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## In the Journals, October 2019

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By Anna Zogas

Here are some highlights from journals with new issues published in October. Enjoy!

### [Annual Review of Anthropology](#)

#### [Physician Anthropologists](#)

*Claire L. Wendland*

Physician anthropologists have contributed extensively to the anthropology of biomedicine, as well as to other aspects of medical anthropology. Their use of detailed clinical case narratives allows elucidation of what is at stake for individuals and communities in the course of any given illness. Biomedically informed observations of bodies illustrate the connections between microscopic harm and macrosocial arrangements, while observations of clinical spaces and medical knowledge production contribute to current debates over evidence, metrics, migration, and humanitarianism. In moving away from culturalist explanations for illness, physician anthropologists have drawn attention to the manifold workings of structural violence—and have often sacrificed the possibility of deep epistemological challenges to biomedicine. While raising a note of caution about the moral authority of physician anthropologists, I recognize that much of this scholarship has laid the intellectual groundwork for a movement toward equity that refuses to justify poor-quality health care for poor people.

### [The Anthropology of Death Revisited](#)

*Matthew Engelke*

This article brings together classic work in the anthropology of death, much of which focused on funerary rites, with more recent studies, some of which continue with the classic focus and some of which introduce distinct views and problematics. The anthropology of death has become a capacious field, linking to broader debates on violence, suffering, medicine, subjectivity, race, gender, faith, modernity, and secularity (among others). In much of this work,

though, we find common concerns with, and recurrent considerations of, certain themes. This review focuses on two of the most important: the symbolic imaginaries of how life conquers death; and, even more centrally, the materiality of death. A range of topics are addressed, including putrescence, burial, bones, commemorations, debts, care, sovereignty, and personal loss.

### [Anthropology Quarterly](#)

#### [Billable Services and the “Therapeutic Fee”: On the Work of Disavowal of Political Economy and its Re-emergence in Clinical Practice](#)

*Talia R. Weiner*

This article analyzes the structural contradictions in the professional lives of social workers and counselors (“psychotherapists”) that give rise to a set of rationalizing discourses that align billing practices with notions of therapeutic appropriateness. I propose that, bound by a normative professional trajectory that prescribes upward mobility on one hand and the performance of a commitment to helping the underprivileged on the other, psychotherapists attempt to manage the ambivalence that these divergent imperatives invoke by working discursively to disavow the role of political economy in shaping their clinical activities. As therapists move along a career path that begins in an agency setting and culminates in private practice, they deploy situated strategies for effacing economic considerations by shifting to a moral register. In so doing, I argue, psychotherapists inadvertently articulate and legitimate a class-differentiated “moral economy of mental healthcare” that reasserts precisely the market-based logics that it seeks to transcend.

### [Critical Public Health](#)

#### [Critical social science \*with\* public health: Agonism, critique and engagement](#)

*Eric Mykhalovskiy, Katherine L. Frohlich, Blake Poland, Erica Di Ruggiero, Melanie J. Rock & Leigha Comer*

This article is about a mode of scholarly practice we call critical social science with public health. The article responds to our dissatisfaction with established approaches to social science engagement with public health that have developed out of Straus’ early distinction between sociology in and of medicine. By critical social science with public health we mean a set of research

practices that orients to epistemological and political differences between social science and public health as productive opportunities. We draw on Mouffe's notion of agonism to ground our argument conceptually and on our collaborative research with tobacco control to substantively illustrate our case. As we imagine it, critical social science with public health unsettles knowledge relations that position social science either as a conceptual resource for public health or as a source of negative critique of public health activities. Critical social science with public health engages directly with public health actors, while remaining committed to the specificity of social science theory and methodology. It aims to transform public health, often by seeking to lessen the harmful effects of public health practice, while, at the same time, contributing to critical social science scholarship.

[An ethnographic study of enrollment obstacles in Rhode Island, USA: struggling to get covered on an Affordable Care Act insurance marketplace](#)

*Jessica Mulligan, Stephanie Arriaga & Jeannette Torres*

The Affordable Care Act (ACA) of 2010 expanded access to health insurance coverage in the United States through online marketplaces that provided subsidized insurance coverage. Nonetheless, many obstacles made it difficult to enroll in and maintain ACA insurance coverage. In this article, we analyze obstacles to enrollment and continuous coverage based on an ethnography of ACA insurance enrollment in Rhode Island. We foreground consumers' experiences and highlight the time and effort that people invested into getting covered. Unlike studies that focus on individual choices and employ a deficit perspective to understand gaps in coverage, this article argues that structural problems related to the organization of the American health insurance system, economic instability and bureaucratic eligibility criteria shaped the experiences of individuals and families seeking coverage. We found that people actively and intensely struggled to enroll and were met with multiple obstacles, most of which were beyond their control. In some cases, these obstacles resulted in gaps in coverage. In almost all cases, they created additional stress, were time consuming and frustrating. The most significant obstacles to enrolling in coverage were bureaucratic barriers, affordability, changes in personal or family status, and knowledge about health insurance and ACA program rules. We end by questioning the ethical basis of a health coverage system structured on 'churn' and offer policy recommendations to design programs that respect people's time, avoid verification

redundancies and are motivated by a mission to expand coverage.

