MACQUARIE UNIVERSITY

ANTH 716/816: Culture, Health & Disease

Unit Guide

Semester 1, 2016

Faculty of Arts

Department of Anthropology

Unit Guide

Department of Anthropology
ANTH716/816: Culture, Health and Disease

Students in this unit should read this Unit Guide carefully. Although the unit convenor reserves the right to make minor alterations during the course of the semester, most essential information for this unit is in this guide. Please contact the convenor if you have any questions.

TEACHING STAFF

Unit convenor

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SEMINARS

Time: Thursday 6-8pm

Location: Check the timetable for the latest updates

Seminar Structure: The course convener will use the first half of the seminar to introduce concepts, provide background information or examples, or offer an overview of the key issues under discussion. The second half of the seminar will be devoted to discussing the issues and readings.

Attendance: Seminar attendance and participation is compulsory. Students who miss more than one seminar without an authorized/approved excuse will risk receiving a lower mark or failing the unit. Attendance is vital.

UNIT DESCRIPTION

Culture affects our bodies, our experience, and even what even consider to be health, illness, and disease. This unit is an introduction to medical anthropology and its core theories, methods, and concepts. Throughout the course, we look at conditions of disease as having social as well as biological origins, and take the position that notions of health and the methods of treating illness are deeply lodged in cultural frameworks. Thus, we treat healing practices, including biomedicine, as inevitably predicated on cultural systems of understanding and larger structures of power. We will consider different notions of disease causality and examine the proposition that good health, and conversely ill health, is never just about the body or biological causation. How people understand illness and where it comes from, and what they do about it when it does occur, tells us a lot about how different societies understand people and their place in the world.

Topics covered will include placebos and the "meaning effect," the healing efficacy of symbols and rituals, illness narratives, the relationship between illness and social experience, clinical encounters, changing concepts of mental health, culture bound syndromes, the body, and structural violence and social suffering. Throughout, we will pay close attentions to the way that class, gender, and ethnicity shape medical systems and health outcomes. As applied anthropologists, we will develop a critical perspective on the ways health policies, medical technologies, and interventions address populations and impact health. We will pay particularly close attention to ways that growing global economic and technological inequalities contribute to human suffering, illness, and disease. We will focus as much on biomedicine and contemporary medical technologies as on exotic (and exoticising) topics such as witchcraft and ritual, to find the exotic within our own Western medical systems and the familiar within other cultural systems.

Unit Learning Outcomes:

1. Introduce students to the scope of medical anthropology and to analyse and discus the literature and central theories related to medical anthropology and the broader study of illness and healing practices in their social and cultural contexts.

2. Understand how biology, culture, politics, and ecology interact to shape illness and health, health systems, and patterns.

3. Interview, analyse, and represent the illness experience of another person, emphasizing the integrative factors (culture, politics, social structure, etc.) influencing their condition.

4. Apply the theories and concepts of medical anthropology to critically evaluate one's own culture and determinants of illness and health.

5. To understand how healing systems often cut across categories of religion, medicine, and social organization.

6. To understand how illness and health (and normality) are constructed within particular social, cultural, political, and environmental contexts.

7. Understand and identify how inequality, social hierarchy, and structural violence generate unequal and often unique health determinants in the global and transnational context.

Macquarie Learning Outcomes

All academic programmes at Macquarie seek to develop graduate capabilities. These are:

COGNITIVE CAPABILITIES

1. Discipline Specific Knowledge and Skills

Our graduates will take with them the intellectual development, depth and breadth of knowledge, scholarly understanding, and specific subject content in their chosen fields to make them competent and confident in their subject or profession. They will be able to demonstrate, where relevant, professional technical competence and meet professional standards. They will be able to articulate the structure of knowledge of their discipline, be able to adapt discipline-specific knowledge to novel situations, and be able to contribute from their discipline to inter-disciplinary solutions to problems.

2. Critical, Analytical and Integrative Thinking

We want our graduates to be capable of reasoning, questioning and analysing, and to integrate and synthesise learning and knowledge from a range of sources and environments; to be able to critique constraints, assumptions and limitations; to be able to think independently and systemically in relation to scholarly activity, in the workplace, and in the world. We want them to have a level of scientific and information technology literacy.

3. Problem Solving and Research Capability

Our graduates should be capable of researching; of analysing, and interpreting and assessing data and information in various forms; of drawing connections across fields of knowledge; and they should be able to relate their knowledge to complex situations at work or in the world, in order to diagnose and solve problems. We want them to have the confidence to take the initiative in doing so, within an awareness of their own limitations.

4. Creative and Innovative

Our graduates will also be capable of creative thinking and of creating knowledge. They will be imaginative and open to experience and capable of innovation at work and in the community. We want them to be engaged in applying their critical, creative thinking.

INTERPERSONAL OR SOCIAL CAPABILITIES

5. Effective Communication

We want to develop in our students the ability to communicate and convey their views in forms effective with different audiences. We want our graduates to take with them the capability to read, listen, question, gather and evaluate information resources in a variety of formats, assess, write clearly, speak effectively, and to use visual communication and communication technologies as appropriate.

6. Engaged and Ethical Local and Global citizens

As local citizens our graduates will be aware of indigenous perspectives and of the nation's historical context. They will be engaged with the challenges of contemporary society and with knowledge and ideas. We want our graduates to have respect for diversity, to be open-minded, sensitive to others and inclusive, and to be open to other cultures and perspectives: they should have a level of cultural literacy. Our graduates should be aware of disadvantage and social justice, and be willing to participate to help create a wiser and better society.

