Key Theories from Critical Medical Anthropology for Public Health Research. Part I: Starting with Foucault: cultures of medicine and meanings of illness

Jennifer J. Carroll

This article summarizes four significant theoretical concepts from the field of Critical Medical Anthropology in two parts: in the first part, biopower/discipline and explanatory models; in the second, structural violence, and identity politics and biological citizenship. The four subjects reviewed here have been chosen for their importance to our understanding of human behaviors related to health and illness, as well as for the impact that they can have on theory, research, and practice in the field of public health. These critical theories can provide new ways of thinking about professional roles, medical decisions, disease diagnosis and etiology, treatment adherence, prevention messaging, and all sorts of health-related behaviors and systems of understanding. They can also help public health researchers shed light on the human beliefs and activities that shape patterns of disease within and across populations. Whether a research question is being formulated or research findings are being analyzed, the critical social theories outlined here can foster a more holistic understanding of the human element in any public health project.

KEYWORDS: social anthropology; medical anthropology; social theory; qualitative research; public health; illness; explanatory models; structural violence; identity; biopower; Foucault.

Ключевые теории критической медицинской антропологии, которые могут быть применены в исследованиях общественного здоровья. Часть 1: Начиная с Фуко: культура медицины и значение болезни

Jennifer J. Carroll

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Данная работа резюмирует четыре важные теоретические концепции, существующие в области Критической Медицинской Антропологии, и состоит из двух частей: в первой части обсуждаются биологическая сила/дисциплина (biopower/discipline) и объясняющие модели (explanatory models), во второй части - структурное насилие (structural violence), а также политика идентичности и биологическое гражданство (identity politics and biological citizenship). Выбор этих четырех тем был продиктован их важностью для понимания поведения людей в связи со здоровьем или болезнью, а также их влиянием на теорию, исследования и практику в области общественного здоровья. Эти критические теории могут предоставить новые подходы для рассмотрения профессиональных ролей, медицинских решений, диагностики и этиологии заболеваний, выполнения лечебных предписаний, формулирования профилактических посланий, а также всех прочих видов связанного со здоровьем поведения и систем его понимания. Они также могут помочь исследователям в области общественного здоровья пролить свет на представления и действия людей, которые могут формировать особенности заболеваний при их сравнении внутри и между популяциями. Как при формулировании исследовательского вопроса, так и при анализе результатов исследования, перечисленные здесь критические социальные теории могут послужить более целостному пониманию человеческого элемента в любом проекте, касающемся общественного здоровья.

Ключові теорії критичної медичної антропології, які можуть бути застосовані в дослідженнях громадського здоров'я. Частина 1: Починаючи з Фуко: культура медицини та значення хвороби

Jennifer J. Carroll

Ця робота резюмує чотири важливі теоретичні концепти, що існують у галузі Критичної Медичної Антропології, у двох частинах: у першій біологічна сила/дисципліна (biopower/discipline) та пояснювальні моделі (explanatory models); у другій структурне насильство (structural violence), а також політика ідентичності та біологічне громадянство (identity politics and biological citizenship). Вибір цих чотирьох тем був продиктований їхньою важливістю для розуміння поведінки людей у зв'язку зі здоров'ям або хворобою, а також їхнім впливом на теорію, дослідження та практику охорони громадського здоров'я. Ці критичні теорії можуть надавати нові шляхи розгляду професійних ролей, медичних рішень, діагностики та етіології захворювань, дотримання лікувального режиму, формулювання профілактичних повідомлень, а також інших видів пов'язаної зі здоров'ям поведінки та систем її розуміння. Вони також можуть допомогти дослідникам в галузі охорони громадського здоров'я пролити світло на уявлення та дії людей, що можуть формувати відмінності захворювань усередині популяцій та між ними. І під час формування дослідницького питання, і під час аналізу результатів дослідження перераховані тут критичні соціальні теорії можуть слугувати більш цілісному розумінню чоловічого елементу у будь-якому проекті, пов'язаному з громадським здоров'ям.

КЛЮЧОВІ СЛОВА: соціальна антропологія; медична антропологія; соціальна теорія; якісні дослідження; громадське здоров'я; хвороба; пояснювальні моделі; структурне насильство; ідентичність; біологічна сила; Фуко.

