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ORIGINAL PAPER

Global Mental Health and Adolescent Anxiety: Kin, Care and Struggle in New Mexico

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Abstract While recent developments within the field of global mental health have illuminated the reality of serious mental health difficulties worldwide, particularly in low-income settings, research that focuses on children and adolescents remains underdeveloped. This is especially the case with respect to ethnographic studies of lived experience of adolescents diagnosed with serious mental health conditions. Drawing from an interdisciplinary study of adolescents in New Mexico who were afflicted with a broad range of disorders according to contemporary research diagnostic criteria, this article focuses on anxiety-related conditions with respect to subjective experience and social–ecological contexts of living with such conditions. We offer preliminary observations regarding the value of linking ethnographic and research diagnostic data to address questions of resilience, endurance, capacity and struggle. These observations are intended as the basis for the formulation of more precise hypotheses about adolescent anxiety, kin, and care under conditions of structural violence marked by psychological, residential, and intergenerational adversity.

Keywords Global mental health · Adolescents · Anxiety · Resilience · Struggle

Introduction

Recent developments within the field of global mental health have served to establish the reality of serious mental health difficulties worldwide (World Health Organization 2005, 2012; Prince et al. 2007; Good 2010; Kieling et al. 2011; Patel

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et al. 2011; Becker and Kleinman 2013; Jenkins and Good 2014); Kohrt and Mendenhall 2015; Kleinman et al. 2016; White et al. 2017), with research on global mental health in the initial stages of being extended to children and adolescents (Kieling et al. 2011; Kohrt et al. 2008, 2010; Floersch 2009; Jenkins 2015b). For example, in a recent review article that argues for the scaling up of treatment for depression and anxiety on the epidemiological basis of highest prevalence (Chisholm et al. 2016), children and adolescents were excluded from the review.

Research on adolescent mental health has largely concentrated on survey and epidemiological studies to recognize the commonality of problems that went largely unrecognized in past decades (Costello, Egger, and Angold 2005; Espinola-Nadurille et al. 2010; Ford, Goodman, and Meltzer 2003; Merikangas et al. 2010). Recent reports suggest that serious mental health difficulties are common among children and adolescents. According to the World Health Organization (2012:6), approximately 20% of children and adolescents are afflicted with some type of mental disorder (Bird 1996; Kessler et al. 2005; Verhulst 1995; WHO 2005). Among adolescents, the highest reported lifetime prevalence is found for anxiety disorders, with onset typically early in childhood (Kessler et al. 2005). The earliest age of onset among children has been consistently found for separation anxiety disorder with panic disorder and generalized anxiety disorder more often in early adolescence (Beesdo, Knappe, and Pine 2009).

Currently available evidence therefore suggests that the most common problems afflicting children/adolescents are a heterogeneous group of anxiety-related disorders (Kessler et al. 2005). Within the field of global mental health, the focus thus far has concentrated more on adult populations, with depression receiving greatest attention primarily because it has been identified as constituting the highest burden of disease among mental disorders when measured by "premature mortality and years lived with disability" (Murray and Lopez 1997:1436). Among younger populations, because depression and anxiety are clearly both significant problems, there is a pressing need to identify social, cultural, psychological, or ecological features associated with these conditions. This is particularly true for children and adolescents living in situations of scarcity and socioeconomic adversity.

The social and cultural correlates and determinants of child/adolescent mental health are poorly understood and therefore require empirical specification. In the field of global mental health, this *a priori* research step is crucial prior undertaking the implementation of manualized evidence-based treatments that fail adequately to take into account the psychocultural meanings and social–ecological realities of adolescents living with serious mental illness (Jenkins 2015a; Mendenhall 2017; White et al. 2017; Jenkins and Kozelka 2017).

In this article, we focus on particular anxiety-related disorders observed among participants in a study of adolescents who had been hospitalized for residential treatment in New Mexico.[1] Our aims are to examine the residential contexts, psychosocial attachments, and subjective experiences of anxiety. We also explore

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issues of resilience and endurance in relation to anxious subjectivities under conditions of structural violence.

Anxiety as a Fundamental Human Process, Attachment, and Situation of Extremity

While anxiety is properly understood as a fundamental experience among all humans (Jenkins 2004; Beesdo, Knappe, and Pine 2009; Tran 2016), it may when severe involve extreme or disabling conditions. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) calls attention to the need to improve access to mental health services for children since "…many of the anxiety disorders develop in childhood and tend to persist if not treated" (American Psychiatric Association 2013). Anxiety disorders have been clinically viewed as debilitating, making everyday tasks difficult. However, because clinical research and treatment does not directly study the social and familial environments to determine how debilitating such conditions may actually be in everyday life, there has been little empirically-derived knowledge to address the validity of such assumptions.

