this ethnic diversity in relation to clinical care of children in the state. However, the current situation for ethnicity in New Mexico has perhaps become more complicated today as a matter of cultural identities in relation to complex "hyperdiversity" (Good et al. 2011). The dominant cultural and global imagination of this rural state as one of beautiful expansive landscapes and a cosmopolitan tourist mecca in Santa Fe is far

less recognized for its exceptionally high rates of child poverty and historically produced institutional subjugation that is anything but beautiful. Our research team is concerned with the mental health consequences of growing up under adverse economic and social conditions that in this case includes inpatient psychiatric treatment.

Ethnographic interviews and observations, along with research psychiatric diagnostic criteria, provide evidence of the prominent place of trauma in the lives of many of the adolescents. Traumatic events and conditions are numerous, including direct violent assaults of all sorts, witnessing deaths, suicide attempts or violent attacks by family and friends, shocking revelations and betrayals (e.g., being disowned or learning of sexual abuse), abrupt residential moves (adolescent ejected or removed from home, family eviction or flight), encounters with police and the juvenile justice system, drug-related violence, hospitalization, among many others. Although initially encountered in an inpatient psychiatric facility, the majority of the ethnographic and psychiatric diagnostic work was carried out in homes. Anthropological interviews and observations were completed for parents, siblings, therapists, doctors, and operators of residential facilities . We also collected ethnographic observations of neighborhoods and communities. The goal was to visit with adolescents and parents and to conduct interviews at various intervals over a period of one to two years.

As of 2010, the U.S. Census reports the population of New Mexico as just over two million residents. This represents a 13.2% growth from the previous decade. The most populous metropolitan areas are Albuquerque and Las Cruces (primary sites of the study), but the rural character of the state overall is noteworthy compared to the rest of the nation (17 vs. 87.4 persons per square mile). Census data show the population as predominantly Hispanic (46.3%), followed by Anglo-American (40.5%) and Native American (9.4%). A national survey in association with the U.S. Census finds a rate of child poverty at 20% and higher for 24 of the 50 states. The highest rates nationwide are for New Mexico at 30% and Mississippi at 32.5% (Macartney 2011:6).

Adverse conditions for survival are longstanding in this locale, although they have been exacerbated under the press of the Great Recession in the United States that has cut a deep and broad incision in the form of job losses, home foreclosures, and radical curtailment of health services beginning in 2008. The lives of adolescents in this study are by and large marked by residential instability and familial fragmentation. For the most part, they live in low-income households, with some living on the rough edge of survival. Conditions included high unemployment, the presence of gangs, violent crime, and a scarcity of social and educational resources. One commodity for which there is no shortage is an array of street drugs. As Garcia (2010) has poignantly captured, New Mexico has the inauspicious distinction of the highest per capita rate of heroin-related deaths in the nation. Overall, drug-related overdoses in New Mexico were recently reported as the leading cause of unintentional death (New Mexico Department of Health 2011). Use of cannabis, alcohol, methamphetamine, and cocaine, among other drugs, is common among New Mexican adolescents (U.S. Department of Health & Human Services 2011).

Mental Health Care in New Mexico: 2005–2011

Although our study of adolescents who had inpatient psychiatric treatment includes a comparison group of non-hospitalized children, this article draws only from the clinically related component. The primary hospital from which research participants were drawn was Children's Psychiatric Hospital (CPH), a large university-based children's psychiatric hospital in Albuquerque. During the five-year period of the SWYEPT study (2005–2011), we saw the length of inpatient stay and clinical services sharply curtailed, to the dismay of clinicians, patients, and families alike.

From a statewide New Mexico perspective, an ethnographic study of mental health professionals (Kano et al. 2009; Watson et al. 2011; Willging and Semansky 2010; Willgin et al. 2009) examines the pragmatic, institutional, and policy effects of behavioral health care reforms underway during the course of our research. These findings are fully in accord with our observations and interaction with staff at CPH. The radical curtailment of services coincided with the centralization of all mental or behavioral health services managed by Value Options, the largest privately held health-care corporation in the country at the time.