INTRODUCTION

Critical Medical Anthropology (CMA) is a sub-field of cultural anthropology that focuses on medicine and medical practices. It is also a specific set of theories and approaches to medicine that consider the philosophical, cultural, and moral systems that are embedded in health practices. Medical anthropologist Merrill Singer described this academic subfield as follows:

Among the major contributions of critical medical anthropology are the following: (1) examination of the social origins of disease and ill health in light of the world economic system; (2) analysis of health policy, health resource allocation, and the role of the State in Third World nations; (3) re-thinking the contemporary understanding of medical pluralism; (4) development of a critique of biomedical ideology, practice, and structure; (5) attending to the role of struggle in health and health care; (6) re-examination of the microlevel of the individual, including illness behavior and illness experience, within the context of macrolevel structures, processes, and relations; and (7) investigation of health and health programs in socialist-oriented countries. (Singer, 1989, p. 1196)

CMA takes the view that the social is equally important as the biological in questions of health and medicine, because "epidemics are fundamentally social processes" (Maher, 2002, p. 312). Thus, when undertaking research related to health and illness, critical medical anthropologists are more likely to focus on the social aspects of health (individual behavior, social relations, social structure, economic forces, political economy, systems of belief, etc.), rather than quantitative data or evidence that could inform traditional statistical or epidemiological studies.

This literature review outlines four key concepts of CMA in two separate parts. In Part 1, published here, the major theories reviewed are *biopower/discipline* and *explanatory models*. In the subsequent Part 2 of this review, the theories that will be addressed are *structural violence*, and *identity politics and biological citizenship*. The discussion of these theories is prefaced in this part by a brief outline of some of CMA's most foundational theories, out of which each of the four topics listed above were developed. A full review of CMA's theoretical contributions is beyond the scope of these articles; therefore, these four topics have been chosen to represent a coherent sample of CMA theory. They are

largely rooted in Michel Foucault's foundational theories of power and subjectivity, and they inform much of CMA's approach to individual behaviors and personhood. The purpose of this review, therefore, is not to provide the reader with a general introduction to CMA, but rather to highlight these specific contributions that this area of research has to offer to public health researchers.

Despite the incredible utility of these theories, analyzing a public health issue through the lens of a concept like bio-power or structural violence does not always lend itself to simple, policy-oriented conclusion. Critical social theories are capable of illuminating patterns in human behavior and society that are messy and difficult to tease apart. This 'messiness' is a central component of CMA research; therefore, developing a level of comfort in dealing with it is important for anyone conducting a public health-related social analysis. The theories presented in this review have not been selected because they are necessarily useful when *applied* to public health problems as a methodological or analytical tool; rather that they are valuable in that they allow public health problems to be *reconceptualized*, rendering new and different perspectives on health, harm, risk, illness, and the social forces behind them all.

In an effort to overcome some of the 'messiness' inherent the reconceptualization of public health problems as "fundamentally social processes" (Maher, 2002, p. 312), the theories included in this review are presented in connection with specific examples of public health programs and concerns. Because it provides such an interesting example of illness both socially and biologically defined, and because I am very familiar with this literature

due to my own research on opiate use and addiction treatment, many of the practical examples offered in this article will reference public health efforts concerning drug use, although a variety of other illustrative examples are included as well. These practical examples are taken from published research in anthropology, sociology, epidemiology, and public health science.

THEORETICAL FOUNDATIONS OF CRITICAL MEDICAL ANTHROPOLOGY

Critical Medical Anthropology had its genesis in the social theories of Michel Foucault, who has written extensively on the topics of discipline, governmentality, and the production of medical knowledge (Foucault, 1975, 1977, 1980, 1982). These theories can, in large part, be found in a compilation of his essays and lectures entitled *Power/Knowledge* (1980), in his book *Discipline and Punish* (1977), and in his famous analysis of the origins of modern medicine, *The Birth of the Clinic: An Archaeology of Medical Perception* (1975). Medical anthropologists have long found these approaches to be fruitful for exploring the social construction of health and illness in contemporary settings. The influence of Foucault's work is apparent in the earliest textbooks and treatises on CMA in the American academy (c.f. Scheper-Hughes & Lock, 1987; Singer & Baer, 1995; Sargent & Johnson,1996), as well as in many well-known and in-depth critiques of the current public health regime authored by medical anthropologists (c.f. Belsham, 1993; Lupton, 1995; Rhodes, 1996).