While there are several clinical sub-types of anxiety-related disorders, in this article we focus on generalized anxiety disorder, panic disorder, and separation anxiety disorders observed among research participants.[2] A helpful formulation of such conditions (particularly panic disorders) has been provided by Hinton and Good (2009:1) as a "medical condition that may be diagnosed when a person experiences recurrent, unexpected attacks of panic or anxiety, followed by persistent concern of having additional attacks or about losing control, going crazy, or having a heart attack." Because Hinton and Good's (2009) formulation incorporates historical and cross-cultural analysis to illustrate a wide range of local idioms of distress in relation to culture and anxiety disorders, their framework provides a useful guide for much-needed studies of panic disorder among children and adolescents in global context. Epidemiologically, 2–3% of adolescents are estimated to have been afflicted with panic disorder without agoraphobia (Beesdo, Knappe, and Pine 2009:488).

Another subtype of anxiety disorder of concern in this article is separation anxiety disorder (SAD), which has been epidemiologically reported among 2.8–4% of children and 8% of adolescents (Beesdo, Knappe, and Pine 2009:488; Walker, Beck, and Anderson 2009). The condition is defined by excessive fear or distress when separated from a primary caregiver. The anxiety is characterized as beyond what is appropriate for an individual's age and persists for a period of least six months during late adolescence, leading to difficulties in daily functioning. Early attachment theorists, beginning with John Bowlby (1960), considered separation

[2] Post-traumatic stress disorder (PTSD) is a diagnostic category that incorporates significant features of anxiety diagnosis; however, for analyses within this study, we have empirically determined the utility of separate and specific analysis of the phenomenological dynamics of this disorder in its own right (Jenkins 2015a, b). While PSTD has been extensively utilized and critiqued with respect to cultural validity, the particular patterning of this disorder is empirically coherent enough to make it a valuable starting point for anthropological and clinical analysis (Hinton and Good 2016).

anxiety as the most significant type of anxiety experienced by humans. Bowlby viewed anxiety and other disorders as caused by the loss of an attachment figure through early experiences of abandonment, death, and extended separation (Levert-Levitt and Sagi-Schwartz 2015).

The cultural validity of Bowlby's attachment theory has been critiqued by anthropologist Robert LeVine (2014), who has demonstrated that maternal practices and values surrounding "attachment" vary greatly cross-culturally (LeVine and Miller 1990; LeVine and Norman 2001; Otto and Keller 2014; Quinn and Mageo 2013). This body of research takes seriously the possibility that styles such as multiple and distributed caregiving, which, under culturally ordinary conditions may well be beneficial rather than harmful as presumed by early attachment theorists (LeVine and New 2008; Otto and Keller 2014; Quinn and Mageo 2013). However, in a context of extraordinary conditions (Jenkins 2015a) of structural violence that includes residential and food insecurity, alcohol and drug addiction, violence in households, neighborhoods, and communities, the quantity or availability of multiple caretakers may be less relevant than a child/adolescents' experience of care in meeting their needs for social, psychological, and residential security.

Brumariu, Obsuth, and Lyons-Ruth (2013:116) observed that "little is known about the links between anxiety disorders and parent–child attachment disorganization" or the "quality of peer relationships in late adolescence." They conducted a study of 109 European-descent families in the U.S. from low to moderate income households. These researchers utilized research diagnostic criteria from the Structured Clinical Interview for Diagnosis (SCID) for anxiety disorder among adolescents (Hjelm et al. 2017), along with additional measures specifically focused on attachment, to find that "adolescents with anxiety disorders and comorbid conditions showed higher levels of attachment disorganization" (Brumariu Obsuth, and Lyons-Ruth 2013:116). Their results showed that these European-American adolescents with anxiety disorders are potentially vulnerable to specific difficulties in social relationships and attachment behaviors (Brumariu Obsuth, and Lyons-Ruth 2013). This is an important finding, although anthropologically there is a limitation for measurement-based psychological studies of attachment since that are not based on data collection of the lived experience of adolescents in homes and communities, particularly those struggling with scarce resources and precarious conditions.

Research Project on Southwest Youth Experience and Psychiatric Disorder

In this article, we draw on ethnographic and clinical data from a six-year longitudinal study funded by the U.S. National Institute of Mental Health entitled "Southwest Youth and the Experience of Psychiatric Treatment" (SWYEPT), for which the first author (JHJ) was Co-Principal Investigator. The adolescents (12–17 years old; average age 14) were recruited to participate in the study while receiving treatment in a residential clinical setting in New Mexico. The goal of the

study was to examine their everyday lives and experiences of psychiatric treatment. The participants of the SWYEPT study were followed for 13 months on average, but the range was from three months to two years. The vast majority of the ethnographic interviews conducted by anthropologist members of the research team were carried out in home settings, although a few took place in coffee shops or parks, at the request of research participants.

The total number of adolescent participants who completed the full range of project procedures included 47 adolescents (25 boys and 22 girls). The youths are ethnically diverse or "hyper-diverse" as recently formulated by Good et al. (2011). Participants identified singularly or as a combination of ethnicities, including Hispano (New Mexican of Spanish descent), Mexican-descent, "Anglo" or of European-descent, First-nation peoples (mixed Pueblo to include Zuni, Laguna, Acoma, and others), with two persons of mixed Asian-American and African-American descent.