The Southwest Youth Experience of Psychiatric Treatment Study

The SWYEPT project included 47 youths (25 boys and 22 girls) between the ages of 13 and 17. Participants were roughly equally distributed across ethnically hybrid groups of mostly Hispanic, Anglo-American, and Native American heritage. On average, the teens were 14 years old. Among the Hispanic group (36.2%), all were born in the United States (primarily New Mexico) and predominantly speak English with limited facility in Spanish, although several reside in households where Spanish is spoken by grandparents or parents. Almost three-quarters had been hospitalized previously on multiple occasions. The youths had commonly committed violent or suicidal acts, experienced recent deaths of loved ones, and had experienced heavy use of drugs and alcohol, legal troubles, physical and/or sexual abuse, and routine self-cutting.

Data from the Structured Clinical Interview for DSM-IV (in the version for children known as the KID-SCID), administered by one of two members of the team (a child psychiatrist and clinical psychologist, both trained specifically to reliably administer this research diagnostic interview) are impressive in terms of the co-occurrence of multiple psychiatric diagnoses. While 13 (27.7%) made full criteria for PTSD, the diagnosis was more likely for girls in our study (8 of 22 or 36.4%) compared with the boys (5 of 25 or 20%). It is critical to bear in mind that in any examination of a particular type of mental illness, persons commonly have diagnostic criteria for more than one disorder. This is particularly true for PTSD, a disorder commonly correlated with major depression/dysthymia. Considering all disorders, in the present study PTSD and depression were nearly always observed to co-occur (91.7%) among girls (all) and boys (save one). (This can be contrasted with depression, in which 44.4% of the girls and 20% of the boys also made criteria for PTSD). Thus, it is important to remember the close correlation of PTSD

and depression not only as a matter of phenomenological experience but also in theorizing about the social determinants of these concurrent disorders.

Anthropological Specification of Psychic Trauma and PTSD

Currently, there is a vast literature on the often-destructive impact of trauma on the self and others (e.g., Breslau 2004; Henry 2006; Hinton et al. 2012; Jenkins 1996a, 1996b; Quesada et al. 2011). Further, there is the question of how to conceptualize psychic trauma in a way deepened by a framework that takes into account the reciprocal shaping of social institutions and personal subjectivity (Fassin et al. 2009; Jenkins 1991). In examining these questions, there is by now a well-known anthropological skepticism surrounding psychiatric diagnostic categories as historical inventions, biologically reductive, lacking in cultural validity, biased in relation to gender, ethnicity, and social class, and products of medicalization (Kleinman 1988).

I concur with the position outlined by Good (1992) that, for anthropologists working in this field, psychiatric diagnostic categories provide a useful starting point for comparison. That is, at the most rudimentary level of comparing constellations of symptoms that tend to "go together," it makes empirical sense to consider these on a preliminary basis. That said, and knowing the foregoing findings in terms of diagnostic categories, my research experience leads me to more questions regarding these categories than any other study that I have conducted. The co-occurrence of disorders—e.g., depression + PTSD + psychosis—confers a degree of complexity that is dizzying. How to account for this? Might some measure of the complexity be due to developmental issues insofar as these are adolescents in (relatively) earlier stages of the onset of illnesses that have not yet fully coalesced in a (relatively) more coherent clinical picture?

Crises and Conditions of Trauma as Extreme, Recurrent, and Unending

On the other hand, is this co-morbidity better understood as a mirror of the severity of the charred social, economic, political, and psychological realities as a matter of lived experience? If so, how should we think about such totalizing forces that produce subjectivity? We have several candidate concepts. There is the notion of the "apparatus" (Foucault 1980:194) as "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions." Notions of violence have figured prominently in anthropological thinking about disease. Scheper-Hughes (1993) has written of the violence of food scarcity configured as a madness of impossible choices for maternal decision-making. Das has written on subjectivity and violence as "conceptual structures of our discipline" that are necessary yet problematic insofar as they are a "professional transformation of suffering" (1995:175).

