

Sharing Wisdom(s) to Enrich Knowledge: Working in a Transdisciplinary Research Team in Medical Anthropology

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ABSTRACT

This paper explains our experience working in a transdisciplinary research team focused on adolescence mental health. It introduces briefly the two key theoretical concepts: participation and transdisciplinarity. In order to be followed with a deep description of the methodology and the creation of the two principal materials resulting from our research: a guide of best practices in adolescent mental health, and a documentary film. Showing in a practical way how the research could be enhanced by the sharing of knowledge.

Key words: *adolescence, mental health, participation, research-action, transdisciplinarity, anthropology, Spain*

Introduction

The use of participative methodologies as a way of approaching anthropological research is a trend that is increasing in the last years. Each time more researchers decide to use this methodological approach in their projects and investigations; because it provides interesting and meaningful results both in an academic and practical way. But this methodology is not as new as somebody could think. Since the beginning of 1940, and increasingly since 1960, a lot of participative initiatives have been documented (mainly in Latin America) addressed to become the community participation into the key element in the health attention field¹. It was not until the meeting of Alma Alta, which took place in 1978, that the participation in health was defined and considered as the cornerstone of the strategy in primary attention in health; promulgating in it the goal of Health for All by the year 2000². After that, in 1986, at the first International Conference of Health Promotion in Ottawa the basic guidelines to improve a »Health for All« were established: social participation and inter-sectoriality³. The increasing use of transdisciplinary methodology occurred in parallel during this decade with »a profusion of projects drawing together social and health scientists to study and recommend solutions for a wide range of health problems«⁴, what is not a coincidence. »New modes of thinking and action and new ways of relating to other modes of thought were required«⁴

and transdisciplinary approach was the key because like Rosenfield said: »it provides the critical element missing from collaborative research as the latter has developed in the 1980's and 1990's«⁴.

Transdisciplinary research counts on the common work of professionals from different disciplines who use shared conceptual framework, blurring the borders between disciplines to construct together new theories, concepts and methods that allow to deal with the common problem in a new and holistic way; developing new conceptual and empirical analyses. It can provide »a more comprehensive organizing construct that more closely represent the historical and present-day reality in which health problems are situated«⁴.

As we can observe through the experience done by several research projects there is no doubt that a participatory methodology in research brings a lot of advantages such as: horizontal communication, symmetric relationships and reciprocity among researchers and informants, it promotes the dialogue and the debate among participants, it is nourished by the members of the group's plurality knowledge (laity and expert), and it achieves that all the participants could feel themselves as an integral and active part of the research, among others. To be able to count with these advantages in our research projects is

always interesting, but for working in field of health it is particularly recommended⁵⁻⁹. And if moreover we have the chance to work in a transdisciplinary research team both the process and the results will be enhanced^{10,11}, as I am going to show along this paper, depending on our research experience focused in adolescent mental health.

The importance of working in transdisciplinary teams in a participative way in the field of health resides, between other factors, in the omnipotent influence of what it is known as »Medical Hegemonic Model« (Modelo Médico Hegemónico). This model generates, in a very subtle way, deep and important asymmetries in both the relationships and the working with the health care system. The majority of participative processes in health are influenced by the biomedic hegemony and its inherent asymmetry¹². The Medical Hegemonic Model is defined by Menéndez like: »the combination of practices, knowledge and theories generated by the development of what is known as a scientific medicine, which has been making to leave as subordinate to the set of practices, knowledge and ideologies that dominated in the social groups, to identify itself as the only way of addressing discomfort, legitimized by both scientific criteria and the State«¹³.

According to this concept we could observe how the specific social involvement of the health sector is under the biomedical paradigm. It »has influenced a particular view on the importance of the scientific physician, which in practice means less legitimacy of medical and other professionals«¹⁴ »and the community in general to take decisions related to the field of knowledge of the professional producing a kind of resignation to control resources and meanings in relation to their own health«⁹. For example the treatments and therapies that the public state health considers to be valid and effective and that therefore it offers citizens are exclusively those of biomedical type, where the opinion of the scientific physician is the only valid. If the patient wants to realize a type of treatment different from the biomedical one it has to resort to the private sector and finances it by himself.

In fact the figure of the doctor and the whole health team is still positioned in a place that in related terms has such asymmetry that makes it difficult to carry forward greatly cutting participatory processes. In order to overcome this situation and to advance participation in health the question of the Medical Hegemonic Model becomes necessary as source of definition and mediator of any process of social participation.

