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Creating Methods that Speak Across Disciplines in Medical Anthropology

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By Emily Mendenhall

María and I finished our three hours together with a blood spot and a hug. It was an extra long hug, and I couldn't be sure if it was her or me who lingered. I was three-fourths of the way through my dissertation research at one of Chicago's oldest public hospital clinics and it had been an intense period. María was one of 28 women who shared with me a devastating narrative of childhood sexual abuse. But today, María was one of two. Even more, these interviews were back-to-back, leading to a seven-hour stretch of interviewing. To say the least, I was exhausted.

I packed up my computer after I finished my field notes (conducted immediately after each interview), and placed my measuring tape, audio-recorder, and dried blood spot—protected in a plastic zip-lock—carefully into my satchel. I picked up my portable scale that I dutifully carried across the hospital each night to tuck away in my office, and I locked the door of the private room in the general medicine clinic where I conducted many interviews. I walked to the elevator and took it down a level to the pharmacy. Each day I savored those minutes as I walked through the pharmacy, filled with people from all walks of life, and most days I ran into someone I knew and conversed with them. These ethnographic moments sometimes gave me the best insight. Yet, that day I was too exhausted for more conversation. I kept my head down and carried my satchel and scale right out the door, crossed the road, entered the hospital, and swerved through the halls until I reached my adjacent office building. I swiped my security card, entered another elevator, and pressed the button for the fourteenth floor. As the door closed, I leaned my back against the wall of the elevator and let out a deep sigh.

The door opened on the fourteenth floor and I rushed to my office where my dedicated mentor still sat at six o'clock, talking on the phone with the loved one of a patient. I set down my gear and heard the click of the phone. I poked my head into her office and she motioned for me to sit down. I collapsed into the chair. She looked at me, and said, "Tough day, huh?"

For the next half-hour we discussed the two Mexican immigrant women I met and spent seven hours interviewing. That day had been one of the

most difficult, where one woman was sexually abused by a relative and another was gang raped and left to die near her village in southern Mexico. These were trying interviews and my mentor knew that these women's narratives were difficult to receive and process. I described the stories to my mentor, a researcher and internal medicine physician in that public hospital clinic, and she said, "I never knew my patients experienced so much suffering. We need to share these stories with the clinic staff."

Eventually, I published my mixed methods research in a book entitled *Syndemic Suffering* as well as peer-reviewed articles, and the women's stories were communicated to the clinic staff at Grand Rounds of the county hospital. In doing so, we believe that the sensitive nature of our findings were communicated effectively both with health care providers and associated research bodies. However, the multiple steps that brought me to that day of interviewing were fundamental for shaping how the mixed ethnographic and survey interviews—complemented with psychiatric inventories, anthropometric measures, and dried blood spots—were designed, implemented, and analyzed. In the following essay, I will explain the multiple waves of data collection we orchestrated – from foundational exploratory focus groups and ethnographic interviews to a large-scale epidemiological survey and finally my mixed-methods dissertation research. Then, I will offer some advice about how to effectively carry out and communicate mixed-methods anthropological research with an audience of mixed company. But first let me begin with our focus groups and exploratory ethnographic research in 2006.

"Have you heard of *susto*?" my mentor inquired. "Susto? I think it means fright, or being frightened. [Pause] Why?" My mentor continued, "Some researchers have found that people use fright to make sense of their diabetes. Some of my Mexican patients connect *susto* with their diabetes. I want to include this in our study." With this prompt I began conducting literature reviews on culture, immigration, and community medicine, and then did more specialized searches for literature on Mexican beliefs, *susto*, diabetes, and acculturation. Over the next several months we orchestrated seventeen focus groups in a multiethnic sample, and I conducted 26 ethnographic interviews with Mexican immigrants with type 2 diabetes under the complementary mentorship of my PhD advisor. I benefited a great deal from collaborating with a physician-researcher and medical anthropologist, receiving mentoring from both the clinical and anthropological angles of the research.

Pairing multiple levels of inquiry enabled us to see through our assumptions and unveiled a clearer frame of our interlocutors' lives, priorities, and needs. The focus group data were published in a health education journal, but the chief utility of these data was to develop a survey administered to 800 patients with diabetes. This survey provided a

robust understanding of the population-level trends around belief, healthcare access, and diabetes care. However, the rich ethnographic data revealed individual-level social and health problems that converged and indicated that, although initially we were concerned with cultural idioms of emotional distress like *susto* and *coraje*, it was the social problems and structural barriers that were at the center of our interlocutors' lives. Rooted in syndemics theory, I coined the phenomenon the VIDDA Syndemic, as the research illustrated how social and health problems clustered together in women's lives. VIDDA stands for structural violence, immigration, depression, diabetes, and abuse; these five factors were described in depth in women's narratives and associated in multivariate regression analyses to demonstrate interdependence. I argue in my book *Syndemic Suffering* that the factors in VIDDA come together as a biofeedback loop where social problems fuel medical problems, which further complicate social and economic experiences.

