Rethinking Psychiatry: Solutions for a Sociogenic Crisis

Helena Hansen, Kevin J. Gutierrez & Saudi Garcia

This essay draws on Frantz Fanon's insights about the sociogenesis of psychiatric disorders, and on the insights of feminist standpoint theory, to sketch a map toward sociogenic mental health. We argue that psychiatry should move away from iatrogenesis (the harms of our current individual-level and pathologizing approach) toward sociogenesis of mental health through robust collaboration with social movements of oppressed people, and their collective healing approaches, ranging from harm reduction centers to community gardens. The essay ends with the outlines of a reinvented, community collaborative psychiatry that supports sociogenesis.

> Our thinking is scarcely able to liberate itself from the anatomo-clinical. We think in terms of organs and focal lesions when we ought to be thinking in terms of functions and disintegration. Our medical view is spatial, where it ought to become more and more temporal.
>
> —Frantz Fanon, *The Psychiatric Writings from Alienation and Freedom*[1]

> Beside phylogeny and ontogeny stands sociogeny.
>
> —Frantz Fanon, *Black Skin, White Masks*[2]

Something is wrong with American psychiatry. Trauma, displacement, and political-economic instability are pervasive. Record rates of drug overdose are named "deaths of despair," the product of dislocation due to increasingly unaffordable housing and the outsourcing of employment. Taken together, these ongoing problems have unraveled our social fabric.[3] The U.S. Surgeon General declared a "youth mental health crisis" based on young Americans' hopelessness and suicide.[4] Racial inequalities across these patterns continue to worsen, with devastating effects on Native American, Black, and Latinx communities, even as white Americans also continue to suffer exponential increases in mental health–related harm and death. Yet U.S. psychiatry has little to offer for these ills. On the contrary, U.S. psychiatry is often a source of inequality and iatrogenic harm, operating within a profit-driven health care system that makes mental

https://doi.org/10.1162/daed_a_02032

health care inaccessible and low-quality even for the white middle class, while clinically supporting police surveillance and mass incarceration in low-income Black and Brown neighborhoods. Psychiatry anchors a medical-prison-industrial complex in which interlocking health care and criminal-legal systems privilege corporate profit-making, and in which the only place Americans are guaranteed mental health services is in jails and prisons.[5] An estimated ten times more people with serious psychiatric diagnoses are incarcerated in prisons than in the remaining state mental hospitals of the United States, making the carceral system the largest provider of public mental health care in the country.[6]

What is the way out of this debacle? Here we (an African American psychiatrist-anthropologist, a Filipino American psychiatrist-narrative medicine scholar, and an Afro-Dominican medical anthropologist-environmental justice activist) draw on Frantz Fanon's insights about the sociogenesis of psychiatric disorders. We also draw on the insights of feminist philosophers of science who developed standpoint theory, including Sandra Harding, Donna Haraway, and Nancy Hartsock, to sketch a map toward sociogenic mental health, supported by a reinvented psychiatry. We argue that psychiatry should move away from iatrogenesis toward sociogenesis of mental health through robust collaboration with social movements of oppressed people.

Though seventy years have passed since Black revolutionary psychiatrist Frantz Fanon published his first book, *Black Skin, White Masks,* his work is just as relevant today. Fanon wrote at a time when psychiatry had begun to differentiate itself from neurology, and during which he was involved in anticolonial liberation movements in Algeria and his native Martinique. Though Fanon has influenced social scholars broadly, his work began with a clinical and scientific interrogation of the differences between neurology and psychiatry. His thesis was a "critique of the biologism of colonial ethnopsychiatry and enabled him to revisit culture in its relation to the body and to history."[7] Fanon trained in an era when the psychiatric discourse oscillated between organogenesis (biological cause) and psychogenesis (psychological cause) of mental illness. His approach transcended these poles to establish the sociogenesis (social and institutional cause) of mental illness.

Fanon's sociogeny posited that the mind, the body, and illness develop in relation to historically produced consciousness and social contexts. Among Black people, these contextually shaped bodily schemas (or habitus) derive from enslavement and colonial racial typologies.[8] The contemporary version of Fanon's sociogenesis would explain the fact that Black men are diagnosed with schizophrenia two to eight times as often as white men by pointing to the severe and persistent educational, employment, and housing segregation of Black Americans, and the fact that Black men are five times as likely to be incarcerated as white men, not to mention that the diagnostic criteria for paranoid schizophrenia historically emerged from stereotypes of Black men as violently paranoid.[9] Critical theorist

Sylvia Wynter drew on Fanon's sociogenesis to conclude that "*what* the brain *does* is itself culturally determined through the mediation of the socialized *sense of self*."[10] Fanon predates and anticipates concepts of structural violence in medicine, yet his sociogeny is rarely cited in medicine, and psychiatry's inattention to sociogenesis persists today.[11]

According to standpoint theory, scientific knowledge emerges from the lived experiences of scientists. In scientific (white male) monocultures, only a narrow slice of human experience guides scientific inquiry and imagination, creating an impoverished scientific knowledge base that confirms the biases of the dominant group. Increasing the range of scientists from different social positions or standpoints (for example, women and people of color) enriches the wellspring of scientific inquiry and imagination, while enhancing the rigor and self-critical ability of the scientific enterprise.[12]

In this essay, we translate insights from Fanon and standpoint theory to recommend that U.S. psychiatry look to movements of socially and politically marginalized people for examples of sociogenic mental health. People who have survived oppression have embodied social-structural knowledge; they have had to resist the toxic ethos of social division and economic extraction. Their techniques redefine mental health away from individual fitness in a social Darwinist dystopia, toward a vision of collective healing through mutual aid.

