

Original Article

Beyond race and ethnicity: How an ethnography of diabetes can contribute to a socially complex approach to hyperglycemia, human suffering, and care.

Laura Montesi

*School of Anthropology and Conservation, University of Kent, Canterbury, UNITED KINGDOM
lm449@kent.ac.uk*

Keywords: diabetes mellitus; indigenous peoples; racialization; social suffering; critical phenomenology; care

Abstract

Background: Diabetes mellitus has recently assumed the form of a public health epidemic and novel "epidemic of signification" (Treichler, 1987). Indigenous peoples have been the objects of biomedical discourses that emphasize ethnoracial differences and genetics as etiological factors associated to type 2 diabetes. In response to the racialization of diabetes, anthropologists have reframed "the meaning of diabetes as a socio-political pathology" (Scheper-Hughes, 2006, p.xviii) and the body as the locus where social history inscribes itself. This paper contributes to this anthropological project by putting forward critical phenomenology as a theoretical and methodological orientation.

Methods: This is a theory-based paper. Core anthropological literature on diabetes from the 1960s to present was reviewed as well as phenomenological philosophy texts.

Results: An ethnographic exploration of the local enactments of care and ways of managing and conceptualizing diabetes may allow us to develop culturally and socially comprehensive medical treatments.

Conclusions: Although genetics do play a role in diabetes, an in-depth analysis of the phenomenon suggests the need to avoid reductionist biomedical approaches and to be aware of the risks implied by the racialization of diabetes. The integration of a phenomenology-inspired approach together with a political economy one in medical anthropology may allow us to look at the indigenous lived experiences of diabetes, while taking into consideration structural violence. Ethnographic research can contribute to a holistic model of care that does not limit itself to therapeutic encounters but incorporates everyday enactments of care and listens to people's concerns.

Diabetes mellitus is not an entirely new phenomenon, but only in recent times has it become of great public concern gaining -- together with non-communicable diseases more generally -- the attention of the World Health Organization, which in 2008 launched an Action Plan for "tackling the world's biggest killers", namely cardiovascular diseases, cancers, diabetes and chronic respiratory diseases (WHO, 2008, p.iii).

Despite the somewhat glib statement that "[W]e have the right vision and knowledge to address these problems" (ibid.), thus implying that difficulties are mainly due to deficient or absent public health policies and not to an understanding of these diseases, a close scrutiny of the discourses produced around diabetes reveals a radically different picture: not only is there no unanimous consensus among scientists about its causes, we find competing paradigms and approaches that emphasize different etiological factors and underpin divergent ideologies and political agendas, with significant social implications in terms of ideas about prevention and treatment interventions. The worldwide rising numbers of people affected by diabetes, the multifactorial nature of the disease, and the failure, to date, to prevent and control it, are some of the key elements that make diabetes a conundrum and a novel "epidemic of signification" (Treichler, 1987) calling for sense-making and the production of a wide array of discourses. The same terminology used for describing diabetes has become an object of debate, since the term "disease" and "illness" are increasingly perceived as too narrow, unable to effectively convey its

multivariability and its pertinence to a wider set of medical conditions such as obesity and hypertension. For this reason, diabetes (particularly type 2, or adult onset diabetes) is addressed today as a metabolic "syndrome", a term that is more suited to capture its complexity and the impossibility of reducing it to a single etiology and course.

Among the factors that seem to predispose people to developing type 2 diabetes, there are those "life-styles" that tend to decrease energy expenditure and augment energy intake. It is mainly in this light that anthropologists entered the debate on T2D in the late 1980s, addressing this metabolic disorder as a "disease of modernization" (Lieberman, 2003; McGarvey, et al., 1989; Stunkard and Sorensen, 1993; Zimmet, et al., 2001) or a "disease of civilization" (Joe and Young, 1993). Although the acknowledgment that culture matters in the development of diabetes represented a milestone, anthropologists have moved beyond this achievement and have played an essential role in: 1) "reading" the biomedical, genetic, and epidemiological practices from a critical stance that deconstructs the making of scientific knowledge (epistemological endeavor) and the crafting of social realities (ontological endeavor); 2) reframing diabetes as a socio-political pathology (Ferreira and Lang, 2006) thus contrasting a tendency to de-politicize non-communicable diseases; 3) advocating for a culturally and socially sensitive treatment.