7. Socially and Environmentally Active and Responsible

We want our graduates to be aware of and have respect for self and others; to be able to work with others as a leader and a team player; to have a sense of connectedness with others and country; and to have a sense of mutual obligation. Our graduates should be informed and active participants in moving society towards sustainability.

PERSONAL CAPABILITIES

8. Capable of Professional and Personal Judgment and Initiative

We want our graduates to have emotional intelligence and sound interpersonal skills and to demonstrate discernment and common sense in their professional and personal judgement. They will exercise initiative as needed. They will be capable of risk assessment, and be able to handle ambiguity and complexity, enabling them to be adaptable in diverse and changing environments.

9. Commitment to Continuous Learning

Our graduates will have enquiring minds and a literate curiosity which will lead them to pursue knowledge for its own sake. They will continue to pursue learning in their careers and as they participate in the world. They will be capable of reflecting on their experiences and relationships with others and the environment, learning from them, and growing - personally, professionally and socially.

UNIT REQUIREMENTS AND EXPECTATIONS

Assessment at a glance

Task	Weight (%)	Due Date	Linked Unit Outcomes	Linked Graduate Capabilities	Brief Description
Participation & Discussion Guide	15	Weekly	1, 2, 3, 4, 5, 6, 7	1, 2, 4, 5, 6, 7, 8, 9	Active attendance and engagement with discussions and a discussion guide based on the readings will be turned in at the conclusion of each class
Essay Exam 1	25	25 April, 5pm	1, 2, 4, 5, 6, 7	1, 2, 3, 5, 6, 7, 8, 9	A selection of essays based on the readings and seminars from the first half of the semester
Essay Exam 2	25	17 June, 5pm	1, 2, 4, 5, 6, 7	1, 2, 3, 5, 9	A selection of essays based on the readings and seminars from the first half of the semester
Illness Narrative	35	30 May, 5pm	2, 3, 5, 6	All	Interview a friend or family member about an illness and write a paper illustrating their illness experience.

REQUIRED TEXT

1. Fadiman, A. 1997. "The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures." New York: Farrar, Straus & Giroux. This book is widely available (I did not place an order at the Co-op). First edition version are fine. I will make PDF copies of chapters available on iLearn as we progress.

2. All other required readings will be available electronically on iLearn. There is no reader.

ASSESSMENT TASKS

1: Seminar Participation and Discussion Guide
Weight: 15%

Due: Weekly (submit 10)

Details: Seminar attendance and participation are mandatory. ***Students are expected to be active participants and demonstrate that they have actively engaged the readings and material presented***. Participation also means contributing to a general atmosphere of scholarly enquiry, showing respect for the opinions of others. If you don't understand or agree with something someone says, ask them to clarify, or explain respectfully why you disagree. Everyone should feel free to speak up. If you are having trouble speaking up in class discussion, please come to speak with the course convenor and together we can strategize ways to facilitate your contribution. One suggestion is to take notes on what you read and to write out questions or comments in advance—this is what the discussion guides are for (see below).

Each week, the unit convenor will assess seminar participation for each student. Points will be awarded for any of the following:

- initiating discussion
- giving information
- asking for information
- raising questions
- restating another's contribution
- asking for clarification
- giving salient examples
- encouraging others
- relieving group tension

Points will be *subtracted* for any of the following:

- expression of unsupported opinions
- attempts to dominate discussion
- mocking others

Students are expected to **complete a Discussion Guide** for each seminar and turn in a physical copy at its conclusion. No emailed or late copies will be accepted unless you have a University approved excuse for your absence. Use the discussion guide to help formulate questions and examples to discuss during the seminar.

There are two parts to the discussion guide. First, review and respond to the week's materials. That is, describe and/or discuss one or more significant themes, ideas, or findings (either for a specific reading or for themes across all). These can be things that struck you as important, not necessarily what the author says is important. You may also make links to current events or connections to your personal experiences, or you can describe how this material might be useful (be used in your career). In the second part of the discussion guide, offer one or more developed questions based on the readings and/or weekly themes to initiate a seminar discussion (I might call on you to offer these). The questions need to be meaningful. Also list any questions that you have regarding the readings that you would like answered. Limit your discussion guides to roughly 400 words.

Each discussion guide will be assessed according to the quality and accuracy of the description, critique, and/or analysis. Your questions will be evaluated according to how thoughtfully they are formed and how relevant they are to the readings and/or weekly theme. Each guide will receive a mark between 1 and 10. Papers that receive a mark between 8 and 10 will explore the implications of arguments in insightful or original ways, clearly represent the author(s) arguments, offer compelling analysis and/or critique, and are clearly written. Papers between 5 and 7 demonstrate a basic to good grasp of the material, present identifiable themes/issues, and attempt to offer original analysis or critique.

There are 11 opportunities to submit a discussion guide this semester (the first seminar and reading week are not eligible for discussion guide submission).You can miss one seminar and/or forget one discussion guide without penalty. You will turn in 10 discussion guides.

You are permitted to miss one seminar without an excuse. Do not submit a disruption of study request unless you have already used your one free absence. If you miss more than one seminar without a disruption of study (see Student Handbook) we will lower your mark. Attendance is vital. Remember that an essay question could be based on the week that you missed. For every unexcused absence beyond three, you will receive an additional 10% reduction in your final grade (4 absences = 10% reduction, 5 absences = 20% reduction, etc.).

