The Stories We Tell or Omit

How Ethnographic (In)Attention Can Obscure Structural Racism in the Anthropology of Mental Healthcare

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Abstract

Anthropologists studying mental healthcare tend to do so through observational and analytic attention to how individuals experience specific clinical and cultural contexts. While narrating lived experience may serve to humanise conditions like mental illness, those of us observing from a White, colonist-descended position can overlook the structural and racialised forces that determine entrance into particular treatment spaces. In doing so, we inadvertently obscure structural racism. This Position Piece critiques my approach as a student-in-training in anthropology, who conducted an ethnography of outpatient, government-funded clozapine clinics in the United Kingdom and Australia. In documenting how these clinics unexpectedly became a central source of moral agency for its clients, I stopped short of examining the demographic dynamics that helped to cultivate moral agency. Focused on other questions of health disparity, I missed the role of race and racism in treatment access pathways, trustworthiness, and experiences of moral agency. Engaging now with disciplinary legacies that shaped my inattention, I reflect on my silencing of racism at an interpersonal, institutional and structural level in my early analysis. I encourage similarly positioned anthropologists studying psychiatric treatment spaces and moral experience to confront how racism can be filtered through the stories we tell.

Keywords

Choosing questions, selecting stories

> 'We cannot progress to becoming an antiracist discipline without confronting the kinds of questions that we have historically evaded' (Gupta and Stoolman 2022, 786).

Anthropologists know well that an individual's treatment, social or medical, always tells a larger story. When describing somebody's lived experience, anthropologists select contextual and narrative information they judge to be most relevant, guided by their training, values, and positionality. In drafting my PhD thesis in 2018, based on an ethnography on clozapine clinic treatments for psychosis, I incrementally culled that which did not seem critical to my arguments. Approaching the last cull, there was an undeveloped detail that I had been reluctant to exclude for reasons I did not yet know. It was the racial identity and incriminated status of one of my research participants, Keith (a pseudonym for his actual White-washed name). In interviews, Keith had described how he was navigating a new life on parole, which included regular clozapine clinic appointments, in a new town: "I don't mix with Blacks down here, you see ... I stay to myself, I do, because they do break 'n enters 'n that". Keith was the only Indigenous Australian I met in the clozapine clinic. Elsewhere in my dissertation I had not mentioned anyone's racial identity. A senior colleague thus advised me to remove demographic details about Keith, lest it draw attention to alternative research questions that I could have asked. I deleted the details, so that he was simply a male clozapine client.

In this Position Piece, I examine how such ethnographic erasure can facilitate a silencing of structural racism within mental healthcare settings. For if we endorse, as I do, the wider disciplinary calls to decolonise anthropology where possible (Mullings 2005; Burton 2015; Williams 2015; Shange 2019; Jobson 2020; Baker 2020; Gupta and Stoolman 2022), anthropologists who study mental healthcare must account for systemic racism in their ethnography. The decolonisation movement seeks to lay bare, contest, and repair the violence of colonisation structures in our field sites, methods, and analytics. As a White, colonist-descended Australian ethnographer-in-training, it was not until the resurgence of the *Black Lives Matter* movement following the death of George Floyd in 2020 that I began to scrutinise my approach.

At the time I was living in the United States, returning to my thesis to write a book (Brown 2022) and reckoning with the realities of racism in my professional and personal life (Brown 2021). I read Leith Mullings's earlier call for those of us studying their own culture 'to confront forthrightly the extent to which structural racism is pervasively embedded in our social system' (2005, 685). I learned about how Australian anthropology has 'tried to distance itself from one of its foundational analytic concepts, race' (Cowlishaw 2000, 108). I considered how Whiteness in

my fieldwork was systematically concealed as a structuring force of power within clinical (and ethnographic) infrastructures. And when I heard about the *Black Lives Matter* protests in the US resounding in Australia, with thousands defying COVID-19 lockdowns to demand justice for the police killing of Indigenous man Kumanjayi Walker through widespread protests (Gunia 2020), my thoughts returned to Keith.