In what remains, I offer three key points about the research design used for that mixed-methods study that demonstrate ideal methods for speaking to implementers in medicine and public health. First, speaking across disciplines requires that we renegotiate what is a suitable "n". In my research I conducted analyses of a variety of data collected among 121 low-income Mexican immigrant women with diabetes in Chicago, including life history narratives, surveys, psychiatric interviews, and biomarker data. Although laborious to collect so many lengthy interviews, the "n" gave me power to speak about narrative trends and associated health outcomes. Second, consider analyzing ethnographic data in qualitative and quantitative ways. Breaking down qualitative data into measureable entities makes it easier for practitioners less familiar with qualitative research to digest and apply. Then, with a large enough "n" you can transport qualitative data into quantitative analyses, bringing narrative into dialogue with health markers. Third, accept that mixed methodological research may require that you analyze, publish, and communicate your work in two or more venues. For tenure in an anthropology department, you need to publish in high-level anthropological journals. But you also need to publish your research in journals and other venues accessible and relevant to applied researchers, clinicians, and policy-makers to ensure research uptake, such as blogs and other online forums (such as the OpED Project at *Huffington Post*).

Let me provide some examples of how I bring ethnographic approaches into dialogue with colleagues in medicine and public health. I conducted my dissertation research around issues of trauma, memory, mental health, and chronic illness among Mexican immigrants seeking diabetes care at a public hospital in Chicago. To meet competing demands from my PhD committee and clinicians at the county hospital, I triangulated in depth life history narrative interviews with surveys about social and economic

experiences, subjective measures of stress, psychiatric inventories, and blood samples. However, instead of conducting ethnographic interviews with a smaller number of people repeated over a lengthy period of engagement, my research incorporated lengthier inquiries during a one-stop interview. Indeed, the one-stop qualitative interview is more common in public health; however, I felt that the in depth interview – which took as short as two and as long as six hours – provided a unique perspective and got to, in this case, the heart of the matter. Because the interview built upon findings from a small ethnographic project, focus group study, and survey with hundreds of participants, this final “wave” of data collection focused on tying up loose ends and further probing into queries left unanswered.

The multi-level analytic strategy I developed was fundamental to my ability to bring this research into dialogue with a broader audience. I made sure to analyze the narrative data not only for the “emergent themes” but also for how the narrator made sense of the events of her life. Like Cheryl Mattingly’s theory of “emplotment” of narratives in the clinical space that “do” something, my research revealed how documented and undocumented Mexican immigrant women used narratives to reconstruct a meaningful life, and especially to make meaning and in some cases link traumatic experiences together. For instance, Rosie, a protagonist in my book, *Syndemic Suffering*, connected a traumatic experience from childhood with the onset of chronic illness in later life. Despite 40 years of relative success, including a master’s degree and high-level position in the education field, she prioritized the trauma of her childhood with the trauma of her adulthood as the most significant periods of her life. Rosie’s story illustrates the depth through which she remembers, organizes, and makes meaning of her life experiences. Importantly, personal narrative accounts are subjective and should be considered in light of the contemporary time and place through which an interlocutor shares her or his story (see also Mendenhall 2012). But the distinct order through which she shares her story provides insight into cultural, social, and psychological factors that may play a fundamental role in the course of one’s life.

Beyond narrative analysis, I quantify my interlocutors’ responses into an Excel spreadsheet that allows me to input them into STATA. Because the “n” was large enough (although this was debated by my PhD committee), I could communicate the qualitative data into quantitative language. This means not only publishing emergent themes in tables and demonstrating the “frequency” in which they were communicated across women’s life stories, but also inputting them into regression analyses to see if certain narratively generated subjective stressors were associated with mental and physical health outcomes. Such an approach is particularly relevant for work with Latin American immigrant populations, as demonstrated by

Susan Weller, Roberta Baer and colleagues. They have made a strong argument for the association between reporting emotional idioms of distress, including *susto* and *nervios* and biomedical measures of distress such as depression and anxiety. Others such as Lesley Jo Weaver and Bonnie Kaiser, in India and Haiti respectively, have combined open-ended and structured interviewing to develop instruments to assess mental health in culturally relevant ways. Indeed, by examining ethnographically-driven markers of distress along with biomedical markers, we can make a stronger case for the need to provide mental health services for populations who are underserved or less visible to the state. Such examples exemplify how ethnographic approaches can become more visible (or brashly, “measureable” and “interpretable”) for biomedical and public health audiences.

Such approaches matter not only to make our work clearly stand out to other communities of practice but also to foster awareness among funders outside of the social sciences. With looming budget cuts to the social sciences and a difficult job market, medical anthropologists must gravitate to research funding and jobs across disciplines. Despite historical lack of funding for ethnographic work, by communicating our research in new ways, and with new “outcomes,” we can bring funders and policy-makers into conversation with the proponents of ethnographic projects. To ensure that our research becomes part of the fabric of public health, we need to flood application pools for public health projects with innovative, interdisciplinary research programs. This might be a multi-layered project, with wave one being an in depth ethnographic study, and wave two a more “measureable” or larger-scale project; it may also be the application and/or extrapolation of a previous ethnographic project. Moreover, our ethnographic work may be situated in collaborative multi-disciplinary teams. By making our research digestible by a wide audience, we ensure that our research becomes integrated into public health paradigms. (Until, of course, we change the culture of power, politics, and privilege in public health research and policy so that ethnographers are given a privileged seat at the table). This is important not only to ensure the relevance and growth of our field of medical anthropology but also to make an impact in the lives of the people with whom we work.

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