The analysis of biomedicine (the science-based system of medicine that is taught in most professional

medical schools) as a cultural system is perhaps Foucault's most important contribution to CMA. Contemporary medical anthropologist Lorna Rhodes has described this cultural system as follows:

> In Western society biomedicine is generally believed to operate in a realm of "facts"; many people experience their most intimate contact with science through the biomedical description of the facts of bodily function and disease. This realm of bodily fact is often perceived to be quite separate from other cultural and social domains. (Rhodes, 1996, pp. 166-167)

Rhodes claims that we are able to deconstruct this false image by "exploring the ways in which [biomedicine] is socially, culturally, and historically constructed and showing how its perspectives influence the lives of its patients" (Rhodes, 1996, p. 164). "For Foucault," Rhodes observes, "medicine is one of a number of related disciplines that have shaped the body as a vulnerable site for the articulation of social relationships" (Rhodes, 1996, p. 168).

Anthropologists observe these social roles and relationships through observation, interviews, conversation, and mutual participation. This methodologically flexible research is called "ethnography." The utility of this method for public health rests in the fact that it allows researchers to "discern how specific risks are created and maintained at the local level" and "contribute to a better understanding of the social processes that underpin inequalities in health and help identify opportunities for interrupting those processes" (Maher, 2002, p. 322). Ethnography is able to make formative contributions to epidemiological research, in particular, because it "challenges [epidemiological] modes and makes possible new

theoretical frameworks" (Chapman & Berggren, 2005, pp. 148-149). Put another way, these concepts are fruitful in applied public health research, because they allow new ways of articulating how the individual is constituted in his own mind and in the imagination of the rest of society. As will be demonstrated in the sections below, they offer new ways to think about why individual people act the way they act, why they do what they do, and how those behaviors shape patterns of individual and population health.

The four topics included in this review (*biopower/discipline, explanatory models, structural violence, and identity politics and biological citizenship*) are all rooted in these Foucauldian theories. Many of these concepts are, in fact, contemporary forms of Foucauldian theories that have emerged from the direct application of Foucault's work to public health and medical practice. Biopower and discipline are concepts that come directly from Foucault's writing and offer an additional perspective on the interaction between power and agency. The concept of explanatory models has been offered as a theory of medical knowledge and of the interaction between different social actors (subjects) who hold different beliefs and forms of knowledge about health and illness. It is, in many ways, a theory of power relations between social actors who may or may not have the same beliefs or knowledge about an illness. Structural violence, especially as it is applied in CMA, is an extension of Foucault's theories of power, power relations, and agency, which allows us to articulate how social structure and power relations shape the choices and limit the ability of individuals to act. Finally, identity politics and biological citizenship are two closely related theories that con-

nect subjectivity (i.e. social roles and identities) and morality in public health practice, allowing researchers to explore how and why individuals become "good patients".

These theories are connected, then, not only by their foundation in Foucauldian social theory, but in their focus on the individual and the relationships that individuals enter into with other individuals, groups, and social or political institutions. Since public health practice also shares its focus between individual and group- or population-level behavior, the application of these theories to public health practice allow for problems of health and illness to be conceived of in a new light, opening up new networks, symbols, and processes for investigation by public health researchers.

DISCIPLINE AND BIOPOWER IN PUBLIC HEALTH PRACTICE

The dual concepts of discipline and biopower come directly from Foucault's theoretical writing, particularly his writing that relates to the phenomena of power and resistance. Foucault claims that these social forces (power and resistance) are relevant only insofar as they are intimately tied to the processes that produce social subjects (i.e. a social role, a personal identity, or a 'type' of person). Specifically, he argues that a subject exists only insofar as it is established within a particular power relationship with other social actors (Foucault, 1982).

Foucault further clarifies that power is not a matter of absolute control, but that the subject, if it is to be a subject as such, must retain its agency. "The 'other' (the one over whom power is exercised) [must] be thoroughly recognized as

and maintained to the very end as a person who acts," (Foucault, 1982, p. 220). Power, then, should not be conceived as actions upon others but as "action[s] upon the *action* of others," (Foucault, 1982, p. 220; emphasis mine). Based on this, the subject is necessarily capable of resisting the power exercised upon it, as well as participating in and validating its own subjectification, as when a subject acts in conformity with the social roles prescribed to it.