2: Mid-Term Essay Exam
Weight: 25%

Due: Monday 25 April, 5pm (through Turnitin)

Details: Students will complete a set of short essays that cover the key concepts within the readings, lectures, and discussions from the first half of the semester. Success in this assignment necessitates seminar attendance, taking careful notes, and completing the readings. The questions will be provided well in advance of the deadline. Submit via Turnitin. More details will be provided later in the semester.

3: Essay Exam Two
Weight: 25%

Due: 17 June, 5pm (through Turnitin)

Details: Students will complete a set of short essays that cover the key concepts within the readings, lectures, and discussions from the second half of the semester. The structure and format will be similar to the first essay exam. Submit via Turnitin.

4: Illness Experience Narrative
Weight: 35%

Due: Monday, 30 May, 5pm (submitted through Turnitin)

Details: You will conduct an interview with a friend or family member about an illness they have experienced and write an "illness narrative" along the lines outlined in the readings from week 3 and 4 (Kleinman and Good). The resulting illness narrative should be no longer than 3,500 words (you are not required to write a full 3,500 words). The purpose of this project is to enhance your understanding of the individual's illness experience by encouraging the interviewee to recall in rich detail the lived experience of the illness in question. Ideally, the resulting illness narrative will capture the person's experience of living with the condition and all of its emotional, spiritual, physical, structural, and political-economic components. More details will be posted on iLearn and discussed in the seminar.

Methods: The first four seminars focus on offering you the necessary background to conduct the interview and write the narrative. A great deal of information will be discussed during these seminars. You are required to identify a willing individual to interview regarding his or her experience with a chronic disease (heart failure, diabetes, arthritis), acute illness, or an equivocal illness (environmental sensitivity, chronic fatigue, fibromyalgia). You will conduct one (or more) semi-structured interviews. Interviews may be conducted in a comfortable location as determined by the participant (for example, a pubic location or within the participant's home). The participant may request that others be present during the interview. You will record the interview and observe interviewees.

You are encouraged to take field-notes during and after the interview (describing, for example, the setting, the interviewee's non-verbal actions, and your own impressions and reflexive response). After conducting the interview, you will write an interpretive analysis of the illness narrative. Specifically, each analysis will discuss how the illness has affected the person's everyday life and perspective. It will include their explanatory model of the illness and an analysis of the contextual elements (political-economic, cultural, environmental) influencing their illness experience. You are encouraged to write in an interpretive style not clinical. That is, do not diagnose; rather, offer a perspective on their experience of their condition.

You cannot interview anyone under the age of 18. Do not solicit interviews from individuals visiting medical offices, clinics, hospitals, or other settings. No flyers or other forms of announcement can be used. The purpose of this project is for class and educational purposes; this is not research and cannot be presented or written about outside of this class. All materials are confidential and cannot be shared with anyone outside of this class. A

pseudonym will be assigned to the interviewee.

This should NOT be about your own illness experience. It is recommended that you reference some of the readings from class, show evidence or insights from discussion and other material in your writing, and you should also find outside sources, either from the anthropology and/or the medical literature, on the illness you are writing about (or a related/similar condition). It is imperative that your written expression is free of grammatical and spelling errors. If English is your second language or if you're not sure about your writing skills, ask someone else to proofread your paper before you hand it in.

Note for the essays and illness experience project: Papers with significant spelling and grammatical errors will be returned ungraded for correction and late penalties will apply.

UNIVERSITY POLICY ON GRADING

University Grading Policy
http://www.mq.edu.au/policy/docs/grading/policy.html

The grade a student receives will signify their overall performance in meeting the learning outcomes of a unit of study. Grades will not be awarded by reference to the achievement of other students nor allocated to fit a predetermined distribution. In determining a grade, due weight will be given to the learning outcomes and level of a unit (ie 100, 200, 300, 800 etc). Graded units will use the following grades:

HD	High Distinction	85-100
D	Distinction	75-84
Cr	Credit	65-74
P	Pass	50-64
F	Fail	0-49

Extensions, Penalties, and Special Consideration

Late submissions on any assignment will incur a penalty, unless the unit convenor has granted an extension due to certificated medical problems or to "unavoidable disruption" (see Undergraduate Student Handbook).

Exceeding the word limit
You will be deducted 1 percentage point for each 20 words you exceed the word limit. Please take the word limit very seriously and try to make your argument concisely and clearly. It is unfair to fellow students if one person has much more space to argue their case while another student sticks firmly to the length guidelines. The word limit is designed to level the essay-writing field, so to speak. You must provide a word count beneath the title when you submit your work. The word limit excludes end-of-text references but it includes footnotes and in-text citations.

No consideration for lost work
It is the student's responsibility to keep a copy (electronic or otherwise) of all written work submitted for each unit. No consideration will be given to claims of 'lost work', no matter

what the circumstances.

Returning assignments
Student work will usually be marked and returned within two to three weeks of receipt. Students who hand their work in *before* the due date will not have it returned early.

The University recognises that at times an event or set of circumstances may occur that:

- Could not have reasonably been anticipated, avoided or guarded against by the student
- AND
- Was beyond the student's control AND
- Caused substantial disruption to the student's capacity for effective study and/or completion of required work AND
- Substantially interfered with the otherwise satisfactory fulfilment of unit or program requirements AND
- Was of at least three (3) consecutive days duration within a study period and/or prevented completion of a formal examination.