I have elaborated a "political ethos" conceived as the cultural organization of feeling and sentiment pertaining to social domains of power and interest for examination of "the nexus among the role of the state in constructing a particular political ethos, the personal emotions of those who dwell in that ethos, and the mental health

consequences of inhabiting such a milieu" (Jenkins 1991:140). Farmer (2004) has argued the utility of a broadly encompassing notion of "structural violence" (built into institutions, practices, and presuppositions), and Quesada et al. (2011) sought to delimit the potentially over-inclusive term to "structural vulnerability." Lovell (2012) has provided an elegant formulation of "extraordinary circumstances," such as what transpired during and in the aftermath of Hurricane Katrina, to take into consideration pre-existing psychiatric vulnerability and yet a remarkable capacity for action and agency in the face of necessity.

Lovell (2012) offers an appealing notion of "precarity" that holds particular value by encompassing an experience-near quality of danger while preserving human sociality under the press of extreme and life-threatening circumstances.[5] In an effort to link long-term stress associated with loss of family, jobs, and community, Adams and colleagues (2009:615) coined the term "chronic disaster syndrome" to draw together the long-term effects of personal trauma, the social arrangements in which disaster is a way of life. In such formulations, the potential problem is not a myopic individualism mired in the complexity of comorbidity but an unwieldy mélange of everything that begs the question of how a multiplicity of factors and levels of analysis are interrelated.

In short, our studies require a dual specification of the situations and conditions of trauma in cultural, social, and human development as well as appreciation of trauma as a complex attunement to the reality of the modulation of raw existence and the structure of experience. Struggles to conceptualize what is at once total-izing and pervasive—having no "post" (or even "pre") to "the" (singular) "trau-matic" event or collective traumatic conditions—pose threats to the very structure of meaning.

Structural situations of Gregory Bateson and colleagues' (1956) notion of the "double bind" present themselves in ironic and fragmentary form as "continuous crisis" and repetitive and predictable cycles of disbelief that defy human cultural and psychological expectations of the possible. In the present study, for example, a broad range of experiential questions emerged that preoccupied the adolescents in relation to existential, cultural, and psychological development. For example, what are the cultural meanings and expectations concerning a mother or a father? What psychological development and transformation occur when a mother doesn't bake cookies because she was high on meth for three days and gone without notice for months at a time? How does a girl organize psychologically around the need for a father who has been in prison her entire lifetime yet she feels she "needs" him now that she is "getting older" (17) and will graduate from high school, get married, become a mother herself?

Case Studies

To take an initial step toward illustrating this point in relation to existential features of psychic trauma that I am interested in here, I briefly describe the situations of Luke and Alisa (pseudonyms). While each case has unique qualities, the two presented here are representative of a pattern of precarious relations that I define below that holds for the 12 adolescents diagnosed with PTSD.

Luke Scott

Luke was 15 years old and in ninth grade. He lived in a low-income neighborhood outside Albuquerque with his mother, two younger sisters, and brother, all of whom have different biological fathers. Luke has received outpatient psychiatric treatment since kindergarten; he was diagnosed at the time with ADHD. Since then, he has had seven inpatient hospitalizations for episodes of explosive anger and was diagnosed with PTSD and oppositional defiant disorder. A recent hospitalization, during which we encountered him, occurred in the wake of a physical fight with his sister for whom Luke's mother called the police, who offered either to arrest him or take him for psychiatric hospitalization. When we met Luke in the hospital, he was quite medicated but managed an apparently well-practiced firm handshake and direct look in the eye. Although chatty and personable, he was easily distracted and could be fidgety.

Luke's mother, Martha Ruiz, is Anglo-American and divorced from Luke's father, who is of Mexican origin. She receives unemployment assistance through a housing subsidy. She has had a series of live-in male partners. The most recent of them is Chuck—who Luke considers a "cool guy"—a full-time truck driver. A previous partner, Kent, biological father of Luke's younger brother, lived with the family from 1998 to 2005. Luke recalled: "For seven years, I thought I loved him as my father." Thus, it was crushing to Luke to have his younger sisters divulge in 2006 that for a period of approximately four years (when Luke was 9–13 years old), his stepfather Kent had sexually abused them. More, Kent handcuffed Luke to a bed and beat him, allowing Kent opportunities to abuse Luke's sisters without Luke's knowledge or interference. Luke struggled with the handcuffs, breaking some of the bars on his bed but not the thicker ones.