As set forth above, the focus of this article concerns participants diagnosed with anxiety-related disorders. Our interest is in exploration of the social, psychological, and structural position of adolescents and families. Previous published works from the study have focused on post-traumatic stress disorder (Jenkins 2015a, b) and depression (Csordas 2013). Through highly specific "dynamic phenomenological processes" Jenkins examined "patterning of conditions of abandonment and neglect that make events of trauma all but routine" (2015a:43). Drawing on the formulation by Lovell (2012), she argued for the utility of the notion of "precarity" to describe the complex historical and social conditions that create the framework of distress and abandonment in New Mexico. Through case studies, she illustrated the manner in which recurrent trauma at the personal and collective levels becomes evident in narratives of lived experience. It was noteworthy that, even in the face of innumerable recurring obstacles, some adolescents fashioned a "self-created system of protection" (Jenkins 2015a:53). Although self-systems are markedly distinct, they create pathways, often non-linear, as a life project designed to endure and survive conditions of repetitive and routinized trauma.

In this study, we utilized research diagnostic criteria for DSM-IV categories according to the child/adolescent version of the Structured Clinical Instrument for Diagnosis (DSM-IV version) or KID-SCID (Hjelm et al. 2017). These procedures were administered by members of the research team, including a highly experienced child psychiatrist and clinical psychologist with decades of experience working locally within this region of great cultural diversity. The research project clinicians completed training in the administration and research-reliable scoring of the Structured Clinical Instrument for Diagnosis or KID-SCID (Hjelm et al. 2017). In addition to collecting SCID data, they provided detailed clinical–ethnographic observations of research encounters, typically carried out in home environments. The methodological advantages of the complementarity and value of ethnographic and research clinical diagnostic procedures has been demonstrated in compelling fashion by the interdisciplinary research team of Csordas et al. (2010).

SCID Findings and Analytic Strategy in Relation to Co-Morbidity

Based on results from the research diagnostic KID-SCID interviews, the diagnoses most commonly observed were depression (81.8% for girls and 40% for boys or 59.6% overall) and anxiety (54.5% for girls and 28% for boys or a total of 40.4% overall). The mean number of all SCID disorders (for which participants made full research diagnostic criteria requiring high degrees of symptom severity) is remarkable as a matter of extremity; the range of diagnosed disorders was between 1 and 6 and the mean number of diagnoses was 3.1 among the girls and 2.3 for the boys (overall mean of 2.7). A particular methodological challenge for the specific study of anxiety among adolescents is the commonly encountered research problem of comorbid conditions such as depressive, bipolar, psychotic-related, attention deficit hyperactivity, conduct disorders, and substance abuse disorders (Ford, Goodman, and Meltzer 2003). And while comorbidity is commonplace across a range of studies (Kessler et al. 2005), within the present study it was particularly pronounced.

To make descriptive observations in relation to anxiety, we chose to adopt an analytic strategy that minimized co-morbidity. We identified cases in which anxiety was either the only SCID diagnosis or comorbidity was restricted to only one or two concurrent conditions (resulting in a sub-sample of 11 or 23.4% of the 47 research participants). Utilizing this approach, results revealed there were two participants with only one diagnosis of anxiety, and both were boys. None of the girls diagnosed with anxiety were without co-morbid conditions. For participants with only one research diagnosis besides anxiety, there were four girls with one additional condition besides anxiety (two with depression, one with bipolar disorder, and one with substance abuse); none of the boys diagnosed with anxiety were found to have only one other concurrent condition. For those participants diagnosed with anxiety and two other concurrent conditions (total of five), three were boys whose mixed symptomatic picture (including depression, substance abuse, ADHD, or conduct disorder) and two were girls (who were simultaneously diagnosed with depression, substance abuse, or PTSD). As complicated a picture as the foregoing suggests, we undertook an analysis of this sub-group within the larger sample to see whether or not any particular features could be identified to help better understand this sub-grouping by excluding cases with more extreme degrees of comorbidity (4–6 diagnosed conditions). Without question, the relatively small number of cases available for this analysis can only be suggestive and more extensive study is required for future research. Nevertheless, this kind of close ethnographic–clinical analysis of a small number of cases of actual lived experience in everyday social contexts that can be valuable for the ethnographic identification and specification of factors and processes of relevance at both individual and group levels of analysis (Aneshensel and Sucoff 1996; Jarrett 1997; Myers 2015).

Residential Instability, Adversity, Attachment, and Anxiety

When examining the eleven cases identified per the above analytic criteria, living arrangements were identified as often in a process of flux (regardless of legal guardianship). Five lived with a grandmother because their parent(s) were unable to

provide care due to drug addiction, incarceration, or whereabouts unknown. Three lived with a parent and siblings although in one of these cases the event which directly precipitated the adolescent's hospitalization was the death of his great grandfather, with whom he felt closely connected socioemotionally. Two of these eleven were in treatment foster care, and one was homeless. In sum, most of the participants in this sub-group with predominant or significant anxiety had living arrangements that were marked by residential and socioemotional insecurity. This instability and adversity can include an array of factors such as social abandonment, neglect, physical, verbal and sexual abuse, frequent residential relocations, residential hospitalizations, poverty, parental drug abuse, parental suicide attempts, parental incarceration, gang violence, placement in foster care, and homelessness. While such situations are not unique for anxiety-related distress only, it is a specific aspect applicable in this analysis. This observation can only be descriptive (rather than causal or correlative), but the insecurity of living arrangement and particular type of anxiety-related distress is suggestive of attachment-related problems that have been commonly observed in other research on anxiety-related conditions in children and adolescents (e.g., Beesdo, Knappe, and Pine 2009).