In such circumstances, students may apply for a Disruption of Studies. Disruption of Studies applications must be supported by evidence to demonstrate the severity of the circumstance(s) and that substantial disruption has been caused to the student's capacity for effective study.

Disruption of Studies applications must include specific details of how the unavoidable disruption affected previously satisfactory work by the student. The University has determined that some circumstances routinely encountered by students are not acceptable grounds for claiming Disruption of Studies. These grounds include, but are not limited, to:

- Routine demands of employment
- Routine family problems such as tension with or between parents, spouses, and other people closely involved with the student
- Difficulties adjusting to university life, to the self-discipline needed to study effectively, and the demands of academic work
- Stress or anxiety associated with examinations, required assignments or any aspect of academic work
- Routine need for financial support
- Routine demands of sport, clubs and social or extra-curricular activities

Conditions existing prior to commencing a unit of study are not grounds for Disruption of Studies. The student is responsible for managing their workload in light of any known or anticipated problems. The student is responsible for contacting Student Support Services if they have a chronic condition.

All Disruption to Studies notifications are to be made online via the University's Ask MQ system. The Student Enquiry Service will process your application and communicate it to your Unit Convenor.

For more information, see http://www.mq.edu.au/policy/docs/disruption_studies/policy.html

PLAGIARISM

The University defines plagiarism in its rules: "Plagiarism involves using the work of another person and presenting it as one's own." Plagiarism is a serious breach of the University's rules and carries significant penalties. You must read the University's definition of plagiarism and its academic honesty policy. These can be found in the Handbook of Undergraduate studies or on the web at: http://www.mq.edu.au/policy/docs/academic_honesty/policy.htm The policies and procedures explain what plagiarism is, how to avoid it, the procedures that will be taken in cases of suspected plagiarism, and the penalties if you are found guilty.

Please note that the availability of online materials has made plagiarism easier for students, but it has also made discovery of plagiarism even easier for convenors of units. We now have specialized databases that can quickly identify the source of particular phrases in a student's work, if not original, and evaluate how much is taken from sources in inappropriate ways. My best advice to you is to become familiar with the guidelines about plagiarism and then 'quarantine' the files that you are actually planning on turning in; that is, do *not* cut and paste materials directly into any work file that you plan to submit, because it is too easy to later on forget which is your original writing and which has come from other sources.
It's so easy to avoid plagiarism: all you have to do is make sure you (a) put in quotes any words taken from another source, and (b) scrupulously reference all quotes and all statements of fact. No matter what, it is always better to cite than to use someone else's words without citation.

In this class I use Turnitin to detect plagiarism and I take it very, very seriously. Plagiarism will result in a mark of zero for that assignment and, depending on the severity of the plagiarism, may result in failing the unit and/or referral to the University Discipline Committee.

ACADEMIC HONESTY

Academic honesty is an integral part of the core values and principles contained in the Macquarie University Ethics Statement: http://www.mq.edu.au/ethics/ethic-statement-final.html.

Its fundamental principle is that all staff and students act with integrity in the creation, development, application and use of ideas and information. This means that:

*All academic work claimed as original is the work of the author making the claim.
*All academic collaborations are acknowledged.
*Academic work is not falsified in any way
*When the ideas of others are used, these ideas are acknowledged appropriately.

The link below has more details about the policy, procedure and schedule of penalties that will apply to breaches of the Academic Honesty Policy which can be viewed at:
http://www.mq.edu.au/policy/docs/academic_honesty/policy.html

STUDENT SUPPORT SERVICES

Macquarie University provides a range of support services for students. For details, visit http://students.mq.edu.au/support/

For all student enquiries, visit Student Connect at http://ask.mq.edu.au

Learning Skills
Learning Skills (http://mq.edu.au/learningskills) provides academic writing resources and study strategies to improve your marks and take control of your study. Services include Workshops; StudyWise; Academic Integrity Module for Students; Ask a Learning Adviser; and, Student Enquiry Service.

Equity Support
Students with a disability are encouraged to contact the Disability Service who can provide appropriate help with any issues that arise during their studies.

IT Help
When using the University's IT, you must adhere to the Acceptable Use Policy. The policy applies to all who connect to the MQ network including students. For help with University computer systems and technology, visit http://informatics.mq.edu.au/help/

Results
Results shown in iLearn, or released directly by your Unit Convenor, are not confirmed as they are subject to final approval by the University. Once approved, final results will be sent to your student email address and will be made available in eStudent.

SEMINAR SCHEDULE AT A GLANCE AND KEY DATES

Week	Date	Lecture	Assessment
1	3 March	Introduction and the Scope of Medical Anthropology	
2	10 March	Belief, Healing, Meaning	
3	17 March	Ethnomedicine	
4	24 March	The Illness Experience I: Constructing Disorder, Experience, and Meaning	
5	31 March	The Illness Experience II: Illness Narratives and Finding Culture and Stress in Talk	

6	7 April	The Culture of Biomedicine	
Semester Break: 11 April to 25 April			
7	28 April	Cultural Competency	Exam (25 Apr)
8	5 May	The Critical Perspective: Pathologies of Power, Structural Violence, and Health as Human Right	
9	12 May	Guest	
10	19 May	Adaptation: Biocultural Approaches	
11	26 May	Research and Reading Week (no seminar)	
12	2 June	Global Health	Illness Narrative (30 May)
13	9 June	Culture and Mental Health	
Exam week	17 June		Exam (17 June)

Seminar Readings and Outline

Please note that minor modifications to the readings might occur during the semester. Adequate warning will always precede these adjustments.