The spatial and temporal implications of Fanon's sociogeny would, today, lead us to reexamine the fifteen-minute psychopharmacology management regime of contemporary U.S. psychiatry, a regime that reflects health insurance policies and a medication-over-psychotherapy focus of care that limit the contact that psychiatrists can have with patients. Fanon's theories would help us attend to the spatial confines of locked psychiatry units, and of the psychiatric wards of jails and prisons, as well as the lack of integration of clinical services with community organizations and activities. We would be reminded that Fanon himself, when working in an Algerian asylum, asked patients what they wanted, and in response, built a soccer field. The colonial apparatus of containment that Fanon encountered in the Algerian War currently takes the form of the U.S. drug war, in which psychiatry is complicit with mass incarceration by supporting mental health courts and drug courts that give judges and probation officers oversight of mental health care. Organized psychiatry also reinforces the idea that serious mental illness is the cause of widespread homelessness in U.S. cities when psychiatrists cite statistics on rates of serious mental illness among unhoused people while remaining silent on housing policies that allow developers to dislocate residents from their neighborhood networks of support.[13] For effective mental health promotion, we need time and space for sociogenic healing. We also need collective projects that nourish all participants and foster mutual aid rather than competition over scarce resources (for example, community gardening).

Here we offer descriptions of three sociogenic mental health movements that contrast with American psychiatry and are based on our collective participant-observation data. These movements work to restore justice rather than reinforce social inequality. They foreground the knowledge and techniques of people who have survived marginalization and existential threats, rather than pharmaceutical and health insurance company–generated treatment protocols. They honor historical memory and ancestral solutions to health problems rather than patented intellectual property as marketable "innovations." They prioritize ecological sustainability over expanding markets for mass-manufactured consumables. Last, they forgo pathology-focused disease in favor of hopeful structures of feeling – styles of affect that emerge at a historical juncture – generated by collective practices.[14]

One of the most significant mutual aid movements of the late twentieth century was harm reduction, which emerged in the 1980s in response to HIV/AIDS among low-income, largely Black and Brown people and people who inject drugs, as well as among men who have sex with men.[15] Founders of harm reduction identified the neglect of public health officials and the oppression of law enforcement agencies enacting drug policies as the primary drivers of HIV-transmission and deaths, rather than the behavior of individuals. Harm reductionists recognized their life-saving interventions as political acts because many, such as syringe exchange, were illegal at the time. These acts led to legalization of syringe exchange, and to government funding for safer sex education and supplies. Two decades later, in the setting of historic overdose deaths in a national "opioid crisis," harm-reduction organizations pioneered community-based distribution of naloxone overdose-reversal kits, test strips to check drug supplies for the ultrapotent opioid fentanyl, and ultimately safer drug consumption facilities, otherwise known as medically supervised overdose-prevention sites.[16]

As focused as harm-reduction organizations have been on public health practice, as well as policy advocacy and activism to legalize and fund these public health practices – they have also fostered the creation of safe, nonjudgmental social spaces for low-wage earners who use drugs. The ethos of the leading grassroots harm-reduction organizations is one of welcome to all, especially those engaged in drug use or sex work. It is one of participatory decision-making, in which people who use drugs are recognized for their expertise in survival, and are employed as public health practitioners and organizational leaders. It is one of community and mutual support, in which those subject to dehumanizing treatment can find refuge and comfort.

Advocates for a harm-reduction approach to opioid use recognize that drug criminalization and social oppression are stronger drivers of overdose and disease than drugs themselves. This approach has parallels in organizations that ac-

knowledge the social marginalization of people with psychiatric diagnoses as a stronger driver of their poor health outcomes than their psychic states. Rather than attempting to eradicate their psychiatric symptoms, these organizations address the social conditions that isolate and harm people with diagnoses. For example, the Hearing Voices Network of people with auditory hallucinations sees hallucinations as self-protective mechanisms that can guide hearers toward self-understanding, rather than as symptoms of disease to be suppressed with medication. A number of other organizations based on Mad Pride, disability rights, and neurodiversity redefine people with psychiatric diagnoses not as diseased and requiring compulsory medical treatment, but as people with alternative sensitivities and abilities to be supported through a restructuring of society, from accommodations in the workplace and peer-led support organizations to housing-first programs that do not require biomedical treatment as a condition for subsidized housing.[17] Such interventions stop the harms of societal marginalization, rather than striving to eliminate psychiatric symptoms in ways that can themselves cause harm.

To illustrate the ethos of harm reduction and its institutional significance, we draw on participant-observation data from three exemplary harm-reduction organizations: Boom! Health, Atira Women's Resource Society, and the Urban Survivors Union.

Boom! Health, one of New York City's oldest harm-reduction centers, is located in a former warehouse near elevated subway tracks in an industrial section of the South Bronx. Helena Hansen first visited Boom! in 2016 with two psychiatry residents and two pre-medical undergraduates. We were warmly greeted by a middle-aged Puerto Rican woman who wore a jean jacket, had hand tattoos, and identified herself as a peer – someone who uses drugs. She ushered us through the welcome lounge where peer workers handed out packs of sandwiches and naloxone overdose-reversal kits to clients who had come in from the cold. She connected us with our host, an assistant director with a public health degree who had grown up in the neighborhood. We followed the assistant director on a tour of the laundry room, where people who had been living in parks and subway cars could shower while running their clothes through the machines, a resting room where peer workers checked those who napped in lounge chairs for signs of overdose. We passed through a kitchen where peer workers prepared food for visitors, to a set of rooms that hosted support groups on different themes and in different formats: survival sex, intergenerational trauma, an LGBT group, a women's only group. We ended at the Boom! pharmacy, operated by a local pharmacist-training school, where prescriptions for medications including buprenorphine, a maintenance medication for opioid-use disorder, could be filled.