Mental health is a subfield where this omnipotence of the Medical Hegemonic Model and its consequences are easily observed. The stigmatization of the patients increases the named asymmetry, positioning in this way the persons in an even lower location. In order to fight against this phenomenon a lot of creative initiatives have emerged in this subfield during last decades¹⁵⁻¹⁸. It is seen that the implementation of participative projects in mental health helps to put mental health patients in a better position, considering them as citizens with the same rights and obligations as the others¹⁹. Participation in Mental Health contributes to give to the people a new and different place

to create new roles and relations, far from the common places characterized by the medicalization and stigmatization²⁰. People with mental health problems need to have meeting points where the stigma of mental health is not present²¹. It is in these new spaces where their experiences and narratives are listened to and valued. It is the use and sharing of this »expert/ lay knowledge« obtained through Participation in Mental Health which could contribute to promote initiatives to overcome the asymmetry of the health care system.

Our research project becomes a good example of this fact. It is entitled: »The emotional distress of adolescents: lifestyles, mental health, and lay strategies used in managing adversity«. It is funded by the Spanish Ministry of Science and Innovation, and by TV3's Marató Foundation, which started in 2009. The main aim of our project was to analyze the social profiles of adolescents with depressive or anxiety disorders and/or subclinical distress, and whether they use or avoid the mental health services.

Avoidance

Mental health problems – particularly subclinical distress conditions, depression and anxiety – are common in adolescents and young adults. In Catalonia, the prevalence of mood disorders is 14.3% and the prevalence of anxiety disorders is considerably higher (31.9%). Despite this, young people are the age group that makes the least use of mental health services. The studies carried out by Merikangas et al.²² and Gulliver, Griffiths and Christensen²³, among others, have found that in many high-income countries only 18–34% of adolescents with diagnosable depressive disorders or anxiety disorders are treated by mental health professionals, even when the service is provided free of charge by the national health system. In order to investigate and analyze this phenomenon a transdisciplinary team composed of several professionals from social and health sciences was recruited; designing together this participative research-action project which counted with the active collaboration of adolescents and young people.

Ours is the first systematic study to have been made in Spain on non-help-seeking among adolescents and young adults with depressive mental distress. The objective of this article is to show, from our own experience, the potentials that this kind of participatory research-action would make on a transdisciplinary mode. Presenting for this two of the main materials that have been emerged like relevant results in our research project: a Guide of Best Practices and a Documentary Film.

Materials and Methods

We used a mixed methods approach to analyze this phenomenon: quantitative-qualitative. First we made a statistical analysis of the Panel of Families and Childhood (PFC), a database drawn up after a longitudinal study of more than 3000 Catalan adolescents designed by the Con-

sorci Institut d'Infància i Món Urbà (CIIMU). The PFC was a longitudinal sociological study done in four waves. It started in 2006 selecting a representative sample of 3004 adolescents living in Catalonia, who were born between 1990 and 1993. New cohorts were included each year during the PFC investigation^{24–26}. The PFC followed a multi-phase sampling. 70 educational centers from all the Catalan territory were selected. The 3004 informants were recruited from these centers; and they were asked about negative emotional states using a self-reported scale (years 2007–2008) and about the previous existence of a depression/anxiety diagnosis (years 2006 and 2010), among lots of other factors. The first stage of our project consisted of analyzing all the quantitative data compiled in the SPSS database from this Panel (PFC), which lasted one year.

Secondly we made an ethnographic study of 105 cases selected from this big sample. The ethnographic method was used because the dialogic relationship it provides supplies the epistemological and methodological base to situate us «between» the lay and the professional groups²⁷ thus enabling us to better understand the different vital worlds of those who belong to this avoidance cycle.

The recruitment of this second stage was done with the propensity matching score technique, obtained through the base of observable predictors with a logistic regression analysis. This technique was used because it attempts to estimate the effect of a treatment, policy, or other intervention by accounting for the covariates that predict receiving the treatment. And it attempts to reduce the bias due to confounding variables that could be found in an estimate of the treatment effect obtained from simply comparing outcomes among units that received the treatment versus those who did not. These reasons make this technique the

best one for the development of our research project. 50 young people were selected for each of the three groups:

- 1 – Subjects with depression/anxiety diagnosed at the first or fourth wave of the PFC according with the narrative of their parents (the question was about the existence of a professional diagnose of depression/anxiety)
- 2 – Subjects with self-perceived depressive discomfort at the second and third waves, but without a professional diagnose.
- 3 – Subjects without self-perceived discomfort or diagnose.