When theorising about social empowerment in mental healthcare, structural racism has seldom been part of the stories anthropologists have told. It is broadly recognised that in cultures that encourage individual responsibility in the face of hardship, those with less socioeconomic power may experience 'diminished moral agency': reduced self-efficacy and reduced ability to foster respectful, productive relationships with others (Blacksher 2002). Moral agency, then, means having the resources to make possible meaningful relationships with others that one respects. For people diagnosed with serious mental illness, replenishing moral agency can be key to experiences of recovery (Myers 2015, 2016). The framework of moral agency has been applied to specific and racialised population groups, to show how expressing 'autobiographical power' over one's own story can be healing, for example, for Black American men diagnosed with psychosis and facing institutional racism (Myers and Ziv 2016). But what about the *structural* racism that is evident when we study a population who is predominantly White? I was motivated to study the lived experiences of clozapine clients because I saw them as heavily marginalised through social and biological circumstances, and facing extreme health disparities. At the time, I did not think about how the clozapine clinic offered up a cross-section of racial disparities in mental healthcare, epitomised by the exceptional circumstances that made Keith's demographics stand out to me, if only subconsciously at first.

In the following, I reveal how evidence of structural, racialised gradients affecting moral agency in the clozapine clinic remained buried in my fieldnotes; provoking analytic engagement but never eventuating in it. Ideally, I would have collaborated with Keith in telling his story here. My institutional access was limited to the time in which I conducted fieldwork, meaning that I could not even recontact Keith to ask about my use of his story as a demonstration of structural injustice. Without consulting him, I risk reifying the very power dynamics and epistemic injustice that I wish to move away from. This is an imperfect process. While we cannot entirely decolonise our work by revising the types of questions we have asked, we can nonetheless confront how racism can be filtered through the stories we tell. Arguably, psychological anthropologists who focus on experiences of moral agency can better account for how structural racism shapes moral agency by attending to the broader context of social care and asking if racial disparities are present. We can build wider awareness of structural racism and show how our small (in)actions relate to bigger (in)justices by limiting or improving the extent to

which we can nourish moral agency for our participants, during or beyond our time with them.

Disciplinary myopia and post-2020 reckoning

During my research, I observed that people diagnosed with 'treatment-resistant schizophrenia' who are taking the notoriously risk-ridden antipsychotic medication clozapine are more empowered than it might first appear when it comes to managing their own health and being accountable to others (Brown 2022). Predictable attention to physical health instead of mental health helps clozapine clients to build a sense of medico-social validity (Brown 2020). Each month, clients at clozapine clinics work together with clinical caregivers to achieve a simple shared goal: certifying that blood markers meet the requirements for another 28 days of clozapine treatment to be safely prescribed without the client experiencing severe blood and heart-related side effects. Clients gain command over their health narrative (Brown and Dennis 2017), and are socially valued as 'good' and reliable people with moral agency, superseding notions of mental illness (Myers 2015; 2016). The frequency of regular visits to the clozapine clinic affords clozapine clients a continuity of care and social engagement that is otherwise largely absent for people living with psychosis in Australia and the United Kingdom where I conducted fieldwork. Moreover, that clozapine is associated with lower mortality overall when compared to other antipsychotics (Vermeulen et al., 2019) may not be a simple matter of medication efficacy—structural influences on health outcomes are pertinent.

Only after completing my PhD did I see that my research, with its focus on health disparity, had captured a predominantly White demographic (88%). Regrettably, social demographics were mostly ethnographer-observed and observed in retrospect: I did not ask my participants to describe their own racial identity; Keith was one of few to volunteer this information indirectly. Surrounded by a scholarly community of a similar demographic background to myself—none of whom studied issues of race or racism in healthcare—racism was not an obvious question or a comfortable analytical frame. Being limited by the specific social worlds of our colleagues, academic mentorship and individual positionality does not mean, however, that we cannot be trained to systematically ask what we are *not* witnessing in our field sites, and how that is connected to what we do witness (Shange 2019).

By not engaging with Keith's Indigenous identity, I unwittingly reinforced a larger pattern of disciplinary inattention. Psychological and psychiatric anthropologists are skilled in exposing how a person's relative social position, social connectedness, and cultural settings impact upon the aetiology, expression, and

progression of psychosis and manifestations of social defeat (Hopper 2008; Myers 2010; Jenkins and Barrett 2003; Jenkins 2015; Luhrmann and Marrow, 2016). Clinician-anthropologists have taken a more political stance, exposing how structural violence and racism have historically shaped diagnoses of schizophrenia and its treatment (Kelly 2005; Metzl 2009; Eliacin 2013; Hansen 2019). Beyond the medical sphere in Australia, ethnography on the experiences of Indigenous Australians in socially and analytically 'messier' urban settings (in which clozapine clinics are located) has historically been devalued, in favour of ethnography that focuses on remote communities, 'who have experienced fewer dislocations, less cultural trauma and limited racial mixing' (Cowlishaw 2000, 108).