Week 1: 3 March
Introduction to and Scope of Medical Anthropology
Medical anthropology encompasses a wide range of theoretical perspectives and sub-disciplines within anthropology. This week we will cover the history, scope, and key concepts in medical anthropology. We will use case studies to introduce the central theoretical perspectives used by medical anthropologists, and discuss the diverse definitions of sickness and health, focusing, in particular, on how sickness has social and cultural underpinnings in its definition, experience, and treatment.

Recommended Readings (not required but a good foundation to read and reference)

Brown, P. 2010. Medical Anthropology: An Introduction to the Fields. In *Understanding and Applying Medical Anthropology*. Boston: McGraw Hill.

Wiley, A. 2008. Anthropological Perspectives on Health and Disease. In *Medical Anthropology: A Biocultural Approach*. Oxford: Oxford University Press.

Kleinman, A and Petryna, A. 2002. Health: Anthropological Aspects. In *International Encyclopedia of the Social and Behavioral Sciences*. London: Elsevier Science, pp. 6495-6499.

Week 2: 10 March
Belief, Healing, Meaning
While we commonly think of healing in terms of material interventions, such as surgery or the use of a substance, healing also occurs through other less tangible forms. This seminar we will discuss the role of belief and meaning within the healing process and how it can help or hinder healing. The placebo effect offers an important case study for understanding the relationship between illness, healing, and cultural meaning. As Daniel Moerman argues, it's not really a placebo effect, it is a meaning effect, and the fact that rates of placebo effect vary widely for different diseases in different parts of the world shows just how culturally variable this meaning is. We will also look at its opposite, the nocebo effect, and discuss how this might explain what some have called voodoo or witchcraft deaths. In this seminar, we will also examine the "problem with belief" in anthropological research and, ultimately, confront the role that belief and meaning play in the healing process.

Required Readings

Moerman D. and Jonas W. 2002. Deconstructing the Placebo Effect and Finding the Meaning Response. *Annals of Internal Medicine* 136:471-476.

Good, Byron. 1994. Medical Anthropology and the Problem of Belief. In *Medicine, Rationality, and Experience*. Cambridge: Cambridge University Press, pp. 1-24.

Lévi- Strauss, C. 1963. The Sorcerer and His Magic. In *Structural Anthropology*, pp. 167-185. New York: Basic Books.

Recommended Readings

Luhrmann, T. 2013. Making God Real and Making God Good: Some Mechanisms Through Which Prayer May Contribute to Healing. *Transcultural Psychiatry* 50(5): 707-725.

Evans-Pritchard, E.E. 1937. Witchcraft, Magic and the Oracles among the Azande. Oxford: Clarendon Press, pp.21-39, 63-83, 540-544.

Hahn, R. 1997. The Nocebo Phenomenon: The Concept, Evidence, and Implications for Public Health. *Preventive Medicine* 26:607–11.

Moerman, D. 2002. Doctors and Patients: The Role of Clinicians on the Placebo Effect. In *Meaning, Medicine and the Placebo Effect*. Cambridge: Cambridge University Press.

Reynolds-Whyte, S., van der Geest, S., and Hardon, A. 2002. Prescribing Physicians: Medicines as Communication. In *Social Lives of Medicines*, pp.117-129. Cambridge: Cambridge University Press.

Week 3: 17 March
Ethnomedicine
Building on the previous week's discussion on the importance of symbols and the role of meaning in illness and healing, we now examine the broader foundations of ethnomedicine. Ethnomedicine is a broad field of study that explores the methods, institutions, and organizing principles that underlie medical systems. We will consider theories of disease causation, principals of curing and efficacy, medical pluralism, and the role of ritual, drama,

and spirits in our emphasis on illness and healing as both a biological and sociocultural process.

Required Readings

Quinlan, M. 2011. Ethnomedicine. *In* A Companion to Medical Anthropology. Oxford: Blackwell.

Paul, B. 1958. The Role of Customs and Beliefs in Sanitation Programs. *American Journal of Public Health*. 48:1502-1506.

Reynolds-Whyte, S., van der Geest, S., and Hardon, A. 2002. Mothers and Children: The Efficacies of Drugs. In *Social Lives of Medicines*, pp. 23-36. Cambridge: Cambridge University Press.

Rebhun, L. 1994. Swallowing Frogs: Anger and Illness in Northeast Brazil. *Medical Anthropology Quarterly* 8(4): 360-382.

Recommended Readings

Konner, M. 1985. Transcendental Medication. *The Sciences*, May/June.

Baer, R., Clark, L., and Peterson C. 1998. Folk Illnesses. In: *Handbook of Immigrant Health*, pp. 183-202.

Foster, G. 1976. Disease Etiologies in Non-Western Medical Systems. *American Anthropologist* 78: 773-782.

L. Garro. 2000. Cultural Meaning, Explanations of Illness, and the Development of Comparative Frameworks. Ethnology 39(4):305-334.

Week 4: 24 March

The Illness Experience I: Constructing Disorder, Experience, and Meaning

The illness experience—the patient's view of sickness, its meanings, and their suffering—is closely shaped by culture. Moreover, the meaning and experience of any illness, which are too often understood as being idiosyncratic or subjective, are reflective of the larger social, political, economic, and moral concerns that surround us. This week we begin to focus on the illness experience in terms of the "materials" used to construct experiences and social categories. We will learn how to consider the patient's point of view in relation to the larger context in which she is embedded. We will start by questioning what is (or constitutes) an "experience." How do people "learn" to have an illness? We will also consider the sick role—or the socially expected behaviour for people with particular types of conditions—and come to see the ways in which metaphor and idioms of distress shape our experience and expression of illness.