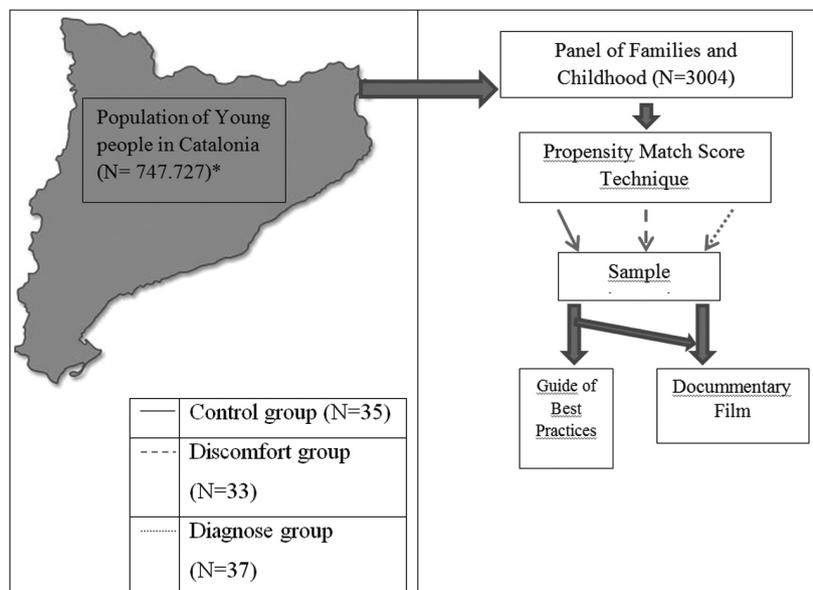
This quantity is owing to a criterion of convenience. The objective was to find a group without diagnostic but with high discomfort, in order to compare it with the group of young people with diagnose. Sample attrition occurred in cases of change of residence, inability to contact the subject, or subjects who declined to be interviewed, and in the end 105 subjects were interviewed: with diagnose = 37, discomfort = 33 and control = 35.

At the beginning of this second stage, the 105 participants from the sample were given a semi-structured interview. These interviews focused on exploring the participants' explanatory models, reasons for not seeking professional help and strategies of self-care. This information was stored and analyzed using the Atlas.ti software.

Subsequently, four focal groups were set up – three formed of young people and one of mental health professionals (including psychologists, social workers, psychiatrists and nurses) – which were used to triangulate the results of the interviews.

Young people in the focal groups were recruited from the 105 sample, including informants from the three different sub groups (Table 1). First, the young people in the

TABLE 1
SELECTION OF THE SAMPLES IN THE DIFFERENT STAGES OF THE RESEARCH'S PROCESS



three focal groups were asked about their perception of the system, the health institutions and the health professionals, what they knew about them, the possible causes of avoidance, and the recommendations that as potential users they felt they would make to overcome the obstacles they had detected.

Then the health professionals were asked about the same issues as the young people. They were provided with the information gleaned from the young people in the previous focal groups so that they would be aware of their opinions about the phenomenon of the avoidance cycle and would have a base on which to generate new contributions.

Once all the information compiled from the four focal groups had been analyzed, a mixed discussion group was set up consisting of young people and professionals. This group discussed and debated the main obstacles preventing access to services perceived by both groups and the recommendations that had been made to overcome these obstacles. The horizontal communication and the symmetrical and reciprocal relations between the young people and the professionals (essential qualities in a good participative model) characterized this discussion group.

The process of drawing up the Guide to Good Practices was cooperative and participative, and involved the joint work of researchers, young people and mental health professionals. The obstacles perceived by both groups were compiled and debated in a deep way during the focal and discussion groups, trying in all moments to distinguish, to demonstrate and to analyze all the possible reasons of this miss-use of mental health services. During this first step of dialogue between the key actors a lot of interesting topics emerged. This point was a very interesting critical analysis in which the different fields of professional knowledge and the lay knowledge were heard, valued and considered in the same decisive way. Integrating thus the different fields of expertise of the principal actors; which is another essential point in the participative research-action²⁹ developed by a transdisciplinary research team. In a second term the process to decide the ways in which these obstacles could be overcome by following the same interactive and co-constructing process; analyzing and debating collaboratively all the possible solutions and its advantages and disadvantages.

All this rich information was compiled and organized by the researchers, and a first draft of the guide was produced. This preliminary document was revised by the professionals and young people participating in the focal and discussion groups. And all the commentaries, suggestions and recommendations about both contents and structure were taken into account to do the final text. The coordination of The Guide was developed by a transdisciplinary team composed of a doctor, a social worker, a psychologist and an anthropologist, all of us specialized in medical anthropology. Being thus this Guide the result of a participative, interactive and transdisciplinary effort by three different groups. In last term, before the publication of The Guide, it was revised by external reviewers, in order to verify the understanding and the qualities of the con-

structed material. Finalizing in this way an enriching and long process.