Following his sister's revelations of sexual abuse, Luke demanded that they tell his mother because he refused to keep such a terrible secret. In the wake of that telling, Kent was arrested and held in custody, pending a trial that particularly preoccupied Luke at the time we met him. Asked what he thought of his hospitalization, Luke said he was there for his "anger, mostly my anger, I have big, erratic blow-ups. I go from flat-line to straight up." During his diagnostic interview with the project psychiatrist, Luke said, "(T)he only reason for my anger is I need to distract myself." He is unwavering, however, in his conviction that his problems started with the trauma inflicted on him and his sisters by Kent.

Luke was reflective about trying to manage his anger but still convinced that his stepfather's abuse was the source of his and his family's troubles, that he simply could not "let it go," and that to do so would be a problem, since he says "I don't want to let go of this thing" because "that day may come when I need it, and if I don't have it then, I'll have to revert it, something that I don't like to do. Use weapons. Because I don't like using weapons in fights." Luke is fully aware that he retains his anger not only as a defensive strategy that keeps him vigilant but also as the fuel for his wish for violent retribution as he grows into becoming a physically capable, stronger young man.

Alisa Sanchez

The second example of psychic trauma is illustrated by the life of a 17-year-old girl of mixed Hispanic heritage with the pseudonym of Alisa. Alisa has scarcely managed to sustain her life in the face of economic hardship and destructive parents who neither understood her nor were concerned with her needs. Suffering numerous insults to the integrity of her development, she struggles with the pain and confusion of a shattered psyche and limited resources for the crafting of a satisfying life. She had been hospitalized eight times since the age of 13. Shortly after turning 17, she gave birth to a healthy baby boy. Yuma, an Isleta Native American and boyfriend of two years, was an active father in the months immediately following the birth.

In the initial telling of what led to her hospitalization, Alisa was adamant that she had been devastated to receive a letter from her father then serving in Iraq that informed her that he wasn't her biological father and had decided to disown her. After he returned to the Albuquerque area, she attempted to contact him by telephone to no avail. She felt that his refusal to take the call was the last straw, reporting that she "freaked out" and began to cry, feeling abandoned. This experience was the immediate precursor to one of her several hospitalizations.

She likewise had several clinical diagnoses over the years but the central and enduring one was PTSD. The acuity of the loss of her relationship to this father figure unfolded in the context of a history of having suffered multiple instances of sexual molestation by her mother's boyfriends or partners. The first she recalled had occurred at age 11, when she was sleeping in the same bed with her mother and her partner at the time while her mother was either asleep or drunk. Adding to the horror of that assault was her family's response to the event for which she felt "blamed and unsupported," with her mother and other relatives trying to minimize what had occurred.

It was immediately after this event that she began self-cutting, on the advice of a friend who had been raped by her father. This became a regular habit in the wake of a subsequent sexual assault as a young teenager by a boy she had "trusted (and) he took advantage of me." By the time of her father's rejection, her narrative draws the connection all too clearly, and literally: "He (her father) cut me out of his life," and she "started cutting" not only to take away the pain but also in a desperate attempt to draw him back into her life.

Alisa was open about the relentless buffeting of her identity and evolution as a child with multiple father figures and abuse by some of the unsavory ones. Still, the most profound insult to her, the renunciation by her adoptive father, loomed largest. She pined for some resolution. The diagnosing research psychiatrist thought perhaps this played into some of her experiences with the need to connect with her boyfriend at the time and the trouble that ensued with their subsequent breakup. Confessing to her boyfriend that she had a friendship with another boy, he became enraged and broke off the relationship. In response, she swallowed a bottle of Seroquel (antipsychotic medication) and, at 17, was hospitalized again. Just as she intended the cutting as a means of bringing back her father, she admitted that the overdose was intended to get her boyfriend to return.