In 2019, Hansen toured Atira Women's Resource Society located on the downtown east side of Vancouver with a group of medical anthropologists.[18] Atira was

internationally known for its safer drug consumption facility reserved for women, Sister Space, which was in actuality a living room – like area on the first floor of an aging high rise, replete with stuffed couches, large windows, and plants that a peer worker meticulously watered. Lighted makeup mirrors that facilitated skin visibility and safer injection into veins – safer because they would not cause the skin breakdown and infection of missed vein injections – were tucked in the corners, making space for a large central table for group meetings. The founder of Atira explained that Sister Space was but one of their many programs, their largest program being hundreds of housing units for women experiencing housing instability and those leaving abusive relationships. Unlike many other low-income housing units, Atira's housing had no requirements for women to be abstinent from drugs, and their children were welcome. In fact, Atira had convinced the British Columbia Child Protective Services authority to allow residents who were using drugs to keep custody of their children by providing twenty-four-hour childcare and early childhood education programs. As the founder explained, many of these women are First Nations (Indigenous) people who had seen multiple generations of children taken from their family's custody due to parental drug and alcohol use. These children were placed in foster care, which elevated their own risk of illicit drug and alcohol use, and therefore also the removal of their own children later in life. For these women, the ability to keep their children enabled their cultural and political survival. Such an arrangement with child welfare agencies would be unthinkable in the United States, where the demonization of mothers who use drugs has justified racially targeted removal of Black American children from their families and communities, with over half of Black families having been subject to child welfare agency surveillance at some point in their lives.[19]

Harm-reduction organizations such as Boom! and Atira are in national and international networks that embed harm-reduction principles and the political voice of people who use drugs into health policy and health systems. The Urban Survivors Union is one such network. With a membership of people who use drugs based in grassroots harm-reduction organizations across the United States, the Urban Survivors Union has launched national and local lobbying efforts to legalize and fund syringe exchange programs and naloxone overdose-prevention kit distribution.[20] Member organizations have run their own trials of fentanyl test strip distribution, and when COVID-19 emerged, its members pioneered virtual safer consumption rooms in which people who were physically isolated and using drugs could monitor each other virtually for signs of overdose. Its members pioneered doorstep delivery of methadone and buprenorphine under COVID-restrictions, and they established computer stations in poor and isolated neighborhoods so that people without digital devices or internet service could attend telehealth visits with methadone or buprenorphine providers. Most recently, a re-

search group of people who use drugs hosted by the Urban Survivors Union conducted a national study of the methadone clinic restrictions that put poor, Black and Brown, disabled, and parenting methadone patients at risk of overdose. Their findings formed the basis for their "Methadone Manifesto," which was featured in the *American Journal of Public Health* and in a national symposium on methadone policy hosted by the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the National Academy of Medicine.[21]

Central to the movement over the past decade to counteract the detrimental impact of systemic racism on mental health is the work of the Brooklyn-based collective Harriet's Apothecary. As several other scholars have noted, Harriet's Apothecary is an example of healing circles dedicated specifically to the trauma of racial oppression.[22] The collective began hosting healing spaces for Black, Indigenous, and queer and trans people in the spring of 2014, supporting the launch of the Movement for Black Lives (Black Lives Matter).[23] Organized as a Black healing collective by Nigerian-born community herbalist Adaku Utah, Harriet's Apothecary "envisions a world where Black, Indigenous, and People of color have the power, healing, and safety needed to live the lives we desire for ourselves and our communities."[24] Named after Underground Railroad conductor Harriet Tubman, the Apothecary remembers and honors Tubman's legacy as a nurse and herbalist who also used botany, geography, astronomy, herbal medicine, and wildlife biology to help lead enslaved people to freedom.[25] The Apothecary holds a plethora of events, including healing villages that train participants in herbal medicine and mindfulness techniques oriented to collective healing and reparations for Black people.[26]

Between 2015 and 2019, Saudi Garcia attended six of the Apothecary's healing villages, including one that was held at the Women's March on Washington in 2017 in partnership with the Movement for Black Lives. Harriet's Apothecary convened in multiple sites, including the Black Women's Blueprint in Crown Heights, a community arts center in East New York, the Brooklyn Museum of Art, and Soul Fire Farm in upstate New York. Its seasonal healing villages were structured as serene spaces where women and queer and trans Black people could feel safe, affirmed, and loved. Those entering these healing spaces were greeted by a small circular table with an altar decorated with a framed black and white portrait of Harriet Tubman sitting proud with her hands gently folded on her lap. Other Black feminist ancestors, such as Audre Lorde, Fannie Lou Hammer, and Toni Morrison, filled the space. Shells, feathers, incense, handwritten notes, candles, scattered earth, and a glass of water also sat alongside the altar beside a curtain quilted from colorful pieces of cloth. Over the years, the quilted curtain grew longer as guests of healing villages were invited to add panels with wishes for love, libera-

tion, and healing. Each apothecary was held in honor of the change of the season. The timing of the event itself invited participants to notice how their minds, bodies, and energy levels changed with the seasons.