Once this process was ended another was started: the creation of a documentary about the adolescence. Following one of the recommendations made in the Guide our research team decided to create a documentary pro normalization of this vital period and the discomforts of it.

To achieve this aim we counted with the collaboration of transdisciplinary professionals specialized in the areas of journalism, documentaries, anthropology and medical anthropology. Increasing in this way our transdisciplinary team.

First of all the script of the documentary was written, inspired by those key points that were cited like recommendations in the Guide to fight against stigmatization. In order to follow the logic of the project two different kinds of «actors» were recruited: mental health professionals and young people. We contacted with some of those professionals that collaborated with us to create the Guide of Best Practices, and with young people from the sample (some of them that collaborated in focal and discussion groups, and others that collaborated only in the interviews).

The aim was to create a dialogue between the two main actors involved (professionals and young people) articulating their points of view. Two different interview guides were made: one for the professionals and other for young people. Interviews were done separately with each participant. The shooting team was compound by a documentary film maker and an anthropologist add a journalist filming the scene (image and sound) and a journalist and medical anthropologist doing the interviews. Once all the interviews were done the shooting team did the production and composition process jointing the different frames of each interview to create a dialogue formed by all the participants in the documentary film.

Results

This paper presents two of the main materials resulted of our investigation that was done in a transdisciplinary way: 1) the Guide of Best Practices in adolescent mental health, and 2) the Documentary Film focused on adolescence.

Guide of Best Practices in adolescent mental health

The Guide of Best Practices for the attention to psycho-emotional problems in adolescents and young adults is a brief and very practical material which has been created as an answer to a detected need: the phenomenon of infra-utilization of mental health services for young people in front of situations of depression and anxiety mainly, but also against the rest of the typical discomforts of this vital period. This Guide is the result of collaborative work and

reflection done in a participative research-action way with a transdisciplinary team. Which has followed the specific objective of encouraging the reflection as an instrument of improvement.

The text is organized in ten main topics that were detected during the collaborative work with the professionals and young people during the discussion and focal groups: 1) Health promotion and prevention, 2) Normalization and destigmatization, 3) Formation (in adolescence and mental health), 4) Coordination and networking, 5) Accessibility, 6) Planning and organization, 7) Quality of communication, 8) Clinical attention, 9) Participation, and 10) Investigation.

Each one of these ten points is composed of several sections which help the reader to understand each topic

and the importance of it, explains the different obstacles detected around it, and gives diverse recommendations made to save the named obstacles, ending with a section that suggests some questions to promote the self-reflection through the self-evaluation.

It is not possible to explain in depth in this paper all the complete content of the Guide. Nevertheless, I would like to mention some of the main lines that have been worked on so as to give a more specific idea of the shortcomings found and the action recommended for improvement. The key topics of the guide are listed below (Table 2).

These key topics emerged from the debate and dialogue created in the focal and discussion groups. Young people from the sample (aged between 18 and 21 years old) and professionals whom work in mental health services is ad-

TABLE 2
TOPICS OF THE GUIDE OF BEST PRACTICES WITH EXAMPLES OF OBSTACLES AND RECOMMENDATIONS

Topics	Obstacles	Recommendations
1. Promotion and prevention of health	Absence of collaborative labor between families and services of youth attention.	Reinforce and promote networking between all health services, young people and their families.
2. Normalization and Destigmatization	Strong stigma associated to mental health discomforts.	Campaign of normalization in mass media. Speeches about mental health to young people, families and non-sanitary professionals to break clichés.
3. Formation in adolescence and mental health	Tendency of adults to: 1) Problematize typical vital events of the adolescence. 2) Devalue the teenagers' knowledge about their own discomfort.	1) Do courses and formation in which design and develop are included adolescents that explain their own experience. 2) Integrate adolescents in the formation process counting with their own experience and expertise.
4. Coordination and networking	Lack of integral attention that involves all the attention services existents.	Foment the coordination and cohesion between all kind of services, and to make possible the integral attention of young people.
5. Accesibility	1) Attention timetables are the same than school timetables. 2) Centralist location of services. 3) Mistakes in the derivation process. Professionals only attend pathological discomforts.	1) Attention timetables out of time of classes. 2) Distribute little services in a more homogenous way in the territory. 3) Attend quotidian problems related with crises of the vital cycle, not only the pathological ones.
• 5.1. General accessibility		
• 5.2. Proactive Information about the services	Lack of information about the services, the place they are, the work that the professionals could do there, ways to access there, requisites to be admitted, which problems could be treated there, which kind of professionals are there, which kind of treatments and therapies are offered there.	1) Publish materials to spread this information. 2) Create information points out of the health services, where young people could go and ask about their doubts on mental health and services. 3) Use new technology and create virtual spaces attends by health professionals where young people could ask about their mental discomforts.
6. Planification, organization and programming of the service	1) Temporality of the visits: Too short visits, and too much wait between one visit and another. 2) Lack of professionals: there are not psychologists in primary care centers.	1) To make possible an early attention in the first visit and shorter the time between visits. 2) Put psychologists in primary care centers to facilitate the accessibility and to contribute to the normalization of psych-emotional discomforts.
• 6.1. Needs detection, planning and adaptation of the service to adolescent public.		