Her mother's severe problem with alcohol was a lifelong source of torment for Alisa. At around age five, she suffered a major injury in a car accident when her

mother was driving while intoxicated. Indeed, Alisa's right arm was very nearly severed. A pretty young girl with long dark hair and striking brown eyes, she was also notable not only for being overweight but also for the long, deep scars that ran the length of her arm. Dealing with her mother's alcoholism from an early age, she says she had to "grow up early" and be "the adult" from the age of six. Being the adult involved making sure at times that her mother was still breathing and being exposed to what she describes as her mother's "bringing different men in the house, being very promiscuous in front of me." With sadness, she relayed that she knew all about sex from the age of four and had nightmares of her mother being brutalized by the men she brought home.

According to SCID research criteria, Alisa's current diagnoses were enduring PTSD and depressive disorder with psychotic features. The latter diagnosis was for a condition that developed post-partum. While breastfeeding, she experienced sexual stimulation that, although not uncommon, terrified her. It brought back her own sexual molestation some years back. Unlike Luke, Alisa did not accept easily the diagnosis of PTSD. At the time she was given that diagnosis, she had had several previous clinical diagnoses and experienced this one as confusing and having been "thrown" at her. During the following year, she was clinically diagnosed with psychosis, which she experienced with both relief and shame. She felt relief in that the diagnosis made sense to her since she had had frightening hallucinatory experiences. She felt shame particularly in relation to her two older sisters who alternately doubted or derided the diagnosis.

Her mother, Ramona, a large and rough-hewn woman of Hispanic heritage with dark hair, had a difficult life herself, growing up in a family of eight where beatings were routine. Her small home was provided to her through a housing subsidy. Ramona has a history of alcohol and drug abuse for which she has been in court-mandated rehabilitation programs using the treatment model from Alcoholics Anonymous. She relayed that she was raped as a child and that her family did not care about her. Ramona sees this lack of care and protection as intergenerational and repetitive: "I look at cycles . . . it keeps repeating itself through the generations and I want it to stop. . . . I've seen cycles my whole life . . . that's what I saw my mother do."

In the wake of the accident involving drunken driving that severely injured Alisa, the judge mandated a court-ordered residential rehabilitation program for Ramona. She was allowed only supervised visits with Alisa for several months. During that time, Alisa lived with her uncle and elder sister. Even though Ramona completed a rehabilitation program following the car accident, she could not maintain her sobriety. Given the need to become "the adult" at age six, it is to Alisa's credit that she appeared as a precocious, contemplative, and empathetic person. Two years after we met her, she had moved out of her mother's house, having been ousted, and was living in a small, messy apartment with her boyfriend and two-year-old son. Even though she was wracked by anxiety, she passed her GED requirement in lieu of having completed high school. She was in the process of enrolling in courses at the local community college, and was interested in becoming a counselor.

Patterns of Precariousness: Trauma and Social Danger

The problem of PTSD has been acknowledged as often not reducible to a single event but rather as a response to recurrent threats to the bodily and psychic integrity. Analysis of the foregoing cases, in accord with others diagnosed with PTSD according to research criteria, reveals a pattern with respect to the conditions in which these youths find themselves, a pattern of precarious conditions that lay the grounds for the transpiration of traumatic events.[5] Identification of such a pattern of instability constitutes a parallel if wider ranging diagnosis of social, psychological, cultural processes in political and historical context. The in-depth interviews provide experience-near accounts of conditions of existence made perilous by abandonment or inadequacy of parental and state protection.

Many of the parents in this group have themselves had chaotic childhoods ravaged by poverty, drug and gang violence, parental neglect or maltreatment. Although a fuller discussion is beyond the scope of this article, these problems need to be traced to take into account New Mexico's colonial history of brutal subjugation and domination of local populations (Chavez 2006; Sanchez 1996). In identifying problems within the proximal space of the family, such relations can be configured within a broader framework of intergenerational and colonial legacy of some five centuries of conflict among Spanish, Native American, Mexican, and Anglo-Americans in contrast to the relatively recent geopolitical designation of New Mexico as part of the American Southwest. This complicated historical situation involves an intricate set of connections that must be considered in order to theorize the precarious conditions that transcend individual or familial households. The political and cultural instability in the region is manifest in families and communities as the collective casualty of colonial and postcolonial conflict.