[Medicine, Anthropology, Theory](#) (*Open Access*)

[Algorithmic futures: The life and death of Google Flu Trends](#) (*open access*)  
*Vincent Duclos*

In the last few years, tracking systems that harvest web data to identify trends, calculate predictions, and warn about potential epidemic outbreaks have proliferated. These systems integrate crowdsourced data and digital traces, collecting information from a variety of online sources, and they promise to change the way governments, institutions, and individuals understand and respond to health concerns. This article examines some of the conceptual and practical challenges raised by the online algorithmic tracking of disease by focusing on the case of Google Flu Trends (GFT). Launched in 2008, GFT was Google's flagship syndromic surveillance system, specializing in 'real-time' tracking of outbreaks of influenza. GFT mined massive amounts of data about online search behavior to extract patterns and anticipate the future of viral activity. But it did a poor job, and Google shut the system down in 2015. This paper focuses on GFT's shortcomings, which were particularly severe during flu epidemics, when GFT struggled to make sense of the unexpected surges in the number of search queries. I suggest two reasons for GFT's difficulties. First, it failed to keep track of the dynamics of contagion, at once biological and digital, as it affected what I call here the 'googling crowds'. Search behavior during epidemics in part stems from a sort of viral anxiety not easily amenable to algorithmic anticipation, to the extent that the algorithm's predictive capacity remains dependent on past data and patterns. Second, I suggest that GFT's troubles were the result of how it collected data and performed what I call 'epidemic reality'. GFT's data became severed from the processes Google aimed to track, and the data took on a life of their own: a trackable life, in which there was little flu left. The story of GFT, I suggest, offers insight into contemporary tensions between the indomitable intensity of collective life and stubborn attempts at its algorithmic formalization.

[Global health futures? Reckoning with a pandemic bond](#) (*open access*)  
*Susan Erikson*

Since 2010, there has been a discernable expansion of global health financing forms using private equity, bonds, and 'facilities'

to finance international development and humanitarian endeavors. I present the logics of the Pandemic Emergency Facility (PEF), a World Bank device that lashes together a bond, cash, and swaps to lie in reserve for an infectious disease outbreak. I explain how the PEF is emblematic of financial devices that have the potential to fund global health aid while offering investors a chance to make money. Reckoning with the pandemic bond means that we take account not only of the PEF (what does it organize and by what logics?) but also of the relationships it cultivates (what does it bind together?) and reproduces (what does it aim to multiply and what does it forsake?). I use 'reckoning with' as an analytic concept to help us think about measures and futures of global health in both economic and ethical registers, as well as to take account of how death data is used. Reckoning with something lets us pause to take account of where we are and where we are going, and helps us think about what we want. Is it necessary to translate the ethical obligation to help those who are suffering into financial devices that make people money, a trend we are clearly in the initial stages of? Are there conditions when the suffering of others as the source of financial speculation becomes desirable?

### [Social Science & Medicine](#)

#### [Collective self-experimentation in patient-led research: How online health communities foster innovation](#)

*Joanna Kempner, John Bailey*

Researchers across academia, government, and private industry increasingly value patient-led research for its ability to produce quick results from large samples of the population. This study examines the role played by self-experimentation in the production of health data collected in these projects. We ask: How does the collaborative context of online health communities, with their ability to facilitate far-reaching collaborations over time and space, transform the practice and epistemological foundations of engaging in  $n = 1$  experimentation? We draw from a digital ethnography of an online patient-led research movement, in which participants engage in self-experiments to develop a protocol for using psilocybe-containing mushrooms as a treatment for cluster headache, an excruciating neurological disease for which there is little medical research and huge unmet treatment need. We find that the collectivizing features of the internet have collectivized self-experimentation. Group dynamics shape everything in "collective self-experimentation," from individual choices of

intervention, reporting of outcomes, data analysis, determinations of efficacy, to embodiment. This study raises important questions about the role that individuals play in the creation of medical knowledge and the data that informs crowdsourced research.

[On the limitations of barriers: Social visibility and weight management in Cuba and Samoa](#)

*Hanna Garth, Jessica Hardin*

Obesity is an enduring global health challenge. Researchers have struggled to understand the barriers and facilitators of weight loss. Using a cross-cultural comparative approach, we move away from a barriers approach to analyze obesity and overweight through the lens of social visibility to understand the persistent failure of most obesity interventions. Drawing on ethnographic data from Cuba and Samoa collected between 2010 and 2017, we argue that social visibility is a framework for analyzing some of the reasons why people do not participate in weight management programs when they have high rates of health literacy and access to free or low-cost programming. Comparing these two places with very different histories of obesity interventions, we trace how weight management practices make people socially visible (in positive and negative ways), specifically analyzing how gender and economic inequalities shape the sociality of obesity. Our findings show that regardless of barriers and facilitators of weight loss at an individual and population level, the ways weight loss activities are incorporated into or conflict with the social dynamics of everyday life can have a profound effect on weight management. Employing visibility as a analytic framework de-individualizes weight responsibility, providing a contextual way to understand the difficulties people face when they manage their weight.