Topics	Obstacles	Recommendations
<ul style="list-style-type: none"> 6.2. Evaluation of the adaptability and the competitiveness of the center 	Lack of systems of evaluation about the users' satisfaction.	Create systems of evaluations about the satisfaction of the users and their families to enhance the services.
7. Quality of the communication	<ol style="list-style-type: none"> 1) Too much professional argot and lack of colloquial and close language. 2) Vertical communication between professionals and adolescents. 	<ol style="list-style-type: none"> 1) Avoid unnecessary professional argot to facilitate the comprehension. 2) Horizontal communication to obtain the users comfort, and therapeutic link.
8. Clinical attention	Lack of adaptation of the clinical history to adolescent patient.	Adapt clinical history including: Psychosocial stressors from this vital phase, compile the patient narrative, compile dates about the context, take in account their values, hopes, experiences, etc.
<ul style="list-style-type: none"> 8.1. Clinical history 8.2. Diagnoses 8.3. Treatments 8.4. Professional-patient relation 	<ol style="list-style-type: none"> 1) Too biomedical diagnoses, lack of considerations about contextual factors. 2) It is not born in mind the subjectivity of the suffered discomfort. 	<ol style="list-style-type: none"> 1) To do psychosocial diagnoses too. 2) Value the lay knowledge of adolescents about their own discomfort.
9. Participation	Lack of spaces for patient's participation.	<ol style="list-style-type: none"> 1) Attend problems related with evolutionary crises. 2) Offer alternative therapies adequate to adolescent public.
10. Investigation	Professionals are used to see investigation like something distant to their professional practice.	<ol style="list-style-type: none"> 1) Professional active hearing. 2) Closer professional manner.
		Create canals for increase the participation. Promote patients participation in their plans of treatment.
		Promote the development of researches focused in the improvement of attention services. Promote the culture of research by the recognition of this kind of work.

dressed to young people (psychiatrist, psychologists, nurses, social workers and doctors) talked, first separately (professionals in one hand and young people in the other hand) and secondly together, about the problems they think exist around infra-utilization of mental health services.

Despite the fact that they seem to belong to different and separate worlds, not all the problems listed in one group and the other were completely different. Many of the obstacles and the reasons for them, detected by one group were not detected by the other, but they were not as distant as they could initially think, because there were also a lot of points in which they agreed completely. There were a lot of similarities in the key points argued by the two groups, which were mentioned and deeply addressed in the final mixed discussion group. The fact of joining the two actors in a same session nourished the results emerged for both show the obstacles and suggest recommendations. Making possible in this way to address the problems detected since diverse perspectives of the actors involved.

In order to read in more detail the different topics, and the guide itself you could find and download the Guide for free in Spanish, Catalan and Italian in this link <http://publicacionsurv.cat/l1ibres-digitalis/antropologia-medica>.

Documentary film

In relation to the documentary film the result was a brief film of 27 minutes long, which joins the discourses of professionals and young people, creating an interactive dialogue. The name of the film is: »Adolescències: crisi, malestar i creixement« which means »Adolescence: crisis, discomfort and growth«. The original version is in Spanish and Catalan, because in this way each speaker talked in the language in which she/he was more confident and comfortable. The objective of the film was to normalize and destigmatize the adolescence and its discomforts. To achieve this objective some crucial topics to destroy the prejudices around this vital period. The participants in the film are four professionals of mental health care (psychiatrists, psychotherapists, and psychoanalysts) and six young adults (three girls and three boys). All the actors answered the same questions, and after that the shooting team selected specific fragments to create the final joint dialogue. Topics treated in the film are: the definition of the adolescence; the crises and discomforts related with this vital period and their causes; the importance of social relations (families and friends); the process of transition between childhood and adulthood, the elections and re-

sponsibilities that it implies; the searching for answers to solve their problems; the different ways to manage these problems and the process of help-seeking (friends, family, music, party, sport, etc.); coping strategies; non-help-seeking of professionals assistance and the reasons of it; stigmatization of mental discomforts; obstacles detected for the infra-utilization of mental health services; and the recommendations to solve these obstacles. Collecting in this way the main topics treated in our research project, giving at the same time a global and concise view of it and its results.