Subjective Experiences of Severe Anxiety: Two Case Illustrations

Attention to the primacy of subjective experience is an epistemic imperative (Kleinman 1998, 2007; Jenkins 2015a) for the illumination of what matters most: people's own experience defined in their own terms as irreducible source of knowledge in the social and health sciences, including medical humanities. In the present instance, critical questions concern these youths' subjective experiences and meanings of anxiety. What are the primary thematic contours of anxiety and the qualities of their embodied experience? To specifically explore questions in relation to the subjectivity of anxiety, we draw on ethnographic and clinical materials from the two cases in which, according to SCID criteria, the only full diagnosis made was for that of anxiety.

Rowen

In the case of Rowen, a seventeen-year old Native American who says he has lived with his grandmother since he was nine years old, although his grandmother reported that she had taken care of him since he was born. The grandmother has also taken care of his older brother and younger sister. His biological mother has long had severe addiction problems and was largely absent for most of his life; he last saw his biological father around age three. Rowen's siblings have been a source of conflict in relation to their hostile attitudes and behaviors toward him, using pejorative language to refer to him, such as calling him 'crazy' or 'stupid.' Rowen said that because his siblings lacked the requisite emotional depth to understand what he was going through, he mostly relied on his grandmother for comfort and empathy, describing her as "nice, caring, supportive, always treats you right, always raises you right."

Rowen was diagnosed according to the SCID criteria only for anxiety. Both he and his grandmother (primary caretaker) referred to his troubles as recurring "episodes." During such an episode, the problem had the potential to spiral out of control. Rowen anthropomorphized these events by referring to them as a female entity in describing the problem as follows: "If you come in a state of panic, you're not going to get a grip on the situation. In fact, you'll be more worried about the panic in handling the situation. Thus she'll take more steps back and you're trying to take forward."

He worried a lot, about his friends, and especially his family. He had suffered the loss of his grandfather (a self-identified "Anglo" pioneer married to his Native American grandmother) who died from lung cancer four years before we met him. He indicated that even though he was extremely proud of his Native American heritage, and wasn't biologically related to his grandfather, he nonetheless had an extremely close bond with the man he considered his grandfather: "I used to think of him, my grandfather, like a stepdad. He taught me right from wrong, taught me all this wisdom and I used to work in the yard with him, dig ditches, plant trees, and work and when we were building our new house, (I) helped him work, build a new house." Besides this loss, Rowen also worried a great deal about his friends, acquaintances, and other members of his family:

> So, it's not just my friends I'm worried about, I'm worrying about how my family is (I: Right), because this year has not been a good year for my family health-wise.
> I: No?
> R: Yeah. My family, some of my family members have died. (Oh, no.) Same with my friends. Some have gone into the hospitals, near-death experiences for them. Not to mention there is a lot of people I misssss (Mm-hm.) That grows and grows daily. (Mm-hm.) Like a burden. (Mm-hm.) Hell, you could say a burden grows bigger than two scoops of raisins, you can say. (Mm! Mm-hm.) And there is just multiple stuff I worry about because of, kind of, kind of my attention span, you could say, so it's not just my friend I'm worried about. In one word, I could sum it up: I'm a sappy boy. [laughs]
> I: OK. [laughs]
> R: Sappy and salty.
> I: Sappy and salty.
> R: Because I worry about a lot of things, yet when it comes time for a curtain call? I put on the best show for whoever's in front of me. (Mm-hm.) I try to exclude my personal drama of everyone else, which is kind of shifting gears like that. (Mm-hm.) And it's not just at home, like whenever I am going on, in the car on the way to town, it, I, it's thought in my head there's so many battles [referring to gangs that have attacked him] that making me depressed that I haven't even told these guys, and with, with all those battles that I'm thinking about with so many issues that's making me a little depressed, like I am missing my friends that, that were once mine, and some people that I once met.

Most striking for Rowen and his grandmother, was the degree to which they were close. Rowen felt more comfortable with his grandmother in the room and his grandmother worried a great deal about her grandson, his condition of becoming fixated on a particular person or thing and worrying about it to the point of becoming extraordinarily worked up as if he would "explode." Rowen and his grandmother told the interviewer (first author) that things had gotten worse, that there were things he could not get out of his head. The episodes could escalate such that his grandmother narrated what might happen during an episode:

> G: His body was doing things. His eyes were burning. He gets these real bad headaches.
> I: Uh-huh. His eyes, eyes were burning and headaches. What was going on with his body? What do you think was happening?
> G: He was just kind of like jerking.
> I: Uh-huh.
> G: And then he would kinda yell out.
> I: Uh-huh.
> G: And then he just didn't want to be, be alone. I tried to make him go to bed because, because of his eyes burning.
> I: Uh-huh.
> G: I said [unintelligible] be in the dark, listen to your music. About ten minutes, fifteen minutes later he came back out and he said he couldn't be by himself.
> I: Huh.
> G: He was afraid to be alone.
> I: Uh-huh.
> G: So, he slept on the couch, so.

