Invisible Populations of the Poor:

Professional Perspectives and Service System Outcasts

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It was about 2:30 on a sunny afternoon, on a boat gliding somewhat aimlessly down the Delaware river, when Theresa's name was announced as the winner of the ship's lottery. Theresa was on a field trip with about 35 other members of the Community Living Room (CLR), a psycho-social rehabilitation program for persons living with HIV/AIDS in need of mental health treatment. The Philadelphia Office of Mental Health program is one of eleven federally funded Center for Mental Health Services demonstration grant sites, and as Project Evaluator I was also on the trip. As an Anthropologist, participating in the program on a regular basis forms a major component of my research. Theresa had already told me, as she gazed out over the rails of our boat, that this brought back to her a time her mother had taken her out on a boat when she was five, and they had been down the shore. But that had been a long time ago. Theresa, like many CLR members, is a recovering addict and only two months into her recovery. She is living with HIV, and has significant mental health issues as well. Just the day before, our program director had sat down to talk to her in a subway stairwell from which she would not emerge, while she worked through another in an ongoing series of bouts with suicidal fears fed by the despair and difficulty of staying "clean". When Theresa won the lottery, she went up to the bridge and took over piloting the boat, making a few captain's announcements while at the helm. When she came down, she carried a Polaroid of herself at the wheel and showed it to me and began to cry. She had never done anything like

this, she said, and her son would be so proud. We labeled and dated the photo to her six year old son, and placed it securely in a folder to protect it till she could get it home and give it to him. The experience was a happy one, in a life where that experience was rare.

The program at the CLR is devoted to providing members with experiences like this one. Its a program where structure is everywhere yet largely invisible. Its a program that consciously strives to harness the unbelievably reintegrating power of the social as a therapeutic mode. And it is this very emphasis on the social that distinguishes not only between the psycho-social model of mental health treatment and the more traditional and common medical model based treatments, but also between the analytic frames brought to the study of these programs by Anthropology on the one hand, and psychology and psychiatry on the other.

Earl is among the founding fathers of the CLR. As is the case with most members, he is fighting addictions. He formalizes with ease on the advantages inherent in the program model he--along with the other members--has helped to evolve. And participating in groups, listening to and talking with the members, as an anthropologist does, permits member insights and perspectives to weave into the analysis of the program. Earl comments on the overwhelming impact of simply being in a program every day with other persons living with similar issues. The stigma of HIV is less of an issue when everyone in the program is facing the same challenge; what members bring to and share within the program becomes the therapeutic

medium. Everyone is struggling with HIV; most everyone is struggling with addictions that were already killing them. One doesn't need to fear disclosure: in fact, members report that the affirming effects of group participation help them deal with disclosure in other settings. And what the members bring each other is a mirroring which affirms reciprocally; many comment that finding out they were HIV positive helped them come to grips with dealing with their addictions; dealing with these issues in a safe environment and sharing their triumphs and tribulations allows each to benefit from what they bring to each other. But programs which emphasize the social context of mental illness and mental health treatment are not standard treatment: in most states they do not qualify for medicaid reimbursement. With the rush to implement managed care systems for delivering mental health services which were traditionally paid for through medicaid, there is significant fear that psychosocial programming will become even more marginalized. From an anthropological analysis of the assumptions underlying and the practice of standard mental health treatment, emerges the finding that these treatment modalities create service system outcasts and have particular difficulty reaching the urban underclasses most in need of service. There are growing populations of persons living with mental illness, addictions, and HIV/AIDS who are often homeless and for whom standard treatment may not be the most appropriate, and who in any case would have trouble accessing services which are structured to be most accessible to those already within the system. Anthropology is particularly well

suited to examine the assumptions underlying the treatment philosophy and the treatment practices, and for evaluating the fit between these systems and the persons for whose benefit they are intended.

Anthropology differs from psychology and psychiatry at a fundamental level: The object of analysis for the anthropologist is always and unremittingly social; for the psychologist and psychiatrist, it is the individual. The alienation of the individual in the modern state is mirrored, and arguably to a certain point, engendered, by a psychologism which isolates the individual as the basic unit of analysis. This point of view fits well with existing political ideologies: analyses which limit the source of illness and damage to forces within the individual are willing partners in a political conspiracy which blames the victim, especially the poor, for their own difficulties. Remarkably, but not surprisingly, a highly positioned official within the NIMH announced recently that the search was on for the "gene for homelessness". NIMH's decade of the brain is only one of the ubiquitous illustrations of this reduction of a social complexity to matters within the individual, and the political consequences of such reactionary interpretive frameworks. There are epistemological differences between psychiatry and psychology, of course: psychiatry posits the wellspring of mental illness in the forces and drives within a person's psyche; psychology constructs a largely behaviorist frame where the individual is reduced to behaviors which are learned and manipulated through stimulus

response conditioning. But both positions isolate the unit of analysis as an individual: the disease is reduced to a set of traits which are then manipulated by the practitioner, with the help of the powerful neuroleptics that have revolutionized mental health care. Goffman's powerful metaphor of the "tinkering professional" comes constantly to mind when observing traditional mental health practitioners. Both the patient and the disease are posited as 'objects': mental illness becomes an entity subject to manipulation by the tinkerer. In traditional practice this is not a reciprocal involvement: the difficult to engage consumers of the urban underclass are often categorized as "resistant to treatment", i.e., individuals who for some inscrutable reason do not choose to deliver up to professional ministrations their person. Consumer empowerment movements have begun to insist on a partnership in treatment, but they cannot change the objectification inherent in the model. And in the case of mental illness the consumer cannot even withdraw from the diseased part, as from a troubled lung or kidney, for the "object" of treatment is one's mind, one's being. There is no concept of system here; neither in the structures of the individual nor in the social context within which matters of identity and being take form. It is interesting that a medically modeled psychiatry and psychology, though premised on a concept of autonomous individual, paradoxically result in the dissolution of the individual in his reduction into objectified traits, characteristics and variables. And that Anthropology, by beginning with a systemic view of the social, can so much more convincingly

portray the individual.