As the work of Garcia (2010) has elegantly portrayed, New Mexico's colonial history is deeply implicated in the psychic trauma of many of its residents.[6] To interpret social inattention and abdication of moral obligation for the provision of protection and care, the legacy of historical trauma, including unconscious residues of subjugation and violation, must be considered together with the contemporary conditions of structural violence (Anderson et al. 2011; Capra 2000). The absence of parental protection may occur in relation to instability of residence and partner, severe drug and alcohol abuse, and emotional volatility. Taken together, these conditions make possible the many forms of abuse and neglect of children from parental unavailability and lack of care. Individual agency and responsibility in the ethics of care under such conditions are hazy at best, although the children in this study demonstrated considerable confusion about security, attachment, and who if anyone was morally accountable for such a precious existence.

Luke met the lack of protection from his mother with the creation of a self-system in which anger is readily and reliably available. His anger protects him even if his mother and her various boyfriends will not. The emotional response to exposure to life-threatening events under conditions of the *absence* of parental protection is anger at the most visible level. More tender emotions of fear and trembling, and even grief over how alone in the world he is when it comes to his own protection, are camouflaged by barefaced and dramatic displays of anger. Yet Luke has done far more than devise an elaborate self-system of anger that is at once protective and

destructive. It seemed to us that his interests in astronomy and having a girlfriend helped protect an estimable if fraught capacity for development, resilience, and even idealism. That he has crafted these under conditions of psychic trauma and adversity appeared extraordinary.

Alisa's life is no less poignant with respect to breakdown in the provision of parental protection as the grounds for sustained and repetitive events that for her have created deep and enduring psychic trauma. In addition to the serious injuries sustained (as for Luke, albeit even more life-threatening), she could not rely on a familial safety net in the face of unrelenting familial crises and residential moves. Alisa's overt problem is not anger but more of one of being lost in an arid sea of misery and misjudgment. Navigating a parched and unreliable social landscape, she has remarkably managed to muster personal resources without succumbing to an otherwise arguably warranted resentment. She lives with a mix of sadness and loss that she could not save her relationship with her mother without surrendering her sanity. She has her child and herself to care for, and this self-created system of protection is what she has.

Identifying Phenomenological Dynamics of Trauma

A primary intent of this article is the exploration of trauma as experienced by adolescents. In sum, I see the striking elements of shared phenomenological lifeworlds of these youths as follows: alternating modes of attention that can be characterized as a kind of "hiding" or social withdrawal, on the one hand, and furious if anxious insistence on attachment and connection, on the other. Equally notable are conflicts over the sense of erasure and non-recognition of self and other that similarly contributes to an objectified invisibility. Most striking to me, however, in this study as well as others (Jenkins 1991, 1996b, 2013; Jenkins and Valiente 1994), is the profound bodily and psychic vertigo commonly experienced when one's sense of reality is ruptured (often recurrently) by traumatic events of penetrating assault, betrayal, and shock.

In the immediate aftermath and subsequently as a distant kind of ghostly refrain seems the sense (and often the actual words) that "I just can't believe. . . . I just can't . . . imagine. . . . I never thought . . . it's not real." Reality is defined by the profound sense of unreality in the realm of what is (un)imaginable. The unbelievability, the unreality, the simultaneity of utter doubt and certainty surrounding what really did or possibly could have happened, marks the shady boundaries of what is felt and not-felt as reality. The phenomenological sense of being in the world that deep bodily and psychic trauma can wield can be summarized as *unfathomability* as an enduring lived reality.

The array of anguish for which the diagnosis of post-traumatic stress disorder might be applied is vast (Breslau 2004; Henry 2006; James 2010; Jenkins 1996a; Kienzler 2008). Questions arise as to whether a vast range of nosological and therapeutic application is called for in light of the reality of the broad range of all-too-common human suffering, or if the diagnosis simply misses or is inadequate to the task of defining and healing. Reasonable arguments can be mounted for both sides of this epistemological quandary.