Asked to talk about what he thought was happening, Rowen narrated that

> … there's no ch—chance of stopping that risk I could have it again. Ever since then we call those episodes 'panic attacks.' Just to get a … to give people a better understanding.. what can trigger these panic attacks are if I feel emotionally disru, disrupted, like sad, angry, all that. Because my – mine has a little thought process disorder, which is like, which it makes the Asperg – where I can feel emotion really easy, and get excited and adrenaline, adrenalized on that emotion real easy.

He reported that he had received a clinical diagnosis of possible Asbergers syndrome, about which the project research psychiatrist expressed doubt but wondered about possible pre-psychotic possibilities (not sufficiently observable at the time to make such diagnosis).

Rowen bit his fingernails a lot, whenever he felt nervous or tense, particularly if he felt an attack or episode was about to happen. When that would happen, typically, his body would start to twitch or to make

> nervous, jerking movements (and) the migraine comes up that thoughts fill in my head in that I'm doing everything wrong and everything I'm going to do is

> going to be like, be, end up in a horrible way and that's when I feel more anxious, the more anxiety comes up, the bigger, the harder, the migraine gets… it's like it all combines and ties into each other, the physical conditions, and the emotional.

He described this to the interviewer (first author) as an overwhelmingly painful experience that he lived in constant fear could occur at any moment. In trying to explain it, he relayed that he had come up with a self-referential name for the pain: "Bone Daddy."

> I: I get it. That's quite interesting. Now, 'Bone Daddy', the pain in your body, what's the pain in your body?
> R: Just like stresses, it strains my muscles and it hurts my bones from the upper layer.
> I: What does it feel like?
> R: It feels like a lot of pain, and a lot of strain on my muscles. It's very uncomfortable.
> I: How often do you have that pain?
> R: It depends on what the situations is like, you know, if I'm having a bad memory or something.
> I: You can feel it?
> R: Yeah.
> I: In your body?
> R: Yeah, I can feel it in my body.
> I: So, um, so you give yourself that name.
> R: Yeah, because of my condition, the way I am.

The social context of his anxiety, fear, and panic was observable primarily in his relationship with his grandmother. Many (but not all) of the interview encounters occurred either with his grandmother in close physical proximity (in an adjacent room) or in the same room together. The social context of the interviews mirrored their daily routine within their home or for events or appointments outside of the home. His grandmother reported what she observed to be Rowen's fears as well as her own fears regarding what would happen when such time would come when she would no longer be able to care for him (e.g., infirmity, death). In one of her interviews, she relayed the following:

> He was afraid to be by himself. I had to be there and there's times like, you know, he just wants to be near me. You know, I don't know that he'll make it on his own. And even at the hospital (his most recent hospitalization of several) he would be in his own room, he was still calling me, wanning you know. He said: 'I just wanna hear your voice. You know, stuff like that.

This shared fear, palpable for both grandson and grandmother, was that as an aging woman with problematic health, Rowen could be left without a caretaker. There was no one else within the family (his siblings, an aunt) willing to do it. Rowen was terrified of losing his grandmother, worrying constantly about her health, her whereabouts, harboring no small amount of guilt about the burden he had

been to her since she had been, in his words, so "motherly to me." Notable, however, were Rowen's preoccupation with trying to control and manage his "episodes" by paying close attention to things in "real time," by trying to pay attention to others' feelings, listening to music, and largest on his list, the goal of trying somehow to learn to live independently from his grandmother in some kind of group-home arrangements, despite the anxiety this aroused in him (being separated from his grandmother). He was interested in struggling and to handle things on his own. He did claim that he had learned some therapeutic techniques during his hospitalizations that he found valuable. Also notable was that despite the fact that he would at times rely on medicalized language at times to refer to his condition, he objected to therapeutic techniques when these were framed in individualized, medicalized language. For example, he relayed that:

> I'm one to admit I really hate the term coping skills. … I understand the purpose of coping skills. In fact, I rather say my coping skills are hobbies. (I see.) But bec, because the reason why I hate that term, not the actual method (Mm-hm.), I do the method of coping skills (Uh-huh.), I hate that term cope, it's coping skills because it's really used by the doctors' way, way too much. … The hell you guys talking about?

He felt that his life situation was remarkably complicated and his concerted efforts to live with his "episodes" were just the way things were in his life, things with which for him he would differentiate as his problems with persons with whom he lived and problems with which he had to *live,* but not *cope*. The whole notion rubbed him wrong.

As a matter of overall subjective experience, however, this particular case illustration of extreme fear of loss of a caregiver to whom one was strongly attached, was also notable among the other participants in this analysis who lived with grandmothers. Moreover, we also observed this particular form of anxiety among other research participants in this sub-sample, including those who were living in treatment foster care, in households with high tension levels with threats of separation from the primary caretaker (through ejection or flight), or were homeless (at the time of hospitalization/entry into the study). In sum, the shared subjective experience of this sub-group of adolescents can be characterized as a struggle with anxious attachments.