The Foucauldian concepts of biopower and discipline have found wide application in CMA research as anthropologists have labored to more fully theorize the construction of subjects under the scope of medical cultures and institutions in contemporary society. CMA promotes the idea that biomedical authority and biomedical knowledge are seats of intense disciplinary powers in society. This disciplinary power can be seen in forces of social governance that focuses on "'risk', 'knowledge' and prevention" in the creation of "'responsibilized'… individuals and communities of interest" and in "the objectives of eliminating risk, danger, and disorder" (Fischer & Poland, 1998, p. 188).

Deborah Lupton's work on discipline and governance in public health discourses demonstrates this fact very well. Lupton makes use of Foucault's notion of the 'medical gaze,' a way of viewing the patient body that does not stop at the clinical record, but also produces abstract knowledge about the body and social paradigms of health, morality, and personhood (Foucault, 1975, pp. 29-31). Lupton, like Foucault, observes that medical and public health statistics have become the primary mechanism for producing knowledge in the era of public health (Lupton, 1995, pp. 25, 42-43). These data

can be seen as disciplinary technologies intended to bring unruly populations under control through public health projects, such as those designed to promote child health (Lupton, 1995, p. 26), vaccination (p. 32), hygiene (p. 34), and so on. Therefore, social roles are created within a moral landscape shaped by biopower, and the nature of those roles (such as 'disciplined,' 'deviant,' 'healthy,' 'sick,' 'at risk,' 'recovered,' etc.) is determined by each person's position within these greater relationships of power.

Anthropologist Philippe Bourgois' research on heroin addiction in the United States provides another good example of these concepts in action. Bourgois adopts Foucault's notion of discipline to mean "moral discipline," the internal desire to act appropriately and in socially acceptable and responsible ways. It is this variety of discipline that American addiction treatment programs attempt to foster in "the hearts, minds, and bodies of deviants [i.e. drug users] who reject sobriety and economic productivity" (Bourgois, 2000, p. 167). Bourgois defines biopower as "the ways historically entrenched institutionalized forms of social control discipline bodies" (Bourgois, 2000, p. 167). In other words, *biopower* is a social force wielded by medical authorities in an attempt to control or *discipline* the way in which people act and to control the ways in which their health and their physical bodies are organized or managed.

After interviewing a number of dissatisfied patients in a US methadone program, Bourgois concludes, "methadone maintenance, when used as a replacement for illicit substances [like heroin], is a particularly concrete example of biopower at work" (Bourgois, 2000, p. 167). He observes that the clinic staff he met sometimes used

variable dosages of methadone as punishment or reward in order to control the behavior of their patients and force them to adopt the role and comportment of "a worthy, well-disciplined citizen/patient who is dutifully on the road to recovery from substance abuse" (Bourgois, 2000, p. 169). Put another way, the methadone clinic, in its attempt to substitute the 'illegal drug' heroin for the 'legal medication' methadone, is an example of biopower, because it supports and reveals a "state-mediated struggle to create disciplined and addicted—but heroin free—subjects" (Bourgois, 2000, p. 182).

Nancy Campbell and Susan Shaw have also argued that "substance abuse has been recognized as a key site where [institutionalized biopower] hits the ground" (Campbell & Shaw, 2008, p. 698). Observing that "addicts have long been represented as unreliable subjects, incapable of self-government, and by extension undeserving of public trust" (2008, p. 697), Campbell and Shaw argue that public health discourses and disease prevention efforts give drug users a platform from which to re-assert themselves as disciplined and moral (and therefore deserving) subjects. "In response to such constructions, users define themselves as ethical beings concerned about the effects of their drug use on themselves and others, and who act responsibly to reduce negative consequences" (2008, p. 698). Drug users would repeat mantras such as "I always use bleach" and "I never share needles" to ethnographers *even while using shared and unsanitized needles right in front of the researcher's eyes* (2008, p.696). These statements, drug users' attempts to position themselves as ethical subjects through claims of

self-regulation, reveal the depth of biopower's influence on drug users' actions and social roles.