Required Readings

Waxler, N. E. 1981. Learning to Be a Leper: A Case Study in the Social Construction of Illness. In *Social Contexts in Health, Illness, and Patient Care*. Cambridge: Cambridge University Press.

Nichter, Mark. 2010. Idioms of Distress Revisited. *Culture, Medicine and Psychiatry*,

34: 401-416.

Kirmayer, Laurence. 1992. The Body's Insistence on Meaning: Metaphor as Presentation and Representation in Illness Experience. *Medical Anthropology Quarterly*, 6(4), pp. 323-46.

Recommended Readings

Desjarlais, Robert. 1994. Struggling Along: The Possibilities for Experience among the Homeless Mentally Ill. *American Anthropologist*, 96: 886-901.

Nichter, Mark. 1981. Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India. *Culture, Medicine and Psychiatry*, 5(4):379-408.

Ware, Norma C. 1992. Suffering and the Social Construction of Illness: The Delegitimation of Illness Experience in Chronic Fatigue Syndrome. *Medical Anthropology Quarterly*, 6(4): 347-361.

Kleinman, A. 1988. The Personal and Social Meanings of Illness. In *The Illness Narratives: Suffering, Healing & the Human Condition*, pp. 31-55. New York: Basic Books.

Week 5: 31 March

The Illness Experience II: Illness Narratives and Finding Culture and Stress in Talk

People externalize their experiences of ill health and healing processes through illness narratives. Narratives are constructed and presented in a language of distress (verbal or non-verbal) that is influenced by one's social, cultural, historical, and political-economic context, and drawn from a repertoire of idiom, metaphors, imagery, and myth. Continuing from last week, this seminar will introduce us to the narrative process. We will discuss how to elicit and analyse illness narratives from a variety of perspectives and emphasize the role that the narratives play in meaning production. This seminar is essential to the completion of the illness experience project.

Required Readings

Hunt, L. 2000. Strategic Suffering: Illness Narratives as Social Empowerment among Mexican Cancer Patients. In *Narrative and the Cultural Construction of Illness and Healing*, pp. 88-107. Berkeley: University of California Press.

Good, B. 1994. The Narrative Representation of Illness. In *Medicine, Rationality, and Experience*, pp. 135-165. Cambridge: Cambridge University Press.

Kleinman, A. 1988. The Personal and Social Meanings of Illness. In *The Illness Narratives: Suffering, Healing & the Human Condition*, pp. 31-55. New York: Basic Books.

M. D. Groleau, Young, A. and Kirmayer, L. 2006. The McGill Illness Narrative Interview (MINI): An interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry*, 43(4): 671-691.

Recommended Readings

Mattingly, C. 1994. The Concept of Therapeutic Emplotment. *Social Science and Medicine,* 38(6):811-822

Garro, L. and Mattingly, C. 2000. Narrative as a Construct and Construction. In *Narrative and the Cultural Construction of Illness and Healing*, pp. 1-49. Berkeley: University of California Press.

Levy. R. and Hollan, D. 1998. Person-Centered Interviewing and Observation. In *Handbook of Methods in Cultural Anthropology*. Walnut Creek, Cal.: Altamira.

Week 6: 7 April

The Culture of Biomedicine

The development of biomedicine over the past few centuries has led to enormous changes in our understanding of the human body and its functions: as the body was penetrated by science it has been commodified and medicalised. The female body has been a particular focus of scientific and medical discourse and women's reproductive functions have become defined in terms of abnormalities that must be treated through medical intervention. This seminar turns a critical lens towards biomedicine, examining its origins and underlying assumptions. Central questions include: How does biomedicine define normality? How do medical practices contribute to the medicalisation of the female body? How does culture inform the practice of medicine and the ways that biological processes are represented?

Required Readings:

Kleinman, Arthur. 1995. What is Specific to Biomedicine? In *Writing at the Margin: Discourse between Anthropology and Medicine*. Berkeley: University of California Press, pp. 21-40.

Good, B. 1994. How Medicine Constructs its Objects. In *Medicine, Rationality, Experience*, pp. 65-87. Cambridge: Cambridge University Press.

Martin, E. 1991. The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotyped Male-Female Roles. *Signs*, 16(3):485-501.

Recommended Readings:

Mishler, E. 1981. Viewpoint: Critical Perspectives on the Biomedical Model. In *Social Contexts of Health, Illness, and Patient Care*, pp. 1-23. New York: Cambridge University Press.

Johnson, T. 1990. Anthropology and the World of Physicians. *Anthropology Newsletter*, November/December.

Martin, E. 1988. Medical Metaphors of Women's Bodies: Birth. In *The Woman in the Body*, pp. 54-67. Boston: Beacon Press.

Gawande, A. 2002. Education of a Knife. In *Complications: A Surgeon's Notes on an Imperfect Science*, pp. 11-34. New York: Picador.