In order to access to the documentary film you can find it with English subtitles in this link for free: <http://antropologia.urv.es/adolescentes/>. The documentary is also available with Portuguese, Italian, Spanish and Catalan subtitles (If you need it in these other languages you could contact us and ask for it, we will send it to you).

Discussion and Conclusions

Achieving a good health care system which works for and to the whole society is possible, but reaching this objective is impossible if the opinions, needs and feelings of the people are not taken into account. The management of social and health problems should be thought about starting from the opportunities and from the practices that promote the recognition of the involved collectives^{29,30}. Is the participation of the different actors involved which makes possible the real integration of both the knowledge and its protagonists. Achieving a new syncretic knowledge which exceeds the addition of the individual parts³¹.

The field of health is a very broad field which englobe a very wide range of topics and phenomena. All these kinds of phenomena could be addressed from very different areas of expertise, from biological sciences to statistics, epidemiology, medical sciences and social sciences among others. Each one of these arenas of expertise could give a specific and particular vision under the phenomenon, contributing to the global knowledge around the phenomenon itself, nourishing it with new hypothesis, methods and theoretical paradigms. But the results of this action are many investigations focused in the same topic, but addressing it in a disconnected way; providing us with interesting but partial and unifocal views. In order to overcome this limitation several concepts have emerged during these past decades: interdisciplinary, multidisciplinary and transdisciplinary. All these three concepts involve in different ways the articulation of several areas of expertise to address a specific research topic^{4,30,32–37}. This articulation contributes to enhance the research nourishing it with different expert wisdom in an interconnected way that results in a deeper and multifocal knowledge.

Several investigations done during last years have demonstrated that the use of this kind of research to deal with health problems is worthy, because it produces interesting and qualitative different results; becoming a good alternative approach to produce new knowledge^{4,38,39}. Transdisciplinarity must be seen in this way like a pro-

cess, an action strategy, addressed to the transformation of science enabling the emergence of new paradigms in the scientific field and new action strategies in the social practice.

Transdisciplinarity by itself is recommendable, but if in addition we decide to work in a participative way it could be even better; because working in a participative research-action project with a transdisciplinary research team brings us many interesting advantages and more-over if we work in the field of health.

Participative research-action is the best way to work to integrate, in an equitable and integrative way, the voices of all the groups involved; overcoming the asymmetry and creating horizontal relations to deal with health care problems in a holistic and integrative way. Because as we have seen the use of participative methodologies as a way of approaching anthropological research could help us to have a better engagement with our informants which results in their empowerment and in their implication in the research project; contributing finally to all these steps to create collaborative forms of anthropological knowledge.

Is for this reason that one of the most important key points that we must take into account when we want to do a participative research-action project is to identify the interested collectives in solving and /or maintaining the problem⁴⁰. In order to work in a proactive way to solve the problem we need to give voice to all the parts and promote a horizontal dialogue between them; collecting all the different points of view to have a complete and global view of the phenomenon. Being the interested parts in our project the mental health care professionals (psychologists, social workers, medical anthropologists, nurses and psychiatrists) and the young people from Catalonia, as I explained before. Another essential point in this kind of research is the participation of all the subjects as active and responsible of the decision making during the entire project. Thus all the persons involved in it (researchers and informants) are responsible and important in the same grade, and the project belongs to all of us in the same measure.

The variety of the composition of the team is another key point that we must take into account because it enriches both process and results of investigation, giving us the extra value of approaching to non-help-seeking phenomena from different areas of knowledge. This point in addition to the social utility of the obtained knowledge transforms our research in an enhanced and practical research. The results of this kind of project have not only academic repercussion, but they have a pragmatic character too. As we have demonstrated with the creation of these two practical materials: the guide of best practices and the documentary film. The working system tries to find a balance between the prearranged designs and the emergent ones, combining the systematic character with the flexibility and the sensibility to the demands of the environment and establishing its efficiency in the theoretical – practical base, the integration of the knowledge of the own protagonists, the intersubjective check and the social usefulness of the knowledge²⁹. In our case it results

of usefulness to reduce the gap between discourse and practice, and to have repercussions in the inequalities in health⁴¹. In a more specific way it helped to us to remove the barriers detected in the process of non-help-seeking, to help to improve in this way the professional practices and the access to specialized services, and to contribute to the normalization of the adolescence and its inherent discomforts between other multiple aspects.