Attendees described systemic racism's impact on community mental and physical well-being. They spoke of health not through the lens of biomedicine, but through the lens of ancient and contemporary plant medicine, food as medicine, and energy-based healing therapies. The events featured local healers who offered their services according to ability to pay, including art therapy, massage, somatic bodywork, nutritional counseling, acupressure, acupuncture, essential oil therapy, Thai yoga massage, reiki, arts-based herbalism, plant-based medicine making, spiritual practices, peer-to-peer counseling sessions, and healing justice workshops. These services were meant "to restore and expand our community's abilities to transform stress and heal trauma."[27] Healing villages offered plant-based meals catered by a local, often Black- or POC-owned restaurant or caterer. Guests would proceed to group sessions centered on processing collective trauma, or to individual therapies for emotional and mental health. Throughout the day, collective song and movement circles invited participants to become fully embodied and release tensions, stress, and feelings of disconnection.

The Apothecary's healing villages are vital because they provide a space for Black people to reconnect with the shreds of the land-based identities and practices that their ancestors, many of whom had lived off the land for generations, had left them. It is a space to acknowledge the harm continually done to their bodies as they survived and moved toward freedom, and to recognize their capacity to protect and heal themselves. In the words of author Carol Zou, "Harriet's Apothecary creates the space to produce multiple narratives about how these traumas [slavery, colonialism, capitalism] manifest and are perpetuated in a contemporary individual body."[28]

Through a decade of advocacy and narrative shift about the intersections of historical trauma and the medical industrial complex, Harriet's Apothecary has conspired with other Black feminist movement leaders in the United States to develop the political philosophy that has come to be known as healing justice.[29] In her participation in the healing villages, Garcia observed how the Apothecary's members and frequent guests were interpersonally linked to Black feminist movements and land-based healing hubs in other parts of the United States. These included the Audre Lorde Project; Soul Fire Farm, the most prominent Black farming hub in the Northeastern United States and a founding member of the Northeastern Farmers of Color Network; Southerners on New Ground; and the Detroit-based Allied Media Conference and Emergent Strategies Immersion Institute. As a 2020 conversation between Adaku Utah; Black, queer and trans, and people of color liberation movement leader Cara Page; and restorative justice and abolition movement leader Mariame Kaba revealed, Harriet's Apothecary is intertwined

with other Black feminist leaders seeking autonomous, community- and land-based solutions to historical trauma and racial and social injustice.[30] Their concerns with ecological preservation and connection to land are central, as reflected in the contributions of the Black farmers' movement through herbal healing and cultivation workshops, as well as farm schools to teach self-sustenance through cultivation and nutrition.

Over the past decade, public health discourse in the United States has focused on food deserts and the aggressive marketing of cheap, nutrient-poor, and calorie-dense processed and fast foods in low-income communities of color as an explanation for their disproportionate diabetes and cardiovascular disease. Environmental justice movements in those communities have further highlighted their lack of green spaces and canopy cover as mental and physical health risks in the era of climate change, as well as the emergence of urban farms and community gardening as a countermeasure.[31] Many U.S. cities and towns have launched local urban farming and community garden initiatives that produce food and increase social connectedness.[32] Studies of the impact of green space creation on abandoned lots and of desegregating city neighborhoods by removing highway overpasses and other race and class barriers by constructing parks and public green spaces demonstrate the mental and physical health benefits of greening the built environment.[33]

New Haven, Connecticut, is one of many U.S. cities that has supported urban farming as health promotion. New Haven Farms collaborates with a local federally qualified health center to serve Medicaid patients in a low-income, primarily Latinx neighborhood. Farm founders started a nonprofit compost collection and sales company that generated income to support the purchase of land and equipment, as well as a cooking school for area residents. Health center providers began writing prescriptions for farm participation to patients at risk for diabetes and other chronic conditions. They presented preliminary pre- and postparticipation data at a local medical school showing that participants' hemoglobin A1C levels, a measurement of blood sugar, went down. Urban farm and community garden organizers also noted the mental health impact of group cultivation, which became a way to build a sense of belonging and social support for local residents.[34]

In 2018–2019, Hansen participated in a community garden founded at the New Haven Armory, which hosted support groups on topics ranging from coping with depression to substance use, along with exercise classes as well as food and clothing drives to support local families in crisis. Psychiatry residents from a nearby training program volunteered as support group coleaders and provided mental health referrals when needed. A local farmer with formal horticultural and environmental training helped participants to label each plant bed with the medicinal and nutritional properties of the crops being harvested.[35]