RECESS (11 April – 25 April)

Week 7: 28 April
Cultural Competency

Anne Fadiman is not an anthropologist, but a journalist who documents some classic problems of medical anthropology and brings anthropological theory to bear on her question of "could Lia's story have had a happier ending?" She takes Arthur Kleinman's concept of the patient's "explanatory model" and crafts an argument for "cultural competency" training in medicine. The notion of cultural competency is in vogue in medical education these days, with many training programs making a cultural competency class mandatory for their medical students. Calls for medical professionals to attain cultural competence in order to better care for minority and underserved patient populations have become so widespread in medicine that they are codified by the American Medical Association. Yet even though the concept of cross-cultural awareness comes from anthropologists, it is anthropologists who have been at the forefront of critiquing cultural competency models. For the Seminar discussion: Consider Paul Farmer's argument that "culture does not explain suffering; it may at worst furnish an alibi" (*Pathologies of Power* p.49). What should the role of culture be in medical care? Should doctors be expected to be competent in other cultures? Is it possible for cultural competency to avoid becoming a "back door for racism"?

Required Readings

Fadiman, A. 1997. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Straus, and Giroux.

Taylor, J. 2003. "Confronting Culture in Medicine's Culture of No Culture." *Academic Medicine,* 78(6):555–559.

Kleinman, A. and Benson, P. 2006. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It." *PLoS Medicine,* 3(10):294.

Lee, A. S. and Farrell, M, 2006. "Is Cultural Competency a Backdoor to Racism?" *Anthropology News,* 47(3):9-10.

Recommended Readings

Taylor, J. 2003. The Story Catches You and Your Fall Down: Tragedy, Ethnography, and Cultural Competence. *Medical Anthropology Quarterly* 17(2):19-181.

Carrillo, J. E., Green, A. R., & Betancourt, J. R. 1999. "Cross-cultural Primary Care: A Patient-based Approach." *Annals of Internal Medicine,* 130(10):829-834.

Koehn, P. H. and Swick, H. M. 2006. "Medical Education for a Changing World: Moving Beyond Cultural Competence into Transnational Competence." *Academic Medicine,* 81(6):548-556.

Week 8: 5 May
The Critical Perspective: Pathologies of Power, Structural Violence, and Health as Human Right

Common biomedical assumptions for sickness and healing place responsibility solely on the individual, using language that invokes notions of personal choice and compliance in health decision-making and treatment. However, larger macro processes play a significant role in structuring the epidemiology of disease and health and, in many respects, leave little or no individual choice as to whether one remains healthy. This seminar introduces the political-economic and social explanations for disease, questioning the relationship between structure and agency and, specifically, how society can make you sick. Additionally, we will discuss why this theoretical perspective often elicits a significant applied and activist approach by medical anthropologists. In the last part of the seminar, we will consider the works of notable applied anthropologist and physician, Paul Farmer, and his argument about the central role that social inequalities play in the geography of disease. We will direct specific attention to his applied approach and the practical elements that can be used within our own anthropological, social service, and/or development interests and work.

Required Readings:

Farmer, P. 1999. Introduction. In *Infection and Inequalities: The Modern Plagues*, pp. 1-17. Berkeley, Los Angeles: University of California Press.

Farmer, P. 2005. Introduction. In P*athologies of Power: Health, Human Rights, and the New War on the Poor*, pp. 1-22. Berkeley: University of California Press. Read to Page 20.

Farmer, P. 2005. On Suffering and Structural Violence. In *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, pp. 29-50. Berkeley: University of California Press.

Recommended Readings:

Kidder, Tracy. "The Good Doctor." *The New Yorker*, July 10, 2000, pp. 40-57.

Virchow, R. (1985) [1879]. "The Charity Physician." In *Collected Essays on Public Health and Epidemiology*, pp. 33-36. Canton, MA: Science History Publications.

Farmer, P. 1999. "Rethinking Emerging Infectious Diseases." In *Infection and Inequalities: The Modern Plagues*, pp. 37-58. Berkeley: University of California Press.

Leatherman, T. 2005. "A Space of Vulnerability in Poverty and Health: Political-Ecology and Biocultural Analysis." *Ethos* 33(1):46-70.

Singer, M. 1995. "Beyond the Ivory Tower: Critical Praxis in Medical Anthropology." *Medical Anthropology Quarterly* 9:1.

Singer, M. et al. 1992. "Why does Juan Garcia have a Drinking Problem?" *Medical Anthropology* 14(1):77-108.

Nichter, M. and Cartwright, E. 1991. "Saving the Children for the Tobacco Industry." *Medical Anthropology Quarterly* 5(3):236– 256.

Week 9: 12 May
Disparate Embodiments: Mindful, Racialized, and Addicted Bodies
This week we continue our discussion on structural violence and health inequalities, but we will approach it from a slightly different angle. First, we will examine anthropological perspectives on the body, particularly how the body can be understood as a means for "being-in-the-world" (the body as an experiencing subject) and as an analytic focal point for understanding social, political, and economic institutions and processes. Focusing on bodies and embodiment—where people literally incorporate into their bodies the social and material realities in which they live—we will consider how the intersections of race, ethnicity, inequality, and addiction are inscribed upon bodies. Dr Anupom Roy will be joining our seminar this week as a guest facilitator.

Required Readings:

Scheper-Hughes, N. and M. Lock. 1987. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1 (1): 6-41. *Read: 6-28 (scan the rest)*

Bourgois, P. and J. Schonberg. 2009. "Introduction" and "A Community of Addicted Bodies." In *Righteous Dopefiend*. Berkeley: University of California Press, pp. 1-7, 15-21 (or all of the intro 1-21), and 79-115.