Mario

Mario was a 16-year-old Hispano male, whose primary caretaker was his grandmother. According to SCID criteria, Mario's only current diagnosis was separation anxiety disorder. This problem affected his willingness to trust others such that he could form and maintain new relationships. Things just always seemed to go wrong every time he tried. He had had no contact with his biological father since he was 3 years old. Mario described moving at least nine times due to difficulties with his mother's boyfriends, one of whom would lock him in his room. Mario conveyed that he felt abandoned at that point. He later moved in with his grandmother. Although for a period of years his biological mother did not live with

him and his grandmother, following court-mandated treatment for addiction, she moved back in with his grandmother, resulting in an unanticipated consequence: his removal to treatment foster care for what unexpectedly turned out to be three years. Mario was forced to change schools during his foster care, which created lapses in his education and led to significant academic difficulties. Mario's grandmother worked tirelessly and overcame many bureaucratic obstacles to eventually have him returned to his family. He was hospitalized in an acute psychiatric clinic and then placed in foster home "for no reason," or at least for reasons he did not understand. He relayed that even if his mother could not care for him, he dearly wished that he could've been "given to [his] grandmother."

Unsurprisingly, then, Mario's anxiety was primarily focused on his grandmother, who suffered from increasingly debilitating rheumatoid arthritis about which he worried a great deal. In fact, Mario expressed great anxiety regarding the wellbeing of his grandmother, who he viewed as the only stable force in his life. This was evident also as a matter of physical comfort; he was unwilling to be touched or hugged by anyone other than his grandmother. In his interviews, Mario conveyed his worry about his grandmother "taking her pills now, or whatever she going to do… (or not do), 'cause she's been, she's forgetful now". He also was particularly concerned about her driving and made sure to remind her to put her signal on whenever she changed lanes.

When asked about what he thought the problem might be in terms of his distress, he and his grandmother reported he did not like to be "out" with other people, that he was exquisitely sensitive to what he feared other people would do or what they might say about him.

> I: And what do you think is going on with you?
> M: I just get nervous around, around like, like when things start to happen and I can't, I don't know what to do anymore I just get nervous and I just start freaking out I guess
> I: Yeah, and what kind of things?
> M: Like my grandmom telling me to clean my room when I already, I'm already starting to clean my room (Mmhmm) and she goes in there and tells me again clean your room and all and then she walks in there, good boy, like a dog or something (Mmm)
> I: And how, that makes you feel, does it make you feel nervous?
> P: Yeah (Mmhmm) I just like, I just like started like you know I don't want to clean no more (Mmhmm) (Mmhmm)

He thought he should get out of the house, to go and play football with peers, and while he tried to enjoy such activities, he found he really could not, indicating he just felt better with his family (primarily his grandmother).

Mario had previously used marijuana and alcohol to alleviate or dull his pain, but during his time in treatment, he discovered a new means for managing pain: drawing. He also reported that he took on responsibility for taking care of the family's dogs. Over the course of the study, he began playing football, but eventually returned to using drugs. His grandmother blamed this on his aunt, who as a long-term drug addict she considered "a bad influence". Mario showed great

emotional care for his grandmother in the form of daily reminders and assistance as he could provide it, even if in an anxious style of care at odds with his own considerable struggles to deal with his often overwhelming anxiety.

Discussion

Having identified a possible relationship between fraught adolescent attachment to caretakers and the subjective experience of anxiety, we can only call for future studies to make further determinations regarding this association. While we recognize the importance of attachment and early childhood development, we argue that deeper and more nuanced understandings of attachment must be derived from lived experience in ways that go beyond what the present study was designed to examine. Certainly, consideration must be given to attachment theory in relation to relationships of strain and entanglement, patterns of abandonment, and separation anxiety. With respect to panic disorder, a key feature has been identified as "catastrophic cognitions," as outlined by Hinton and Good (2009), to include cognitions such as the fear of losing control or going crazy, fear of dying, and derealization or depersonalization. Study participants with anxiety-related panic discussed their desire to "control" their anxiety, stress, or anger. This is tied to their interpretation of culturally acceptable emotions and is reflective of the precarity of their social context. By controlling their emotional reactions, respondents hoped to better navigate their situation. Common clinical expectations entail the idea that people who suffer from anxiety disorders typically have reactions that are somehow out of proportion to the situation or stimulus. This sort of logic is of limited utility for adolescents whose lives are marked by enduring conditions and persistent events of structural violence. Such experiences cannot be reduced to individual response or personal reaction styles. This is not to indicate, however, that personal reactional styles are not of importance. Indeed, they have been shown to vary across individuals living in "roughly" similar situations of adversity and insecurity (Jarrett 1997). In this study, there is an array of documented strategies to manage difficulties that vary across individuals, including self-cutting, exercise, talking with family, friends, and therapists, religious rituals, bodily and social attachment to music, care for animals, breathing, drawing, social drugs, hobbies, protective isolation, reading, playing sports, using a stress ball, watching TV, playing games, and often, writing in journals. Children with separation anxiety disorder might be more inclined to attempt to provide care (within the limits of their own afflictions) for their caregivers to avoid real or perceived abandonment. Concern about their caregivers, then, are matters of affective compassion as well as self-preservation. The presumption that persons living with a mental illness lack the capacity for social engagement, including caregiving, is commonly applied to adults and children alike who are often considered deficient in fundamental human capacities (Jenkins 2004). The socially stigmatizing production of common cultural perceptions of persons with mental illness as "not fully human" or "incapable" of caregiving, in some cases to significant degrees, flies in the face of ethnographic research (as detailed in Jenkins 2015a) including responsibilities for kin caregiving. One note of caution, of