As a discipline that oftentimes hides behind cultural explanations for human differences or conflations between race and class, anthropology has obscured structural racism (Mullings 2005; Baker 2020). Structural racism decentres the social category of race as it might operate at the individual level to instead capture how 'institutions, policies, and structures reproduce racial inequality without overtly targeting its victims' (Mullings 2005, 679). Despite recent calls for an abolitionist and decolonised American anthropology (Shange 2019; Jobson 2020), with some activist efforts from Australian anthropologists in the wake of the murder of Kumanjayi Walker (see Musharbash 2022), the anthropology of mental healthcare has been slow to engage. Clear motivation was evident at the SPA (Society for Physchological Anthropology) 2021 Biennial Meeting of the American Anthropological Association to widen the subdiscipline to include analyses of racism, politics, and justice in its members' research (Lester 2021). Taking action, however, presents a significant challenge to a discipline that has predominantly seen itself as apolitical—a challenge that reverberates across medicine.

The stark racial disparities associated with the COVID-19 pandemic coupled with the 2020 global resurgence of *Black Lives Matter* have galvanised many interdisciplinary medical researchers to focus on issues of structural violence and structural racism in healthcare (Boyd et al. 2020; Sabatello et al. 2020). There is momentum to move beyond the implicit bias of the clinician, or the 'mistrust' experienced by the patient towards the clinician, to examine the intersecting, collective, and systemic factors that breed health inequity. These factors include long-standing exclusionary policies such as housing segregation, disparities in education, incarceration and healthcare access, unrepresentative medical data sets, and the absence of minority voices in academic knowledge and prestigious medical journal publications (Yearby 2018; Boyd et al. 2020; McFarling 2021).

Researchers are operating under the limits of institutions and funding bodies, which often fail to address these problems of systemic racism in their funding opportunities and by not checking for biases across study design, data collection,

and analytic paradigms that tend to exclude communities of colour (McFarling 2021). However, appreciation for an antiracist lens is growing amongst researchers, including in the fields of psychiatry and psychosis research (Shim 2021; Kalin 2021; Anglin et al. 2021; Oluwoye et al. 2021; Morgan 2022).

Decolonising anthropology could happen on a large scale through an antiracist revisioning of past disciplinary questions and through generating an academic culture that includes and appeals to scholars of colour (Gupta and Stoolman 2022). Decolonising subdisciplines, like psychological anthropology, could transpire through antiracist revisions to small-scale fieldwork and analysis. Ethnographic methods are strong enough to capture interpersonal racism in the immediate sense of capturing raw data. However, a more deliberate analytic effort is required to uncover how interpersonal power relates to structural power and racism, and how this intersects with and shapes lived experiences. With this is mind, I returned to my dataset and looked for evidence of how the presences and absences of racism related to broader health disparities and structural inequalities in mental healthcare, which ultimately gave new meaning to the individual experiences of moral agency, or its absence, which I had been trained to see.

Clozapine treatment and structural racism

Perhaps the biggest clue to unearthing evidence of structural racism was in how Keith had accessed clozapine in the first place. He was one of few participants to access this medication due to his incarceration. Access to clozapine is strict because it is a medication with potentially life-threatening side effects. There are just two pathways for people diagnosed with schizophrenia to be given this medication. The first pathway opens up when an individual is deemed to be a danger to themselves and has received enough trials of antipsychotic medications to warrant something stronger. The second opens up when an individual poses a danger to others, often at the point at which they are incarcerated.