But if we want to do a research like this we must keep in mind that it requires a hard work and deep preparation too: to achieve our goals working in a transdisciplinary team »each team member needs to become sufficiently familiar with the concepts and approaches of his/her colleagues as to blur the disciplinary bounds and enable the team to focus on the problem as part of broader phenomena: as this happens, discipline authorization fades in importance, and the problem and its context guide an appropriately broader and deeper analysis«⁴². The crucial point to achieve the success around this concept and its practice was given by Almeida Filho in 2000: »the basis resides in the possibility of communication not between disciplinary fields, but between agents in each field, through the circulation not of the discourses, but of the subjects of the discourses«⁴², and »those agents from the scientific practice whom have access to a transdisciplinary formation are whom can transit between at least two disciplinary fields«⁴², like is the case of current medical anthropologists, who move around medical and social sciences.

Finally in order to sum up we could say that our experience shows that the use of a methodological approach based on the participative research-action and carried out by a transdisciplinary team of health and social sciences researchers enriches both the process of investigation, the obtained results and the produced materials. Articulation of these complementary approaches allowed

us to create a transdisciplinary dialogue which nourished from interconnected knowledge, contributing to increase a more practical knowledge, fruit of the union of shared wisdoms.

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REFERENCES

- HARO JA, DE KEIJZER B, Participación comunitaria en salud: evaluación de experiencias y tareas para el futuro (Colegio de Sonora, México, 1998). — 2. WORLD HEALTH ORGANIZATION, United Nations Children's Fund, Primary Health Care: Report of the International Conference on Primary Health Care, Alma Alta, U.S.S.R. (World Health Organization, Geneva, 1978). — 3. ANIGSTEIN MS, *Rev Mad*, 19 (2008) 77. DOI: 10.5354/0718-0527.2008.13898. — 4. ROSENFELD PL, *Soc Sci Med*, 35 (1992) 1343. — 5. ABRANTES-PEGO R, *Salud Publica Mex*, 41 (1999) 444. — 6. SANABRIA RAMOS G, *Rev Cubana Salud Pública*, 3 (2004) 30. — 7. ORTEGA LÓPEZ A, MORALES ASENCIO JM, RENGEL DÍAZA C, PEÑAS CÁRDENAS EM, GONZÁLEZ RODRÍGUEZA MJ, PRADO DE LA SIERRA R, *Aten Primaria*, 4 (2014) 46. DOI: 10.1016/j.aprim.2013.09.006. — 8. NAVAS PEROZO R, ROJAS DE MORALES T, ÁLVAREZ CJ, FOX DELGADO M, *Revista de Ciencias Sociales*, 2 (2010) 261. — 9. VÁZQUEZ NAVARRETE ML, FERREIRA DA SILVA MJ, SIQUEIRA CAMPOS E, CAMPOS PEREIRA AP, DA SILVA DINIZ A, LEITE VERAS I, KRUEZ GRANDE DE ARRUDA I, *Rev Esp Salud Pública*, 76 (2002) 149. DOI: 10.1590/S1135-57272002000500018. — 10. HILLS M, MULLETT J, CARROLL S, *Rev Panam Salud Publica*, 21 (2007) 125. — 11. SOSA LORENZO I, RODRÍGUEZ SALVÁ A, ÁLVAREZ PÉREZ A, BONET GORBEA M, MEDISAN, 17 (2013) 4. — 12. FERNÁNDEZ-LAMELAS E, VEGA-MONTEAGUDO C, *Enferm Clin*, 20 (2010) 260. DOI: 10.1016/j.enfcli.2010.05.003. — 13. MENÉNDEZ E,

- Morir de Alcohol Saber y Hegemonía Médica, (Editorial Alianza, México, 1990). — 14. WEINSTEIN M, Participación Social en Salud: Acciones en curso. In: CORREA E, NOE M (Eds), *Nociones de una Ciudadanía que Crece*, (FLACSO, Chile, 1998). — 15. CORREA URQUIZA M, SILVA T, BELLOC M, MARTÍNEZ HERNÁNDEZ A, *Quaderns de l'ICA*, 22 (2006) 9. — 16. MUNARRIZ FERRANDIS M, *Rev Asoc Esp Neuropsiq*, 33 (2013) 118. DOI: 10.4321/S0211-57352013000200001. — 17. FAGUNDES S, *Saúde Mental Coletiva: construção no Rio Grande do Sul*. In: BEZERRA JÚNIOR B, AMARANTE P (Orgs.) *Psiquiatria sem hospício*, (Relume Dumará, Rio de Janeiro, 1992). — 18. OLIVERA A, *Interrogant*, 6 (2005) 56. — 19. CASAL ÁLVAREZ JC, *Estudios de Psicología*, 16 (2011) 1. DOI: 10.1590/S1413-294X2011000300021. — 20. RADIO NIKOSIA, *El libro de Radio Nikosia: Voces que hablan desde la locura*, (Gedisa, Barcelona, 2005). — 21. PALACIOS A, BARIFFI F, *La discapacidad como una cuestión de Derechos Humanos. Una aproximación a la Convención Internacional sobre los derechos humanos de las personas con Discapacidad*. (Editorial Cinca, Madrid, 2007). — 22. MERIKANGAS KR, HE JP, BURSTEIN M, SWANSON SA, AVENEVOLI S, CUI L, BENJET C, GEORGIADIS K, SWENDSEN J, *J Am Acad Child Adolesc Psychiatry*, 49 (2010) 980. DOI: 10.1016/j.jaac.2010.05.017. — 23. GULLIVER A, GRIFFITHS KM, CHRISTENSEN H, *BMC Psychiatry*, 10 (2010) 113. DOI: 10.1186/1471-244X-10-113. — 24. INSTITUT D'INFÀNCIA I MÓN URBÀ (CIIMU, Barcelona, 2012). — 25. JULIÀ A, ESCAPA S, MARÍ-