Hansen had previously worked as a psychiatrist in the outpatient addiction clinic of Bellevue Hospital, which hosted a sobriety garden planted and cultivated by patients and staff. The sobriety garden, which operated for twenty-five years on a half-acre plot bordering the hospital and Franklin Delano Roosevelt Highway, was both a site for horticultural therapy and community-building for a socially disconnected patient population, often referred from the city's homeless shelter system or mandated to the clinic by drug courts. On any given weekday from March to November, patients would be found side by side with clinic staff tilling the soil, weeding, and watering or harvesting flowers, nectarines, pears, raspberries, melons, squash, beans, corn, tomatoes and greens, as well as building benches, trellises, or garden sculptures. Clinical staff saw gardening as uniquely therapeutic for patients who had extensive trauma histories that made them uncomfortable in traditional in-office talk therapy. The embodied nature of working in the soil led to forms of physical expression and conversation that would not have been possible within a clinical office. In addition, the seasonal cycles of communal planting, tending, and harvesting, as well as patients' cooking groups in which people who often had not prepared their own food in many years learned to feed themselves, held symbolic significance for those who were also cultivating their own recovery. On weekends, the garden served as a nidus of social connection, hosting holiday barbecues and musical events as well as sobriety anniversary and birthday parties over the years. People came to the garden when in emotional crisis or on the verge of relapse to recenter themselves and find a sense of refuge. The garden housed sculptures created by patients who used pieces of their family chinaware and jewelry as accents in lions, rams, and a huge serpent biting its tail (representing the circle of life) that framed the garden beds, forming an oasis in the midst of family and neighborhood violence. As the director of the clinic and founder of the sobriety garden, Annatina Miescher explained that she practiced psychiatry as "art with found objects: our job is to help people take the shards of their difficult lives and put them back together in new and beautiful ways."

Urban farms and community gardens in many other cities and towns have similarly taken on community building and health promotion functions. The Los Angeles Unified School District launched an initiative to create urban farms on all of its public school lots as part of a health and environment education program.[36] This initiative has the potential to significantly increase green space and canopy cover in Los Angeles County, where the school district is the single largest landholder, and where lack of green canopy has been identified as a major driver of unequal deaths by neighborhood, race, and class during heat waves, as well as a primary driver of deaths among people on psychiatric medications that compromise their auto-regulation of body temperature.

Urban farms are also a lever for racial justice in low-income communities of color that have been displaced from their lands and moved to food and canopy

deserts. This forced dislocation has affected Indigenous, Black, and Latinx farmers in agricultural areas as well as city residents forced out of their neighborhoods by high housing prices and gentrification. Urban farms and community gardens not only provide food; they also transmit cultural knowledge as a remedy for ruptured relationships among people and the land.[37] They remediate root causes of sociogenic mental health problems.[38]

These models of community-based mental health promotion address the deficits of American psychiatry on several levels. They foster collective wellness rather than rooting out personal pathology. They cultivate connection and belonging rather than individual treatment in psychiatric units that separate patients from community life. They embrace difference rather than conformation to "normal" behavior. They teach plant-based treatments, and body and mind training rather than relying on pharmaceuticals. Through community organizing and policy advocacy, they ultimately address the political drivers of mental distress, including structural oppression by race, ethnicity, class, migrant status, gender, and sexual orientation.

This begs the question: what is the role of psychiatrists in these models? First, biomedical practitioners have participated in community-based initiatives from their beginnings. Registered nurses were primary co-organizers, alongside people who use drugs, of the first harm-reduction sites in Vancouver in the 1980s and 1990s. In the United States, physicians, nurses, and other medical professionals were key collaborators in early syringe exchange sites, they conducted research on the effectiveness of syringe exchange that led to its legalization, and they staffed innovative medical service units, such as mobile harm-reduction vans offering clean syringes during the early years of the AIDS epidemic and, more recently, naloxone overdose-reversal kits, fentanyl test strips, buprenorphine prescriptions for opioid use disorder, and treatment referrals.[39] Their work demonstrates the value of biomedical clinics crosslinking with community-based care to offer trusted and timely treatment for those with acute and serious needs. Biomedical practitioners who prescribe farming and gardening as therapy, and who augment the mental health support and education provided at those sites, show how biomedical and holistic community-based health interventions can be joined.

Even the biological turn of contemporary psychiatry, which stems from the materialist, reductionist impulse of Western biomedicine to root psychic phenomena in the brain and body – currently in neurotransmitters and genes – can illuminate the mechanisms by which community-building, social justice initiatives, and green spaces are beneficial. Psychiatric research can foreground the biosocial turn in the life sciences – to neuroplasticity, epigenetics, and the microbiome in gut-brain interaction – to explain how social environments influence brain development and function. This would require an inversion of the received wisdom that

socially dysfunctional behaviors are driven by inherited biological traits. It would lead us to ask instead how social techniques have biological effects. In a Western cultural framework in which psychic phenomena are only "real" if they can literally be seen in the body – through neuroimaging and molecular markers – biological psychiatry can legitimize mental health-fostering social technologies.[40]

American psychiatry's own survival as a specialty is at stake. Even before the COVID-19 pandemic, over the backdrop of critical shortages of psychiatrists in public clinics and hospitals, U.S. physicians were reporting record levels of burnout and leaving clinical practice.[41] The leading reasons offered for burnout involved providers' inability to address the social and systemic drivers of their patients' health outcomes. For psychiatry to survive as a profession, to attract and retain practitioners, psychiatrists must be enabled to intervene on social and systemic drivers of their patients' health.[42]

What would it take to promote such a paradigm shift? It would require clinical practitioners to elevate the status of community organizations and nonpharmaceutical interventions at all levels of psychiatric training, practice, and institutions, as well as to directly address the institutional and policy drivers of poor health outcomes through collaboration with community organizations, other public sectors such as schools, parks and recreation, and legal aid organizations, not to mention policy advocacy. A growing chorus of academic medicine leaders are calling for such a shift, with terms ranging from "upstream healthcare" to "structural competency."[43] Medical schools in the United States are adding curricula in social determinants of health and health justice. Medical students and residents are calling for faculty who are cross-trained in critical social science and humanities scholarship to teach these topics.