In an account of the range of situational application and the geographic circulation of the term, Fassin and colleagues (2009) offer an historical analysis of trauma as "empire" instituted through uncontested claims of the veracity and moral worthiness of PTSD. The problem of contestation and the logic of care meriting treatment and compensation can be less straightforward elsewhere (Hoge et al. 2006; Young 1997). Adolescents in particular are not trying to "get stuff" (i.e., services, statuses, diagnoses). The diagnosis may be experienced as much as an imposition, as was the case when Alisa said that mental health professionals "threw the PTSD at me."

I am less concerned with the ontological, historical, or political status of PTSD and more interested in the lives of adolescents struggling with raw existence of trauma. My preference for the term "trauma" over that of PTSD is based on cultural and existential considerations and my identification of several complex and distinctive factors that define the social and psychological experience. First is the structure of the experience of psychic trauma as circumscribing one's being-in-the-world. Under enduring and inescapable conditions of psychic trauma, habitual self-processes of protection may occur through *absorption* or *dissociation*. Absorption occurs as preoccupation and dissociation as disconnection and detachment of self and traumatic world. Whether through absorption or dissociation (or both), the taking up of the trauma into psychic structure can provide enshrinement or respite. Although adaptation following exposure to warfare is intricate, we know about the modes of defense and adaptation of adolescents regularly subjected to traumatic events as the everyday conditions of their lives.

Not included in Diagnostic and Statistical Manual (DSM) criteria but crucial to understanding is the cultural meaning of the injury as within or beyond the bounds of human making. When injury is perpetrated by interpersonal force of violence, there may be a personal degradation of psychological and moral moorings of trust, security, and safety. When perpetrated by intimates of households and neighborhoods, the affront goes to the core of psychological conditions for social relations ruptured by betrayal. The rupture of trust by betrayal can, surprisingly, be reported as the "worst" of all that has occurred (Hollifield et al. 2005). The particularity of response to traumatic events based on rigorous methodological attention to cultural validity provides empirical support for a theoretical model of culture, psyche, and social world as inextricable.

Concluding Remarks

In this article, I have discussed the reciprocal shaping of subjective experience and social institutions, particularly in relation to the provision of care through state-run health care facilities and the family sector. When understood as separate levels of analysis, institution, and experience both appear abstract and without substance, whereas in lived experience they are vitally intertwined in the fabric and the "rhythm of life" (Jenkins 1997). Based on my analysis of ethnographic materials from this study, I have argued that: (1) cultural and psychological analysis of trauma requires an understanding at both the personal and the collective level to apprehend the depth and durability of the problem. The foundation for this analysis compels us toward a philosophical anthropology and a historical psychology; and (2) there is an identifiable pattern of conditions of abandonment and neglect that make possible

the events of trauma as an etiological structure for violations of the psychic dignity and bodily integrity of children. The danger is doubly so for girls. As a matter of oppression, it comes as no surprise that the systematicity of such arrangements is common among the economically and socially disenfranchised. These conditions provide the etiological grounds for traumatic violation, often routine and repetitive, in the lived experience of the young. Resources that could counter such maltreatment within the health care and educational sectors are either unavailable or inadequate to the task of transforming adverse conditions and events that foreclose the horizons of possibility for youths.

These conditions present profound challenges for young and developing persons who must navigate conditions that threaten their existential grounding of moral sensibility and sufficiency as "life-affirming" in the sense outlined by Nietzsche (1967). The problem posed by the need to create cultural meaning was described by Geertz (1973:100) in relation to the notion of chaos, with his assertion that "bafflement, suffering, and a sense of intractable ethical paradox are all, if they become intense enough or are sustained long enough, radical challenges to the proposition that life is comprehensible and that we can, by taking thought, orient ourselves effectively within it" (1973:100). For children and adolescents, the breaking point brought on by uninterpretability may threaten their very existence.