These analyses are instructive not for their ability to inform public health policy, but for the ways in which they encourage us to ask how elements of social and moral control are shaping public health practices and policies. Who is responsible for our health? Who should be managing health risks as they arise? Who is to blame when illness or injury occurs? As the writing of Bourgois and of Campbell and Shaw reveals, disciplinary powers in public health projects can shape the way in which at-risk individuals present themselves and their behaviors. On the one hand, such control has the potential to promote more desirable, risk-reducing behaviors among at-risk populations, such as refusing to re-use syringes or have unprotected sex. On the other hand, those behavior changes may not be motivated by informed and rational choice to reduce risk, but rather upon concern for one's moral standing as a member of society, as sharing needles is not seen as something done by a 'good person.' This is an important distinction to be aware of when, for example, working to increase access to health services, as a misunderstanding of the motivations behind treatment seeking behaviors will hinder the success of any attempt to connect treatment and care with at-risk populations. This concern is, then, moral and ethical as much as it is practical and concrete.

EXPLANATORY MODELS

The term 'explanatory model' was coined by medical anthropologist Arthur Kleinman (1988). Explanatory models are the culturally specific logics of disease, a narrative

understanding of what illness is and what can be expected from it. This logic shapes our perceptions of and interactions with the culturally constructed and socially organized, lived experiences of illness. Explanatory models provide patients and caregivers with answers to key question about illness, such as "How does one contract this disease?", "What are its signs and symptoms?" and "How should one seek treatment and care for this disease?" (Kleinman, 1988, p. 43). Kleinman argues that explanatory models are responses to urgent circumstances and "justifications for practical action more than statements of a theoretical and rigorous nature" (1988, p. 121). They tell us how we should act when confronted with illness and how to respond to disease.

This is a key concept for exploring and resolving public health problems for a number of reasons. First, the nature of the explanatory models adopted in a particular place or by a particular person will shape their view of the most appropriate reaction to that disease. For example, if drug use is understood as a willful, deliberate, criminal activity, then the appropriate response would be to punish drug users as criminals (for anthropological work exploring the criminalization of addiction, see Spradley, 1970; Bourgois, 1995; Becker, 1963; Bourgois & Schonberg, 2009). On the other hand, if addiction is perceived as a disease, as a disorder of the body or of the mind over which each person has limited control, then the appropriate response would be to treat that individual as a patient, to provide pharmacological or psychological therapy (for anthropological work exploring addiction as a medical disease, see Carr, 2010; Garcia, 2010; Bourgois, 2000; Carroll, 2011).

Second, it is important to recognize that explanatory models can be shared between groups or individuals, such as the widely held belief that a cold or other such minor illness can be caused by a draft or a chill in the room. Alternatively, there may be differences between the explanatory models held by different people. Those differences may be significant, or they may be slight. Kleinman emphasized that even the different individuals in a single health care setting can hold conflicting explanatory models of the same disease. In his book *The Illness Narratives* (1988), he offers the example of William Steele, a man who began suffering from severe asthma following his fortieth birthday. While Mr. Steele and his doctor both agreed on his diagnosis (asthma), they disagreed about the underlying cause. Mr. Steele believed that his asthma was triggered by the stress of his fortieth birthday, whereas his doctor understood asthma as an illness whose "ultimate cause is unknown." (Kleinman, 1988, pp. 123-4). Despite the significant overlap in the explanatory models held by Mr. Steele and his doctor, this minor disagreement had significant consequences. Believing that his doctor never fully understood the causes of his illness, Mr. Steele began taking his medication improperly, particularly during times of personal stress, which resulted in making him much sicker (Kleinman, 1988, pp. 125).

Anthropologist Barbra Erickson (2007) offers another example of conflicting explanatory models in her description of people exposing themselves to radiation found naturally in certain caves in Montana. Erickson helps her readers make sense of this uncommon behavior by describing how the explanatory models held by persons who practice radon exposure for therapeutic

reasons are different than the dominant, biomedical explanatory model, which "portrays radon as a toxic substance" (Erickson, 2007, p. 2). Erickson notes that the many explanatory models used by those exposing themselves to radon varied quite a bit from one another. Some of these patients told her that there are different 'kinds' of radon, and that the radon in the mine was of a non-harmful variety (pp. 8-9). Others claimed that the radon could not be harmful because it was a 'natural' substance (p. 9). Still others argued that the dosage of radiation they were receiving in the mines was so low that it could not trigger the harmful effects that one might expect from radiation exposure (p. 11).