For the first pathway, early and sustained access to mental health support is critical. Treatment involves a willing psychiatrist as well as support from others (family or social care services) that renders this process manageable, positive, and trustworthy. Clients require close blood testing and heart monitoring, especially in the beginning of treatment, making clozapine administration infeasible without reliable caregiving. Typically, people are offered or given clozapine while in the hospital, after a suicide attempt, or when family (if not the individual) have advocated for clozapine. In the hospital, it is easier to monitor side effects. In the community, this monitoring is more challenging; there needs to be commitment and trust on the part of the person taking clozapine to stick to the management plan once they have been discharged. The client would first need housing,

productive relationships with family or social workers, and access to basic health services before a clozapine treatment regimen becomes workable.

For those without these structural supports or who have declined treatment previously, the second path in Australia and the UK becomes available when there is a mandatory treatment order from the criminal justice system. Unless blood and heart-related side effects directly endangers their life, many people in forensic psychiatric facilities with a diagnosis of schizophrenia are required to take clozapine. I have a family member in Ireland in this situation and was not personally ready to pursue research on this pathway. Perhaps my position as a White ethnographer with a White family member accessing clozapine in a forensic psychiatric facility produced further obscuration of the role of race and racism in access pathways. In the community clozapine clinic, I met only a small handful of clients who were on parole at the time, which is a form of community supervision that sociologists have critiqued as a shadow 'mass supervision' system to mass incarceration (Phelps 2020). One of these clients was Keith.

Aged 55, Keith was new to clozapine and had accessed medical treatment about thirty years later than many of my research participants of his age who were White. He had been diagnosed with schizophrenia in his forties as part of the criminal procedure that saw him sentenced. He described much of his early life as 'institutionalised': he was held in youth centres from the age of five following the death of his single mother, and was later in and out of foster homes and jail.

In Australia, the genocide and slavery of First Nations people, in the service of settler-colonist society and wealth, has culminated in pronounced health and incarceration inequities (Carson et al. 2007; Battams et al. 2021; Horton 2022). With a life expectancy gap of ten years, and significantly higher unemployment and substance abuse challenges, Indigenous Australians, especially males, are ten times more likely than non-Indigenous Australians to be unhoused and seven times more likely to die by suicide—particularly Indigenous children and adolescents under 15, who are 12 times more likely to die by suicide (Pawson et al. 2018; Calma, Dudgeon, and Bray 2017; Campbell et al. 2016; Gibson et al. 2021). Indigenous Australians are more likely to experience substance abuse and are up to five times more likely to be diagnosed with psychotic illness (Gynther et al. 2019). Despite comprising 3% of the general population, Indigenous Australians comprise 28% of the incarcerated population, and 40% of those who are diagnosed with psychotic illness also experience incarceration, with their diagnosis of psychosis often coinciding with their incarceration (Charlson et al. 2021).

I cannot find precise data on what proportion of Indigenous Australian clozapine clients accessed clozapine through carceral pathways versus community treatment. However, across the global community, people of colour are less likely

to be prescribed clozapine in general than White populations (Williams et al. 2020). In the UK, Black patients diagnosed with treatment resistant schizophrenia are half as likely to be prescribed clozapine as White patients (Das-Munshi, Bhugra, and Crawford 2018). In the US, White American veterans are three times more likely than African American veterans and Hispanic American veterans to be prescribed clozapine (Copeland et al. 2003). In one Australian state (Queensland) with high Indigenous population and psychosis diagnosis rates, only 6% of community-based clozapine clients are Indigenous (Siskind et al. 2019). Thus, clozapine clients are relatively privileged in their access to community treatments and this privilege extends in limited ways to Indigenous Australians like Keith.

Of course, structural, institutional, and interpersonal racism interact and reinforce one another, especially when it comes to inequities in mental healthcare (Nazroo, Bhui, and Rhodes 2019). Keith told me he was staying out of trouble by limiting his non-clinic social interactions to time spent with his sister and nephew, who lived in the same government-housing block. He was otherwise avoiding 'mix[ing] with Blacks', whom he associated with crime and poverty. Keith made it clear that the clozapine clinic offered a lifestyle that was morally 'good', a lifestyle that contrasted with one of crime and poverty; one shaped by White supremacy, the other by anti-Blackness.

Racism and moral agency: Uncomfortable fieldnotes

A return to my fieldnotes revealed that Keith's experience of moral agency depended on which clinical worker he was with, and whether they treated him differently because of their racism or lack thereof. These differences cannot be reduced to professional hierarchies alone, and, in turn, provide a new theorisation of moral agency in the clozapine clinic context. Indeed, one way that anthropologists of mental healthcare can serve as 'vector[s] for therapeusis and moral development' (Bromley 2019, 110) for research participants is by acknowledging where our own racialised positionality is uncomfortably tested against that of both clients and clinicians.