This article is but a first step in the examination of ruptures of cultural meaning, inadequacies of social institutions, and interpretations that can fully address the phenomenological and historical aspects of psychic trauma among youths. The analysis is also limited insofar as these are youths who actually had psychiatric treatment and cannot be empirically compared with sociodemographically similar children who have not received any care or have not experienced trauma.[7] A strength of the work (i.e., anthropological work with a relatively large number of carefully diagnosed teens whose lives can give us a broader appreciation for the types of problems from which they suffer) is also a limitation, in that this is not an intensive study of one neighborhood or village.

While ethnopsychological, cultural, and social accounts of trauma among persons are critical, they are insufficient insofar as they fail to incorporate an understanding of the intergenerational, collective reach of trauma. The notion of a collective reach of trauma that I have in mind is rooted in an appraisal of interrelated social–psychological processes and conditions of adversity: (1) the mental health effects of structural violence and vulnerability (Biehl 2005; Bourgois and Schonberg 2009; Farmer 2004; Good et al. 2006; Henry 2006; James 2010; Lovell 1997; Quesada et al. 2011; Scheper-Hughes 1993); (2) the role of the state in constructing a political ethos that produces insecurity and conditions for the possibility of oxymoronic recurrent extraordinarily damaging events (Jenkins 1991; Lovell 2012); (3) the reproduction and transmission of state-produced warfare and political violence as domestic abuse within family settings (Martín-Baró 1988); and (4) intergenerational inheritance of loss and longing in a context of ache and disconnection (Garcia 2010). Across these levels of analysis, I see institutional oppression and neglect of citizens by the state as tragically reproduced and enacted within domestic settings (Jenkins 1991). These interwoven processes twist the experiential field of families and individuals to form enduring social–psychic webs of subjugation, unambiguous ferocity for survival, or an alternatingly vexed and enervated being-in-the-world.

Notes

1. It is common in anthropology and other social sciences to understand the contemporary term "adolescent" as a historically and culturally fluid determination of the last century (e.g., Mead 1928).

2. Research for this article was supported by the National Institute for Mental Health Research Grant 1 R01 MH071781, Thomas J. Csordas, and Janis H. Jenkins, Co-PIs. We are grateful to Dr. David Mullen and the dedicated clinical staff of the Children's Psychiatric Hospital of the University of New Mexico Medical School, and all the participants in the "Southwest Youth Experience of Psychiatric Treatment" (SWYEPT) Project who took the time to speak with us on several occasions about their experience. Special thanks are due to members of our research team including Bridget Haas, Whitney Duncan, Heather Spector Hallman, Allen Tran, Jessica Novak, Nofit Itzhak, Celeste Padilla, Richelle Bettencourt, Michael Storck, Elisa Dimas, and Mary Bancroft.

3. Not all adolescents and parents were interviewed beyond an initial set of visits. Some were lost to follow-up due to geographic moves out of state for which we did not have logistic capability or we could not locate them. We did make repeat visits to Texas, Colorado, and California. For New Mexico, our research team scoured the entire state and carried out ethnographic interviews.

4. Upon entering the state, roadside signs and license plates alike are emblazoned in vivid yellow and red colors that hail New Mexico as the "Land of Enchantment." For the past six years, I have given presentations (conferences and invited lectures), in which I have used powerpoint slides that ironically refer to the Land of Enchantment; however, I wish to note that I recently came across an excellent account by Trujillo (2009) that also uses this term specifically for transformation in northern New Mexico. In this respect, the present work contributes to more recent anthropological scholarship of New Mexico that troubles an idyllic narrative of New Mexico (Garcia 2010; Trujillo 2009; Willging and Semansky 2010).

5. Lovell (2012) provides a nuanced application of the notion of ontological "precarity" rooted in etymological origin in supplication as a mode of subjectivity.

6. Thanks to one of the reviewers for noting this point precisely.

7. Not presented here are forthcoming comparative analyses from the SWYEPT study of adolescents who, according to research diagnostic criteria, have no psychiatric disorders nor have they received any treatment.

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