course, applies insofar as persons must be judged (by their kin) to be reliably capable (which often means in regular treatment). Anyone, child or adult, who acts disruptively or with potential for violence are reasonably deemed not fit for providing care. But this is a matter of appropriate and efficacious treatment and not a matter of inherent deficiency or danger. Indeed, our longitudinal studies provide evidence of significant involvement in caretaking and an array of domestic labor for many such persons who are not in an acute state of crisis and who have improved or recovered with the assistance of supportive kin and therapeutic treatment (Jenkins 2015b).

Anxiety and the Role of Resilience

The research construct of resilience is "broadly defined as the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development" (Masten 2014a:6). The role of resilience has been invoked across many fields, including psychology and other social and health sciences (Ager 2013; Boin, Comfort, and Demchak 2010; Fleming and Ledogar 2008; Rutter 2006). Several contemporary researchers who work with children recognize the influence of cultural, socio-economic, and community contexts in relation to the study of resilience (Ungar et al. 2007). Initial studies tended to be conducted with middle and upper-class European-descent groups, with an emphasis on academic performance, self-esteem, and family attachment, but were not formulated in relation to how the notion of resilience might apply across diverse ecological zones (Boyden and Mann 2005; Ungar et al. 2007). It is important to recall that Masten's (2001) notion of resilience was framed not as static but instead as a dynamic process. Further, she emphasized the "ordinariness" of "resilience (that) does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in the minds, brains, and bodies of children, in their families and relationships, and in their communities" (Masten 2001:235). In this sense, resilience is not just about an individual's experience, but also intersubjective experience. Given this, Masten (2014b) argued that resilience studies cannot usefully rely primarily on biographical or anecdotal single person case studies. Individual accounts must be contextualized within the social, economic, and political milieu of persons' everyday lives. Researchers on childhood resilience believe, "there are levels of risk and adversity so overwhelming that resilience does not occur and recovery is extraordinarily rare or impossible" (Masten and Obradovic 2006:23). This is illustrated by research which shows that individual characteristics, such as higher intelligence, can increase developmental competence, but "do not overcome the effects of high environment risk" (Sameroff and Rosenblum 2006:123). We believe that the case materials from this study provide evidence of the capacity to endure in precarious conditions; however, the utility of the concept of resilience in the present context, while hardly irrelevant, appears elusive and must await further analysis in to weigh in further regarding its utility.

Resilience as a theoretical concept holds appeal within the mental health field because it encompasses hope and recovery. A useful deconstruction of biomedical narratives of risk and resilience has been provided by medical anthropologist

Panter-Brick (2014). She argues that "risk and resilience are concepts that make intuitive sense but often elude simple definition" (Panter-Brick 2014:432) because they are ambiguous notions for which measurement is fraught. Instead, multifaceted interpretations are required (Panter-Brick and Leckman 2013). Panter-Brick further observes "… the term resilience has been used carelessly to refer, within high-risk groups, to individuals who somehow 'beat the odds' of adversity. The literature on resilience… is peppered with terms such as 'resilient children' and 'resilient genes.' This usage all-too-easily blends statistical statements with personal attributes and biosocial categorization" for which it is vital that we find a way to identify "key resources to sustain well-being" (Panter-Brick 2014:432). It may well be that the conceptual pair vulnerability-resilience holds less value than the more existentially and ecologically attuned conceptual pair of precarity-struggle as theorized by Jenkins (2015a). In future analyses from the present study, we plan to examine such resources to determine whether patterns can be identified by diagnostic sub-groups, gender, or individually variable styles of response within the broader context of structural violence. Recalling Michelle Rosado's understanding of emotions as at once social and cultural, physical and psychological, sociological and individual, we also recognize persons not as individuals first but primarily as *social persons* (1984:151). This intersubjective framing of sentiment and person was argued by Jenkins (1991) with the formulation of "political ethos" whereby sentiment is shaped by social domains of power and interest, and psychological trauma understood at both personal and collective levels. The ethnographic study of grandmothers in Nicaragua by Kristin Yarris (2014) contributes to understandings of familial households headed by grandmothers charged with the care of children when mothers are absent in relation to the economic forces of migration. Yarris' study shows that such arrangements are the source of particular ambivalence, pain, and "the uncertainties of the social location inhabited by grandmother caregivers," who experience a particular form of cultural distress as *"pensando mucho"* (or "thinking too much") (2014:474). Complicated kin relationships are also the primary focus of Angela Garcia's *The Pastoral Clinic* (2010). In her ethnography, Garcia explores themes of addiction, dependency, and social suffering in New Mexico amongst Hispano heroin addicts. She describes the historical, political, and cultural conditions of New Mexico, which led to zones of social abandonment, as well as the pattern of intergenerational suffering. Parents and children who were "co-addicts," often mothers and daughters, procured and used heroin together. The cases in Garcia's book reveal the "long-silenced female genealogy of heroin addiction" (Garcia 2010:148). The case illustrations presented here for Rowen and Mario illustrate the intersubjective quality of complicated anxious entanglements and attachments of grandchildren and grandmothers as primary caretakers. The bonds of Rowen and Mario, like relationships described in Yarris' and Garcia's work, have been forged over the adversities that they faced together within familial legacies of loss, worry, loneliness, and ambivalence. Grandparents, parents, and children struggle with poverty, mental illness, drug abuse, trauma, emotional distress, and a lack of resources to deal with these adversities.