Recommended Readings:

See iLearn

Week 10: 19 May
Adaptation: Biocultural Approaches
Biocultural approaches in medical anthropology critically attend to the intersections between biological and cultural theories and methods for answering questions about well-being and the ways in which disease and embodiment are integrated. This week we will be focusing on the role of adaptation in both evolutionary and cultural forms. We will consider the roles of natural selection, pathogen evolution, and contrast the slow pace of biological evolution with more rapid forms of cultural adaptation. We will also explore the health challenges facing earlier human populations and consider how and why things change. To conclude we will question what diseases the future might hold in the context of rapid change and our historical and evolutionary history.

Required Readings:

Nesse, R. and Williams, G. 1998. Evolution and the Origins of Disease. *Scientific American* 279(5):86-93.

Brown, P. 1981. Cultural Adaptation to Endemic Malaria in Sardinia. *Medical Anthropology* 5(3):311-339.

Barrett, R., et al. 1998. Emerging and Re-emerging Infectious Diseases: The Third Epidemiologic Transition. *Annual Review of Anthropology* 27:247-271.

Recommended Readings:

Eaton, B. 2002. Evolutionary Health Promotion. *Preventive Medicine* 34:109-118.

Eaton, S. B., Shostak, M. and Konner, M. 1988. Stone Agers in the Fast Lane: Chronic Degenerative Diseases in Evolutionary Context. *American Journal of Medicine* 84:739-749.

Nesse, R. 2008. Evolution: Medicine's Most Basic Science. *The Lancet* 372: S21-S27.

Armelagos, G. et al. 2005. Evolutionary, Historical and Political Economic Perspectives on Health and Disease. *Social Science and Medicine* 61(4):755-765.

Week 11: 26 May
Research and Reading Week
There is no seminar or readings this week. Complete you illness narrative projects.

Week 12: 2 June
Global Health
Global health recognizes a holistic understanding of health that transcends borders and encompasses the links and transnational movements of people, materials, and ideas. We will explore a framework for understanding the complex ways health and disease intersect within a range of global contexts, institutions, and practices. The health challenges and quality of life within and between communities and nations are unequal. While gains have been made in global health over the past decades, the gap reflected in health and heath care disparities remains significant and, in some regions, is increasing. In order to affect change at the individual, community and global levels, we need to appreciate how human biology and health are shaped by the larger contexts in which they are embedded and the dynamic and uneven circulation of resources, technology, culture, values and people. Since health solutions are context dependent, a primary goal of this seminar is to develop skills to think creatively about health problems and envision innovative ways of confronting health issues and identifying the benefits and consequences of interventions and their impact.

Required Readings:

Biehl, J. and Petryna, A. 2013. "Critical Global Health." In *When People Come First*.

Renee, E. 2010. "Introduction: Protesting Polio." *The Politics of Polio in Northern Nigeria*.

Recommended Readings:

Langwick, S 2007. "Devils, Parasites, and Fierce Needles: Healing and the Politics of Translation in Southern Tanzania." *Science, Technology, and Human Values* 32(1):88-117.

Farmer, P. 1996. "Social Inequalities and Emerging Infectious Diseases." *Emerging Infectious Diseases,* 2(4):259-269.

Critical Anthropology for Global Health (CAGH) Study Group. 2008. "What can critical medical anthropology contribute to global health - A health systems perspective."

Cohen, Jon. (2006). "The New World of Global Health." *Science*, January 13, 311(5758):162-167

Week 13: 9 June
Culture and Mental Health

At this point in the unit, it has become clear that culture defines normality and how illness is experienced depends upon the person's broader context. If we consider sickness to have social and cultural underpinnings in its definition, experience, and treatment, then a logical assumption is that different cultures will demonstrate different forms of illness. This becomes particularly salient when we look at culture and mental health. In this seminar we will consider mental illness cross-culturally and discuss the globalization of "Western" forms or categories of mental illness. We will ask: What is a mental disorder and how does culture influence how we define mental disorders? We will also engage the debate between those that believe that universal forms of mental illness and treatment approaches exist and those that consider it risky and a form of Western neo-colonialism.

Required Readings

Kleinman, A. 1988. "Do Psychiatric Disorders Differ in Different Cultures?" In *Rethinking Psychiatry: From Cultural Category to Personal Experience*, pp. 18–33. New York: Free Press.

Watters, E. 2010. "The Americanization of Mental Illness." *New York Times*

Obeyesekere, G. (1985). Depression, Buddhism, and the Work of Culture in Sri Lanka. Culture and Depression. Berkeley: University of California Press, pp. 134-152.

Recommended Readings

Summerfield, D. 2008. "How scientifically valid is the knowledge base of global mental health?" British Medical Journal 336(7651): 992-994.

Patel, Vikram. 2010. "Global Mental Health: A new global health field comes of age." *The Journal of the American Medical Association*, 303(19). 1976-1977.

P. Collins, V. Patel, S. Joestl, et al. 2011. "Grand Challenges in Global Mental health." *Nature* 475(27): 27-30.

Kleinman, Arthur. 2009. Global Mental Health: A Failure to Humanity? *The Lancet* 374(9690): 603-604.

Suwanlert, S. and Hahn, R. 2008. "Do Some Illnesses Exist Only Among Members of a Particular Culture? The Case of Phii Pob." In *Taking Sides: Clashing Views in Cultural Anthropology*. New York: McGraw Hill.

Anderson, J. 1996. "Is Childhood Hyperactivity the Product of Western Culture?" *The Lancet* 348:73-74.

Kleinman, A. 1988. "What is a Psychiatric Diagnosis?" In *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press.