There are psycho-social rehabilitation programs which do not subscribe to--and are in turn not validated by--either of the two positions underlying traditional practice. As an anthropologist I was intrigued by this alternate approach which consciously sets out to dissolve the practitioner/patient dyad and its consequent objectification, through structured group activities which minimize differences between staff and members. The Community Living Room is an innovative psycho-social program, an exploratory pilot program funded to "identify promising new mental health treatments for persons living with HIV/AIDS.". From the beginning, the intent was to create a member driven program; a program consisting of a series of well thought out one or two hour long group sessions all carefully structured to address the issues raised by living with the multiple realities of mental illness, addictions and HIV/AIDS. The program relies heavily on volunteer group facilitators, especially for the HIV/AIDS education and herbal therapies groups, and a very devoted group of permanent staff members that run support groups and workshops. Emphasis is given groups which produce tangible outputs: members produce a newspaper, poems, short stories, art work and videos. But the primary therapeutic element in the groups are the members themselves. Program staff facilitate, but the members create.

Groups are therapeutic vehicles for allowing the normal restructuring inherent in successful, positive and supportive interactions full expression. A carefully organized group program

unleashes the tremendous potential of the group in overcoming the isolation, alienation and deadly self-imaging that is the norm for the persons we see in our program. The program provides a safe haven--a place that is not the street, and that allows for the emergence of a phenomenon foreign to most of our modern existences--the emergence of a sense of a community and the kind of individual definition and fulfillment that is only possible within a well functioning community. And there is an issue of cultural relevance here as well. Our members--mostly African American and all poor--come from environments that are paradoxically in many ways stronger in their awareness of the importance of community and its potential benefits than we more prosperous middle class adherents of liberal individualism. Members value the community living room's contribution to their sense of well being. Our conclusion is that group based programs, for our particular membership, make contributions toward therapeutic efficacy that counseling programs alone could not accomplish. Our success also translates into very direct improvements in members' interest in caring for themselves and managing their addictions and medication. The program works with the members desire to live and work through the difficulties presented by their HIV status, addictions and mental health issues.

The application of Anthropological methods' more holistic approach to the object of analysis produces significant findings. The program evaluation will be able to show that the program has allowed regular members to generalize from the program experiences

into their daily lives: that AIDS education groups give members the confidence and knowledge to begin taking control of their health care; that a supportive environment provides the stability to achieve improvements in other areas of life, such as housing, accessing benefits, or paid work. Interestingly, we are finding that the stigma of HIV is less, to our members, than the stigma of mental illness, and that acquiring HIV is often seen as a wake up call to take control over a life out of control. Anthropological methods offer alternatives to the reductionist individualism and objectification inherent in the application of certain narrowly conceived quantitative methods, and they can be overwhelmingly convincing in their own right. And by thorough examination of the systems of meanings that participants bring to their encounters, the systemic unraveling of the world taken for granted of all players, anthropology can offer an unrivalled portrait of the social whole that must be the target of any meaningful analysis. More importantly, anthropologists can use that knowledge to influence policy makers to better understand the often competing agendas of different stakeholders and support the positions of those least empowered. This is a contribution of an applied anthropology.

Well constructed quantitative methods are not antithetical to an anthropological approach so much as they are insufficient. It is not the use of numbers but the analytic reductionism which precedes their application that is often problematic. What anthropology can bring to established mental health services

research--a multi-million dollar industry that rarely involves anthropologists--is a collaboration based on a careful assessment of the contribution and limitations of each approach. Analysis of the worlds taken for granted of the different disciplines involved forms the basis for a collaboration which optimizes the strengths of each approach. There is a group of anthropologists meeting to explore a collaboration with like minded mental health researchers in other disciplines.

Anthropological methods are extremely powerful in conducting formative evaluations. As Project Evaluator of the Community Living Room and a representative of the Philadelphia Office of Mental Health, I used a combination of quantitative and qualitative methods to perform an anthropological analysis of the program from its inception. These methods were the basis of several program reorganizations in staff and decision making structures, and were extremely useful in forging a path between contentious political struggles largely outside but impinging upon the program. The object of the reorganizations was always to move the program in the direction indicated by our members as providing the best support. Anthropology does not make a commitment to provide an "objective" analysis in any of the overused meanings of that term; what we must make is a commitment to a morally inspired analysis that applies our efforts to those most in need. The members of the Community Living Room lead unbelievably difficult lives. Their strength of character, determination, resilience and resourcefulness in the face of the challenges of their daily existence are overwhelming.

The goal is to provide a program which does justice to what the members bring to it: a reflection of their will to live.

The epistemological issues consequent to the dominance of psychology/psychiatry based service interventions and evaluation technologies lead to treatment and research devoid of the concept of the social and premised on the primacy of the individual. This leads to undervaluation of the social factors involved in the etiology and treatment of the various issues plaguing poor persons living with mental illness and has a variety of consequences, most notably lack of attention to the issue of culturally appropriate treatment modalities. I have sought to show that anthropological methods can materially contribute to the analysis of the underlying assumptions of research into and the practice of mental health treatment, in the formative evaluations of programs, and most significantly, in the applied quest for the design and implementation of programs best suited to those for whom they are intended. Persons receiving publicly funded mental health treatment are poor, with the majority members of minority groups who are often homeless and living with mental illness, substance abuse issues, and with increasing frequency, HIV. Anthropologists have an opportunity to influence a treatment system which marginalizes those most in need through advocacy for more humane policy.