While a review of the anthropological literature on diabetes is beyond the scope of this paper, the key objective here is to explore whether and how anthropologists can make a substantial contribution to

understanding diabetes, to helping tackle it, and to developing new lines of enquiry that lay the groundwork for a socially complex approach to hyperglycemia, human suffering, and care. Thus, the question is: In what ways can an ethnography of diabetes help us gain unique insights into the lived experiences of people with diabetes and into both the proximate and ultimate causes of this pathology? I will try to answer this question by analyzing the shortcomings of a purely biomedical and genetic approach to diabetes with particular reference to the dangers involved in racializing diseases; by exploring the benefits but also the limits of introducing culture in the reframing of diabetes; and by proposing that the integration of a phenomenologically inspired approach and a political economy one in medical anthropology may allow us to look at the indigenous lived experiences and views on what diabetes is, while taking into consideration social inequality and structural violence (Scheper-Hughes, 1992; Wikan, 1990; Good, 1994; Biehl, et al., 2007), and to suggest a holistic model of care that does not limit itself to the therapeutic encounter but incorporates everyday enactments of care and listens to people's "compelling concerns" (Wikan, 1990: 38).

Diabethnic?

The expression "epidemic of signification" was used by Paula Treichler (1987) to lay bare the multiple ways in which AIDS is given meaning and talked about through a semantic work that constitutes the biomedical and the popular practices and discourses. Given the novelty and obscurity of T2D,

this semantic (and material) exercise has also become prevalent in diabetes discourse and this linguistic poietic work has been enmeshed in the process of producing social realities. Although the etiological factors associated to T2D are largely environmental and behavioral, ethnoracial differences and genetics have been particular, common catalysts of attention in the biomedical discourse. As Montoya highlights "geneticists, epidemiologists, government analysts, and journalists frame diabetes as an ethnoracial disease" (2011, p.7) thus justifying the practices of blood sampling and extraction of DNA from certain groups of people chosen on the basis of race and ethnicity. Although race and ethnicity are not considered scientific categories but social constructs, they have been used and appropriated by biomedicine and genetics in the attempt to answer why some human groups seem to be more struck by diabetes than others. In fact, diabetes seems to represent a threat for vulnerable populations such as indigenous peoples. Of particular interest has been the case of Native American groups, as for example the Pima, the Inuit, and the Navajo Indians. The rapid rise of T2D among these populations has led to the consideration of genetics as the explanatory key to diabetes. In this regard, the suggestive albeit increasingly criticized theory of the "thrifty gene" elaborated by geneticist James Neel (1962) has provided an appealing explanatory framework. Neel suggested that early hunter-gatherers had acquired a genotype particularly capable of storing energy for later periods of famine. This selective genetic advantage proved to be detrimental with the rapid change of the environmental conditions, the increase

of food availability, and the end of the feast-or-famine cycle. In other words, the advent of “civilization” supposedly had the effect of turning an advantage into a disadvantage that makes certain populations susceptible to the development of diabetes.