- KLOSE M, MARÍ-KLOSE P, Adicciones, 24 (2012) 309. — 26. MARTÍNEZ-HERNÁNDEZ Á, MARÍ-KLOSE M, JULIÀ A, ESCAPA S, MARÍ-KLOSE P, DIGIACOMO S, Gac Sanit, 26 (2012) 5. DOI:10.1016/j.gaceta.2011.09.030. — 27. MARTINEZ-HERNAEZ A, Rev Saúde Pública, 44 (2010) 3. DOI: 10.1590/S0034-89102010005000016. — 28. OBSERVATORIO DE LA JUVENTUD EN ESPAÑA, Juventud en cifras. Población. Actualización Enero 2011, Gobierno de España, 2011. — 29. SCANDROGLIO B, LÓPEZ J, AIBR. Revista de Antropología Iberoamericana, 5 (2010) 2. DOI: 10.11156/aibr.050204. — 30. SCHNITMAN DF, Nuevos paradigmas en la resolución de conflictos, (Granica, Buenos Aires, 2000). — 31. BETANCOURT JA, Rev Panam Salud Publica, 34 (2013) 5. — 32. DE ALVARENGA AT, SOMMERMAN A, DE SOUZA ALVAREZ AM, Saúde e Sociedade, 14 (2005) 3. DOI: 10.1590/S0104-12902005000300003. — 33. CHOI BC, PAK AW, Clin Invest Med, 30 (2007) 6. — 34. FAWCETT J, Nurs Sci Q, 26 (2013) 383. DOI: 10.1177/0894318413500408. — 35. CHOI BC, PAK AW, Clin Invest Med, 6 (2006) 29. — 36. CHOI BC, PAK AW, Clin Invest Med, 1 (2008) 31. — 37. LUZ MT, Saúde Soc. São Paulo, 2 (2009) 18. — 38. RATCLIFFE JM, Integrative, transdisciplinary research methodology: principles and application strategies. (International workshop on integrative approaches to research in agricultura, health and fertility. University British Columbia, Vancouver, British Columbia, Canada, 1989). — 39. HIRSCH HADORN G, HOFFMANN-RIEM H, BIBER-KLEMM S, GROSSENBACHER-MANSUY W, JOYE D, POHL C, WIESMANN U, ZEMP E (Eds), Handbook of Transdisciplinary Research, (Springer, Berlin, 2008). — 40. CLEMENTE M, Psicología Social Aplicada, (Eudema, Madrid, 1992). — 41. BARTEN F, Saúde debate, 36 (2012) 94, DOI: 10.1590/S0103-11042012000300005. — 42. ALMEIDA FILHO N, RAP, 6 (2000) 34.

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DIJELJENJE MUDROSTI I OBOGAĆIVANJE ZNANJA: RAD U TRANSDISCIPLINARNOM ISTRAŽIVAČKOM TIMU MEDICINSKE ANTROPOLOGIJE

SAŽETAK

Ovaj članak objašnjava naše iskustvo rada u transdisciplinarnom istraživačkom timu usmjerenom na mentalno zdravlje u adolescenciji. Ukratko uvodi dvija ključna teorijska koncepta: sudjelovanje i transdisciplinarnost. Stvoreni su vodič za najbolje prakse mentalnog zdravlja u adolescenciji i dokumentarni film, u svrhu dubljeg opisa metodologije i stvaranja dva glavna materijala koji proizlaze iz našeg istraživanja. Prikazujemo na praktičan način kako se istraživanje može poboljšati dijeljenjem znanja.