The missing element in these efforts is a change in the balance of power. Change requires robust partnerships with low-income and marginalized communities that respect the expertise of those with lived experience. For instance, Yale University's Program for Recovery and Community Health is led by faculty with lived experience of serious psychiatric diagnoses, and employs community leaders with lived experience as instructors and researchers.[44] Charles Drew University in Los Angeles, founded in 1969 on the heels of the Watts riots to address long-standing medical neglect of Black and Latinx residents, has long hired community faculty who have expertise in community-organizing for health justice rather than biomedical degrees.[45] Ultimately, biomedically trained practitioners themselves must be intentionally recruited from the communities least served by, and historically exploited by, biomedicine. One successful model for this in psychiatry is the Minority Mentor Network of the University of Texas, a network of psychiatrists from groups underrepresented in medicine who organized themselves and secured institutional support to mentor and support each other at all levels. The mentoring starts with pre-medical students from communities under-

represented in medicine, and continues at each level of professional growth, as interns and residents mentor the medical students, junior faculty mentor residents and fellows, and senior faculty mentor junior faculty. In its first decade, the network significantly increased the diversity of faculty members and leaders in psychiatry departments in the University of Texas system.[46]

Ultimately, changing the psychiatric paradigm involves contending with the economic, as well as political, foundations of practice. Change will not come from the pharmaceutical and health insurance companies that currently drive professional practice, nor from health policymakers or regulators. Psychiatrists must organize this change, in recognition of Rudolph Virchow's famous observation in 1848 that "Medicine is a social science, and politics nothing but medicine at a larger scale," with the addition that medicine is also politics, on a community-partner and clinician-training scale.[47]

ABOUT THE AUTHORS

Helena Hansen is Professor of Psychiatry and Cochair of Research Theme in Translational Social Science and Health Equity at the David Geffen School of Medicine, as well as Associate Director of the Center for Social Medicine at UCLA. She has published in journals such as *JAMA*, *The New England Journal of Medicine*, and *Social Science and Medicine*.

Kevin J. Gutierrez is a resident psychiatrist at New York University Langone Medical Center, and a former Minority Fellow in the American Psychiatric Association and Substance Abuse and Mental Health Services Administration. He is a former instructor in the Master of Science in Narrative Medicine Program at Columbia University. His work on the integration of critical race theory, decolonial theory, and the medical humanities into medical education has been published in journals such as *The New England Journal of Medicine*, *Academic Medicine*, and *Journal of Medical Humanities*.

Saudi Garcia is a Mellon Postdoctoral Research Fellow and incoming Assistant Professor of Anthropology (2024) at The New School. She has published in journals such as *The Lancet* and *Tapuya: Latin American Science, Technology and Society*.

ENDNOTES

[1] Frantz Fanon, *The Psychiatric Writings from Alienation and Freedom*, ed. Jean Khalfa and Robert J. C. Young, trans. Steven Corcoran (New York : Bloomsbury Publishing, 2020), 51.

[2] Frantz Fanon, *Black Skin, White Masks*, trans. Charles Lam Markmann (New York : Grove Press, 1967), 11.

[3] Anne Case and Angus Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton, N.J. : Princeton University Press, 2020).

[4] U.S. Department of Health and Human Services, "U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic," December 7, 2021, https://web.archive.org/web/20211211081852/https://www.hhs.gov/about/news/2021/12/07/us-surgeon-general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html.

[5] Daniel Eisenkraft Klein and Joana Madureira Lima, "The Prison Industrial Complex as a Commercial Determinant of Health," *American Journal of Public Health* 111 (10) (2021) : 1750–1752, https://doi.org/10.2105/AJPH.2021.306467 ; Barbara Ehrenreich and John Ehrenreich, "The Medical-Industrial Complex : *Men, Money and Medicine* by Eli Ginzberg and Miriam Ostow," *The New York Review of Books*, December 17, 1970, 14, https://www.nybooks.com/articles/1970/12/17/the-medical-industrial-complex ; and Henry J. Steadman and Joseph J. Cocozza, eds., *Mental Illness in America's Prisons* (Seattle : National Coalition for the Mentally Ill in America's Prisons, 1993).

[6] Treatment Advocacy Center, "Serious Mental Illness Prevalence in Jails and Prisons," September 1, 2016, https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695.

[7] Fanon, *The Psychiatric Writings from Alienation and Freedom*, xii.

[8] Fanon, *Black Skin, White Masks*. For more on *habitus*, see Pierre Bourdieu, *Outline of a Theory of Practice*, trans. Richard Nice (Cambridge : Cambridge University Press, 1977).

[9] Ashley Nellis, "The Color of Justice : Racial and Ethnic Disparity in State Prisons," The Sentencing Project, October 13, 2021, https://www.sentencingproject.org/reports/the-color-of-justice-racial-and-ethnic-disparity-in-state-prisons-the-sentencing-project ; Robert Schwartz and David M. Blankenship, "Racial Disparities in Psychotic Disorder Diagnosis : A Review of the Empirical Literature," *World Journal of Psychiatry* 4 (4) (2014) : 133–140, http://dx.doi.org/10.5498/wjp.v4.i4.133 ; and Jonathan M. Metzl, *The Protest Psychosis : How Schizophrenia Became a Black Disease* (Boston : Beacon Press, 2010).