This theory still retains a certain influence in the public, the popular, and part of the scientific discourse. As Margery Fee (2006) underscores, “a rather unclear scientific hypothesis” (the thrifty genotype) “was transformed into a clearcut racializing account” (2006, p.2990) and achieved relatively popular success. For instance, a recent article in the Mexican online newspaper SinEmbargo.MX reported the findings of a research group of the Laboratory of Diabetes of the Chemistry Faculty at Universidad Nacional Autónoma de México (UNAM): Mexicans are genetically predisposed to diabetes because 70% of their genetic component is, on average, Indigenous (25% Caucasian; 5% African). The indigenous genetic component, “fantastic” in times of famine, has today turned into a problem. The study suggests that diabetes might be eradicated by studying indigenous genetics, and finding and isolating the DNA sequencing responsible for the disease. Genetic modification is, therefore, presented as the solution (Mónica Ocampo, 2013), thus overlooking the dietary, social, political, and ecological causes of diabetes, and justifying the collection of blood samples from people of 13 ethnic groups in Mexico. As Montoya duly remarks: “While all human groups are potential DNA donors, not every group has an equal chance of being targeted for genetics research” (2011, p.151).

This disparity of treatment can be dangerous since scientific narratives can have a racializing effect. The link between knowledge and power is well acknowledged and the capacity to place boundaries and categorize diseases and human groups may have the effect of further stigmatizing and marginalizing the weak while, at the same time, concealing the historical and political factors that influence health and illness. The danger implied in the racialization (and geneticization) of diabetes is particularly serious in countries like Mexico which are characterized by large indigenous populations and histories of colonization and racism, where the discrimination against them can be reinforced by a “scientific” discourse.

The interplay of genetics and ethnicity in the explanation of diabetes gives rise to a twofold process: racial emplacement, i.e. the transformation of group identities into group biologies (Montoya, 2011, p.110) and biosociality, i.e. “a phenomenon whereby individuals appropriate biogenetic discourse as part of their identity” (ibid., p.174). This endeavor has the effect of pathologizing ethnicity and placing the burden of culpability (and responsibility) on people with diabetes themselves, while concealing the political and economic forces exerting power behind and within the diabetic bodies. Indigenous peoples are particularly at risk and might suffer from a disempowering effect: after all, diabetes runs in the blood. The correlation between diabetes and ethnicity may metaphorically create a new identity: the “diabethnic”, which is doubly detrimental since it flattens a rich and complex identity upon one single condition (being diabetic), and it marks race or ethnicity from the external (being

classified as indigenous and pertaining to an ethnic group that bears a tainted genetic inheritance).

The point here is not about dismissing the genetic component and role in the development of diabetes but to warn against a reductionist approach that tends to overlook other factors and de-politicize illness. Furthermore, the recent rise of diabetes across the world and diverse populations --what Ferzacca calls "diabetes without borders" (2012, p.416)-- has pointed out that perhaps the genetic etiology is not the most prominent. Different populations show similar incidence rates of diabetes. For instance, Mol underscores that in the Netherlands T2D "has a comparatively high incidence among Hindu immigrants from Surinam" and she asks in what ways "they resemble the Canadian Inuit" (2008, p.64). How many human groups of ex hunter-gatherers should we postulate to explain current trends? How many ethnic groups should we account for? Is the diabetnic a really useful category for understanding diabetes?

Diabetic habits?

If genetics is only one among many components, where should we look for an answer to the diabetes epidemic? Physicians, social scientists, and epidemiologists look at culture change as an important factor that is boosting prevalence rates worldwide¹. The shift is from people who share genes to people who share habits (Mol 2008, p.65), or better still bad habits: mainly over-eating and/or unhealthy eating and conducting a sedentary life. The concept of "risk factor" is related to that of "lifestyle"

¹ For a comprehensive literature review see Ferzacca (2012).

which in turn is associated to "control". The key to the biomedical treatment of diabetes lies in the capacity to monitor glycemic indexes through conducting a "healthy" lifestyle and controlling diet. Culture has assumed a prominent role and has become part of biomedical health care strategies that recognize the need to understand patients' backgrounds. Nevertheless, even this culturally comprehensive approach bears its ambiguities: cultural diversity can be perceived as the obstacle to prevention and compliance.