The main insight of Erickson's work is that each patient in the radon mines had to find a way to *coordinate* and *harmonize* their radon-seeking activities with the known dangers of this radiation. She argues, "for Americans traveling to the Montana radon mines, [the] toxic model of radon must be reconstructed or replaced. Having chosen to use radon therapy, an ill person must construct an explanatory model of radon that will make this course of action seem rational." (Erickson, 2007, p. 2) In other words, developing a new explanatory model for radon to replace the toxic model required intellectual work. This is a key insight, because it reveals that explanatory models are not static or concrete. Rather, they require constant maintenance and effort in order to maintain a sense of reality and coherency in the face of contrary evidence or different ways of understanding.

Third, it is very important to note that the biomedical approach is, itself, an explanatory model. It serves as both instruction and justification for particular actions taken

in response to human illness. In Kleinman's words,

> The modern medical bureaucracy and the helping professions that work within it…are oriented to treat suffering as a problem of mechanical breakdown requiring a technical fix. They arrange for the therapeutic manipulation of disease problems in place of meaningful moral (or spiritual) responses to illness problems (Kleinman, 1988, p.28).

To put it another way, Kleinman argues that the biomedical model declares medical problems to be physiological or biochemical in nature and that treatment ought to be directed towards the individual organism. This feature of the biomedical explanatory model is often called *medicalization*.

In my own research on drug addiction and treatment in Ukraine, an interesting and gender-based explanatory model for addiction revealed itself through semi-structured interviews with clinicians and social workers working in this field. As one social worker put it:

> There are a higher percentage of men in our [substitution therapy] program, because a higher percentage of drug addicts are male…Women are psychologically stronger than men. Woman can cope with their problems. They are also very home-oriented and are focused on things like their jobs and their kids. Here, people are on drugs because they can't cope with their problems.

In other words, it was revealed that a number of harm reduction workers with whom I spoke understood drug use among men to be rooted in depression (a medical condition that can be relieved by proper medical treatment) whereas drug use among women was understood to be the result of a weakened moral constitution (a personal problem, not a medical problem requiring medical attention).

Such an androcentric model of addiction can foster an environment in which women feel unwelcome in harm reduction programs, simply because so few of them are expected to show up. Female drug users can also be erased from both public and professional imaginations through the idea that women are just "too serious" to be involved in that kind of behavior. It then becomes more difficult to integrate a woman-centered approach to public health into existing HIV-prevention and harm reduction networks, because the core issues that are believed to drive a woman to drug use in the first place are considered to be personal problems that are not within the scope of biomedical intervention. Thus, understanding the explanatory models held by clinicians, social workers, and service providers is crucial for designing and implementing interventions or programs with a real and positive effect on high-risk drug users, regardless of their gender.

CONCLUSION

The theories that have been discussed in the first part of this review, *biopower/discipline* and *explanatory models*, address the most fundamental cultural aspects of health, illness, and medicine. They reveal the fact that medical knowledge, medical authority, and even our own lived experiences of illness are shaped by culture and are anything but static.

In the second part of this review, two additional theories will be presented, which are useful for grounding medical issues and public health concerns in their social contexts. These theories are *structural violence* and *identity politics and biological citizenship*. These major theories from CMA go a step beyond those presented here in the first part of this review: rather than illuminating how experiences of health and illness are culturally constructed, the theories of *structural violence* and *identity politics and biological citizenship* have emerged from scholars' explorations of how actors negotiate the cultural landscape of health and illness. How does one make choices concerning one's health? What does one stand to gain or lose by becoming sick, seeking treatment, or actively presenting disease?

All of these considerations are important for public health research, as they bring new perspectives on human behaviors and encourage innovative and adaptive thinking in the design of public health interventions.

ABOUT THE AUTHOR

Jennifer J. Carroll is a doctoral candidate in the joint PhD/MPH program at the University of Washington, earning her degrees in Anthropology and Epidemiology.

Email: jencarr2@u.washington.edu

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