[10] Sylvia Wynter, "Towards the Sociogenic Principle : Fanon, Identity, the Puzzle of Conscious Experience, and What It Is Like to Be 'Black,'" in *National Identities and Sociopolitical Changes in Latin America*, ed. Antonio Gomez-Moriana and Mercedes Duran-Cogan (London : Routledge, 2001), 37.

[11] Andrea J. Pitts, "That Close and Contagious Death : Symptomatology, Sociogeny, and Structural Oppression," *Theory & Event* 24 (2) (2021) : 621, https://doi.org/10.1353/tae.2021.0032.

[12] Sandra Harding, ed., *The Feminist Standpoint Theory Reader : Intellectual and Political Controversies* (London : Routledge, 2004) ; Nancy C. M. Hartsock, *The Feminist Standpoint Revisited, and Other Essays* (London : Routledge, 1998) ; and Donna Haraway, "Situated Knowledges : The Science Question in Feminism and the Privilege of Partial Perspective," in

Feminist Theory Reader: Local and Global Perspectives, 5th edition, ed. Carole McCann and Seung-Kyung Kim (London: Routledge, 2020), 303–310.

[13] Mindy Thompson Fullilove, *Root Shock: How Tearing Up City Neighborhoods Hurts America, and What We Can Do About It* (New York: New Village Press, 2004).

[14] Raymond Williams, *Marxism and Literature* (Oxford: Oxford University Press, 1977).

[15] Don C. Des Jarlais, "Harm Reduction in the USA: The Research Perspective and an Archive to David Purchase," *Harm Reduction Journal* 14 (1) (2017): 1–7, https://doi.org/10.1186/s12954-017-0178-6.

[16] National Harm Reduction Coalition, "Evolution of the Movement," https://harmreduction.org/movement/evolution (accessed September 7, 2023); and Shoshana V. Aronawitz, Jennifer J. Carroll, Helena Hansen, et al., "Substance Use Policy and Practice in the COVID-19 Pandemic: Learning from Early Pandemic Responses through Internationally Comparative Field Data," *Global Public Health Reports* 17 (12) (2022): 3654–3669, https://doi.org/10.1080/17441692.2022.2129720.

[17] See The Icarus Project NYC, http://nycicarus.org (accessed September 7, 2023); Fireweed Collective, https://fireweedcollective.org (accessed September 7, 2023); Mad in America: Science, Psychiatry, and Social Justice, https://www.madinamerica.com (accessed September 7, 2023); and Summer Schrader, Nev Jones, and Mona Shattell, "Mad Pride: Reflections on Sociopolitical Identity and Mental Diversity in the Context of Culturally Competent Psychiatric Care," *Issues in Mental Health Nursing* 34 (1) (2013): 62–64, https://doi.org/10.3109/01612840.2012.740769.

[18] See Atira Women's Resource Society, https://atira.bc.ca.

[19] Dorothy Roberts, *Torn Apart: How the Child Welfare System Destroys Black Families – and How Abolition Can Build a Safer World* (New York: Basic Books, 2022).

[20] See Urban Survivors Union, https://www.druguservoice.org.

[21] Caty Simon, Louise Vincent, Abby Coulter, et al., "The Methadone Manifesto: Treatment Experiences and Policy Recommendations from Methadone Patient Activists," *American Journal of Public Health* 112 (S2) (2022): S117–S122, https://doi.org/10.2105/AJPH.2021.306665; and Lisa Bain, Sheena M. Posey Norris, and Clare Stroud, *Methadone Treatment for Opioid Use Disorder: Improving Access through Regulatory and Legal Change: Proceedings of a Workshop* (Washington, D.C.: National Academies Press, 2022), https://nap.nationalacademies.org/catalog/26635/methadone-treatment-for-opioid-use-disorder-improving-access-through-regulatory.

[22] Jeremy Andersen, Ed Altwies, Jonah Bossewitch, et al., "Mad Resistance/Mad Alternatives: Democratizing Mental Health Care," in *Community Mental Health: Challenges for the 21st Century*, 3rd ed., ed. Samuel J. Rosenberg and Jessica Rosenberg (London: Routledge, 2017), 19–36; and Carol Zou, "Post-Traumatic Stress Poetics in Socially Engaged Art: Healing as Praxis," in *Contemporary Art and Disability Studies* (London: Routledge, 2019), 87–98.

[23] "A Brief History of Civil Rights in the United States: The Black Lives Matter Movement," Vernon E. Jordan Law Library, Howard University School of Law, last modified January 6, 2023, https://library.law.howard.edu/civilrightshistory/BLM.

[24] Harriet's Apothecary, "Who We Are," http://www.harrietsapothecary.com/who-we-are (accessed September 7, 2023).

[25] Liza Weisstuch, "Harriet Tubman Is Famous for Being an Abolitionist and Political Activist, but She Was Also a Naturalist," *Smithsonian Magazine*, March 10, 2022, https://www.smithsonianmag.com/history/harriet-tubman-is-famous-for-being-an-abolitionist-and-political-activist-but-she-was-also-a-naturalist-180979689.

[26] For a sample of such events, see "Beatbox Botanicals Presents: Harriet's Apothecary Summer Edition," June 13, 2015, https://www.facebook.com/events/818829208201045.

[27] Harriet's Apothecary, "What We Do," http://www.harrietsapothecary.com/what-we-do (accessed September 14, 2023).

[28] Zou, "Post-Traumatic Stress Poetics in Socially Engaged Art," 95.