[“I was obligated to accept”: A qualitative exploration of contraceptive coercion](#)

*Leigh Senderowicz*

Despite narratives about empowering women through contraception, global family planning programs are evaluated primarily by their ability to increase contraceptive uptake and reduce fertility in the developing world. Some scholars have raised concerns that this emphasis on fertility reduction and contraceptive uptake may contribute to situations where women are coerced into adopting contraceptive services they do not fully understand or want. Yet surprisingly little data have been collected to investigate

whether such coercion exists or how it might manifest. In-depth interviews with 49 women of reproductive age in a sub-Saharan African country begin to fill this knowledge gap. Respondents reported a range of non-autonomous experiences including biased or directive counseling, dramatically limited contraceptive method mix, scare tactics, provision of false medical information, refusal to remove provider-dependent methods, and the non-consented provision of long-acting methods. The results show that, rather than a binary outcome, coercion sits on a spectrum and need not involve overt force or violence, but can also result from more quotidian limits to free, full, and informed choice. The study finds that global family planning policies and discourses do appear to incentivize coercive practices. It also calls into question the central role of intentionality, by demonstrating how coercion can arise from structural causes as well as interpersonal ones. By showing how contraceptive autonomy may be limited even by providers working in good faith, these results argue for an end to the instrumentalization of women's bodies, and for a radical reconceptualization of family planning goals and measurements to focus exclusively on reproductive health, rights and justice.

[Circularity, psychiatry & biomarkers: The operationalisation of Alzheimer's & stress in research](#)

*James Rupert Fletcher and Rasmus Hoffman Birk*

This paper analyses the use of biomarkers in contemporary psychiatric research, arguing that this research has problems of circularity. Focusing on the specific cases of Alzheimer's disease and stress research, we show how these fields have a circular usage of two biomarkers – amyloid-beta and cortisol respectively. We argue that the resulting circularity can be understood as a case of ontological gestalt switching, wherein one object (e.g. Alzheimer's disease) is switched with an object that differs in some way (e.g. protein aggregation). Such circularity can impede research because it entails stripping away important specificities, whereby characteristics that are not directly shared between two switched objects are inevitably forfeited. The losing of specificities can exacerbate discrepancies between illness and disease and lead to the homogenisation of diverse populations and disease subtypes, as has been shown to hamper Alzheimer's research. In response, we suggest that the use of biomarkers in psychiatric research should be subject to guidelines, under which such practices must be articulated in a simplified vocabulary that encourages reflexivity regarding potential instances of circularity.

[From decision to incision: Ideologies of gender in surgical cancer care](#)*Piper Sledge*

In this paper, I draw on the narratives of 57 individuals whose gender identities and decisions about their bodies trouble the medical protocols for breast and gynecological cancer care. I focus here on the decision-making process for three groups of elective surgeries: hysterectomy, prophylactic bilateral and contralateral mastectomy, and breast reconstruction. These elective surgeries illustrate places in medical interactions where patients and providers rely on frames of gender to determine whether a given surgery is an appropriate option for cancer prevention or care. These cases also explain how patient experiences of medical interactions are shaped by and thus reproduce ideologies of gender through the bodies of patients. While clinical practice and medical decisions are supposedly determined through the principles of evidence-based medicine and patient-centered care, I show that ideas about gender can actually supersede both medical evidence and patient desires for their bodies in the care of gynecological and breast cancers.

[Sociology of Health & Illness](#)[Digitising psychiatry? Sociotechnical expectations, performative nominalism and biomedical virtue in \(digital\) psychiatric praxis](#)*Martyn Pickersgill*

Digital artefacts and infrastructures have been presented as ever more urgent and necessary for mental health research and practice. Telepsychiatry, mHealth, and now digital psychiatry have been promoted in this regard, among other endeavours. Smartphone apps have formed a particular focus of promissory statements regarding the improvement of epistemic and clinical work in psychiatry. This article contextualises and historicises some of these developments. In doing so, I show how purportedly novel fields have been constituted in part through practices of 'performative nominalism' (whereby articulations of a neologism in relation to established and recent developments participate in producing the referent of the new term). Central to this has been implicit and explicit extolment of what I term biomedical virtues in public-facing and professionally orientated discourse. I document how emphases on various virtues have shifted with the attention of psychiatry to different digital modalities, culminating with knowledge-production in mental health as one significant focus.



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