Following one of his psychiatric consultations at the clozapine clinic after Keith had left the room, I wrote in my fieldnotes that his (White) psychiatrist had commented to me: 'at the time Keith was born, Indigenous people weren't able to vote, so he's used to being locked up for acting out'. This comment had followed a tense exchange between Keith and the psychiatrist. I wrote: 'The consult felt a little unnatural, as though [the psychiatrist] was perhaps questioning more than necessary partly for my benefit, asking him if he remembered why he was on clozapine … "now just remind me what the naughty thing you did was?" to which Keith shook his head, "nup"'. I noted how the session had concluded by the

psychiatrist increasing Keith's clozapine dose. In retrospect, this was an instance of structural racism merging with interpersonal racism to shape the clinical encounter.

I had been complicit by not engaging with how the psychiatrist likely would not have made such provocations if I were an Indigenous Australian or person of colour. On another day, I noted how, when the same psychiatrist had asked whether I had any more interviews for the afternoon and I said a follow-up with Keith, they said, 'he's one of our special ones'. I could have asked what he meant, but instead I just let the comment go. Given I had started to form a collegial relationship with the psychiatrist, who was both helping me recruit client participants and serving as a research participant himself, I did not want to make waves. I saw myself as playing a morally supportive role for clients in subtler ways by filling gaps in the clinical circuitry (Brown 2020) and viewing Keith as one of many clozapine clients who should not be treated differently; not 'special' for any reason.

Rereading further, I saw that Keith's interactions with an African Australian nurse, Zoya, had been easier to observe. Zoya built rapport with Keith through demonstrations of her faith in his ability to look after himself. Within the clozapine side effect checklist, Keith was able to shape the clinical conversation around his health concerns. Zoya was also quick to give Keith the benefit of the doubt when he reported that the team had been failing to drop by with his medication each evening (as he was new to clozapine). Whereas other team members would try to jog his memory and suggest that the cannabis he smoked was causing memory challenges, Zoya agreed with Keith that they must have forgotten, blaming the issue on staffing shortages. Having been made aware of Keith's memory challenges (possibly also due to clozapine), I suggested that she check the medical notes. But in learning about previous confusion, Zoya still did not challenge Keith's memory, instead focusing on the future prospect that this medication drop-off arrangement was temporary. He laughed, 'I can do it myself, I'm a big boy now!'

I witnessed how Keith had found ways to express his moral agency in the clozapine clinic, though I had overlooked that he struggled more than his White peers in doing so. I did not interrogate the precise interpersonal dynamics that hindered or helped him, and how those dynamics were racialised. In hindsight, I should have concluded: it was likely a combination of secure housing arrangements, reliable family contacts, regular clozapine clinic visits, *and* Zoya's antiracist interactions with Keith that nourished his moral agency.

Conclusion

It is precisely because structural racism has interpersonal, institutional *and* structural manifestations that anthropologists applying analytic frameworks such as moral agency to mental healthcare may struggle to attend to it. Preoccupied by individual manifestations, we may miss the forest for the trees. As Metzl has cautioned of racism in psychiatry, 'focusing on the individual obscures the impact of the structural' and 'what, or who, its [psychiatry's] ontologies, categories, and provider networks leave out' (2009, 202, 204). Community access to clozapine clinic treatment, I only now see, was a pathway for those with structural support. Keith should have existed as an Indigenous Australian man in my thesis, one of whom had accessed clozapine through the criminal justice system, which reinforced the structural racism he had endured his whole life.

While anthropologists studying mental healthcare are trained to attend to individual and institutional power, if we are to join the wider disciplinary decolonisation efforts in anthropology, we must redress the ways in which anthropological fieldwork and analytic frames focused on the individual can obscure the structural. Structural racism can be appreciated by connecting the threads of interpersonal and institutional power imbalances. My reconsideration of Keith's experience can guide anthropologists of mental healthcare to attend to the question of how race and racism shape moral experience.

Authorship statement

Julia E.H. Brown is the sole author of this manuscript.

Ethics statement

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