[29] Mia Mingus, "Medical Industrial Complex Visual," Leaving Evidence, February 6, 2015, https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual; and Deva R. Woodly, *Reckoning: Black Lives Matter and the Democratic Necessity of Social Movements* (Oxford: Oxford University Press, 2021).

[30] Adaku Utah, Cara Page, and Mariame Kaba, "Healing and Transformative Justice: Imagining Black Feminist/Abolitionist Futures," Goethe-Institut New York, July 31, 2020, https://www.youtube.com/watch?v=3fDHrgaTmpo.

[31] Sungmin Lee, Ryun Jung Lee, and Sebastian Scherr, "How Tree Canopy Cover Can Reduce Urban Suicide Attempts: A Geospatial Analysis of the Moderating Role of Area Deprivation," *Landscape and Urban Planning* 230 (2023): 104606, https://doi.org/10.1016/j.landurbplan.2022.104606; and Xiaoqi Feng, Renin Toms, and Thomas Astell-Burt, "The Nexus between Urban Green Space, Housing Type, and Mental Health," *Social Psychiatry and Psychiatric Epidemiology* 57 (9) (2022): 1917–1923, https://doi.org/10.1007/s00127-022-02266-2.

[32] Lucy O. Deikmann, Leslie C. Gray, and Chan Le Thai, "More than Food: The Social Benefits of Localized Urban Food Systems," *Frontiers in Sustainable Food Systems* 4 (2020): 29, https://doi.org/10.3389/fsufs.2020.534219.

[33] Charles C. Branas, Eugenia South, Michelle C. Kondo, et al., "Citywide Cluster Randomized Trial to Restore Blighted Vacant Land and Its Effects on Violence, Crime, and Fear," *Proceedings of the National Academy of Sciences* 115 (12) (2018): 2946–2951, https://doi.org/10.1073/pnas.1718503115; and Mindy Thompson Fullilove, *Urban Alchemy: Restoring Joy in America's Sorted-Out Cities* (New York: New York University Press, 2013).

[34] John Hanc, "What the Doctor Ordered: Urban Farming," *The New York Times*, November 6, 2014, https://www.nytimes.com/2014/11/07/giving/what-the-doctor-ordered-urban-farming-.html.

[35] Allison Hadley, "Urban Agriculture and Food Justice Take Root in New Haven," Edible Nutmeg, December 10, 2020, https://ediblenutmeg.ediblecommunities.com/food-thought/urban-agriculture-and-food-justice-take-root-new-haven.

[36] Los Angeles Unified, "Los Angeles Unified School Board Moves Forward to Create New School Gardens and Community-Shared Outdoor Spaces," February 9, 2021, https://achieve.lausd.net/site/default.aspx?PageType=3&DomainID=4&ModuleInstanceID=4466&ViewID=6446EE88-D30C-497E-9316-3F8874B3E108&RenderLoc=0&FlexDataID=102549&PageID=1%5C.

[37] Karen Washington, "How Urban Agriculture Can Fight Racism in the Food System," Civil Eats, July 10, 2020, https://civileats.com/2020/07/10/op-ed-how-urban-agriculture-can-fight-racism-in-the-food-system.

[38] Thin Lei Win, "In the U.S., Black-Run Urban Farms Fight Food Inequality," *Context*, July 28, 2020, https://www.context.news/socioeconomic-inclusion/long-read/in-the-us-black-run-urban-farms-fight-food-inequality.

[39] National Harm Reduction Coalition, https://harmreduction.org (accessed September 7, 2023).

[40] Joseph Dumit, *Picturing Personhood: Brain Scans and Biomedical Identity* (Princeton, N.J.: Princeton University Press, 2004).

[41] Tait D. Shanafelt, Sonja Boone, Litjen Tan, et al., "Burnout and Satisfaction with Work-Life Balance among U.S. Physicians Relative to the General US Population," *Archives of Internal Medicine* 172 (18) (2012): 1377–1385, https://doi.org/10.1001/archinternmed.2012.3199; and Rachel Willard-Grace, Margae Knox, Beatrice Huang, et al., "Burnout and Health Care Workforce Turnover," *The Annals of Family Medicine* 17 (1) (2019): 36–41, https://doi.org/10.1370/afm.2338.

[42] Fenton, *Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health, Summary of Findings from a Survey of America's Physicians* (Princeton, N.J.: Robert Wood Johnson Foundation, 2011).

[43] For "upstream healthcare," see HealthBegins, https://healthbegins.org (accessed September 7, 2023); and for "structural competency," see Structural Competency: New Medicine for Inequalities That Are Making Us Sick, https://structuralcompetency.org (accessed September 7, 2023).

[44] The Yale Program for Recovery and Community Health, https://medicine.yale.edu/psychiatry/prch (accessed September 7, 2023).

[45] "CDU Community Research," Charles R. Drew University of Medicine and Science, https://www.cdrewu.edu/research/Center/Community (accessed September 7, 2023).

[46] Toi Blakley Harris, Ayesha Mian, James W. Lomax, et al., "The Texas Regional Psychiatry Minority Mentor Network: A Regional Effort to Increase Psychiatry's Workforce Diversity," *Academic Psychiatry* 36 (1) (2012): 60–63, https://doi.org/10.1176/appi.ap.09070107.

[47] Ryan Meili and Nigel Hewett, "Turning Virchow Upside Down: Medicine Is Politics on a Smaller Scale," *Journal of the Royal Society of Medicine* 109 (7) (2016): 256–258, https://doi.org/10.1177/0141076816656482.