There is a robust research foundation that has demonstrated a relationship between adverse childhood experience (poverty, neglect, maltreatment, physical,

sexual, and psychological abuse) and development of an array of mental disorders (Beardslee, Chien, and Bell 2011; Fitzsimons et al. 2016; Tillfors et al. 2009; Hoeve et al. 2015; Kelleher et al. 2013; Cutajar et al. 2010; Kelleher et al. 2013; Daruy-Filho et al. 2011). It is abundantly clear that such social pathologies are good for *no one's* mental health. Nevertheless, it is important to bear in mind that there is an even broader picture of adversity and intergenerational instability in the present ethnographic case, coupled with structural violence and historically rooted trauma, that has created the unsteady terrain of precarity for these research participants. Although the adolescents were encouraged to focus more on their health while in psychiatric treatment, their experiences often included many challenges of financial stress and familial insecurity that affected their outlook on their future prospects.

Over the course of the study, it became apparent that access to mental health services for low-income families, already scarce, was becoming even more significantly difficult to obtain. Changes to state and local health resources greatly affected the experiences of the adolescents and their families in terms of options for care, medications, and treatment. Increasing barriers and limited access to health services influenced the long-term recovery plans of the families. Many participants and their kin discussed being unable to afford the quality of care they required. The scarcity of healthcare resources is a global issue is a global health issue affecting all societies. Most families are able to bear the expense of non-familial caregivers or the cost of premium coverage for both physical and mental health.

In many ways, we are convinced that "enduring" among these adolescents and their families was significant, while in psychiatric treatment and when living in household situations of (oxymoronic) "continuous crisis." The social and temporal configuration of endurance holds a greater resonance for this ethnographic analysis, and also as recently argued by Arthur Kleinman, than do contemporary studies of resilience. During psychiatric treatment, the teens were encouraged by staff to come up with daily goals and develop new positive coping strategies. Resilience might be a larger goal of the clinics; however, it may not one be employed realistically realized in the social contexts herein. Endurance better applies to the many residential adversities and intergenerational instabilities they have faced. Lotte Segal argues that "enduring distress, be it due to chronic mental illness or detention, begs conceptualization that can accommodate not only the efficacy of but also the failure of narrative" (Segal 2016:17). Segal focuses on "dissolving" narratives of Palestinian resistance, and in this sense, we have tried to put forth dissolving narratives about endurance from adolescents in psychiatric treatment in New Mexico. For the current analysis of anxiety and caregiver attachment, we have preferred to foreground the lived experience of the participants in terms of endurance and the centrality of processes of struggle, as more fully formulated elsewhere (Jenkins 2015a).

Conclusion

Global mental health is an emerging field of study and there is a pressing need for transnational and regional studies of anxiety (and other conditions) among adolescents. As increased anxiety and depression are potential risks for caregivers,

it is crucial also that researchers analyze the experiences of caregivers along with those receiving care. The adolescents in this study often experienced anxiety in their relationships with their primary caretaker. While we have used attachment theory as a starting point for conceptualizations about separation anxiety, we argue that attachment theory is limited in scope to explore the conditions of precarity and structural violence present in New Mexico. The patterns of abandonment, residential adversity and instability, as well as routine trauma that were commonplace in research participants' lives, call for new interpretations about the capacity for endurance that analytically foreground engaged processes of *struggle*. Also, for adolescents with anxiety disorders, the assumption is that they are not capable of providing care appears not entirely appear to be true in the present case studies. The attachment and provision of care to their primary caretakers may be a source of strength to manage what Jenkins (2015a) formulates as "extraordinary conditions" (anxiety and residential adversity).

Without question, the relatively small number of cases available for this analysis can only be suggestive and more extensive study is required for future research. Nevertheless, we believe that the value of the data presented has methodological value by virtue of the combination of ethnographic and research diagnostic interviews in producing knowledge that is complementary to enrich anthropological and clinical accounts (Csordas 2010) that are conducted "not in the abstract but in the context of a study actually carried out in the field" (Jarrett 1997).

Future interdisciplinary studies utilizing complementary procedures carried out in local communities are needed to investigate capacity, struggle, and possibilities for adolescents and kin who actually live with serious conditions of mental illnesses in complex contexts of structural violence.

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