Borovoy and Hine (2008), working with elderly Russian Jewish émigrés to the U.S., a group considered particularly "difficult" with frequent stories of non-compliance, think about how the recent attention of health care providers to cultural differences is actually hampering the delivery of good health services; this is because the concept of "culture" in use is highly reified and encloses "bad patients" into the boundaries of a culture which is conceptualized as an obstacle. In addition, the concept of culture is only applied to patients and not to the doctors (2008, p.3). This approach, based on an unequal power relationship, ends up riddled with ideas of culpability. Borovoy and Hine aim at showing that medical knowledge and praxis are cultural constructs and that the misrecognition of this makes non-compliance automatically fall only on patients' shoulders. The acknowledgment of the cultural construction of biomedicine is a first step towards an equal, value-free analysis of the different language, health and illness criteria evaluations that take place in the clinical encounter.

As a consequence of the reification of culture, patients' identities are reduced to their allegedly cultural belonging and are converted into monoliths (Aime 2004, p.54), deprived of their complexities and multiple histories. This procedure is in line with today's tendency to excessively emphasize identity, one identity (*ibid.*, p.56), thus transforming any kind of problem (including non-compliance to a biomedical treatment) in a cultural or ethnic conflict. Risky lifestyles and non-compliance during treatment is not always or only due to "culture". As Steve Ferzacca shows with his study of older American men with T2D, non-compliance does not depend on relevant cultural discrepancies (both patients and physicians share core values such as self-discipline, productivity, and health), or on acts of resistance; escaping an essentialist and static view of structure vs. agency and biomedicine vs. patient lifeworld, Ferzacca suggests "consider[ing] the ways in which the regulated improvisations of le couple médecin-malade are made upon common ground" (2000, p.30; emphasis in the original) and viewing "biopower as a configuration of shared values [...] which provides the generative potential for the 'regulated improvisations', or hybrid medical practices, illustrative of idiosyncratic ethics and technologies (regimes) in the cultivations of particular lives" (*ibid.*, p.31). Despite sharing cultural values with physicians, these older American men also thought of themselves in a particular phase of their life, retirement, that allowed them to be indulgent (*ibid.*, p.37). This is why "culture" by itself is not enough: particular selves are cultivated differently

at diverse times and in particular everyday contexts (*ibid.*, p.37).

Attentiveness to the (multiple) self, to personhood(s), temporal fluidities, and local generative practices makes the anthropological contribution to an understanding of diabetes essential; this is something I return to in the next section. An approach to diabetes based on the extensive use of the concept of "lifestyle", whether associated to individuals or cultures, is too weak to be revealing and useful. In both cases, Rock (2003) argues, the meanings attached to such practices are overlooked. Thus, lifestyle is "an assemblage of bodily practices that are amenable to quantification" (2003, p.156) but do not reveal anything about local meanings and knowledge. In fact, "'lifestyle' differs from culture" (*ibid.*, p.155) and "to prove effective, interventions need to resonate with local knowledge and to address local circumstance" (*ibid.*, p.157). The fact that different populations may show a similar lifestyle does not help us to tailor health interventions since the deep understandings, the local ways of thinking are set apart. Lifestyles cannot be abstracted from other factors such as social structure, environment, history, and political economy, and an understanding of the onset, development, and experience of T2D would benefit from an approach which takes into consideration lived experiences in particular times and places within contexts influenced and limited by broader political economic forces.

According to Melanie Rock, the social suffering approach promoted by (part of) anthropology to health issues "can assist in explicating why, in the

contemporary period, blood tends to be sweeter in some populations than in others" (ibid., p.163). This approach has allowed us to identify the bidirectionality of diabetes and stress, and, as a consequence, to go beyond race and ethnicity and ask "whether suffering is more common in some populations than in others and, if so, why" (ibid., p.163). As evident from the preceding discussion, attention to human suffering as lived, embodied, and expressed in particular circumstances calls for ethnographies of diabetes which listen to the voices of people with diabetes, attend to their concerns, resonate with local contexts, and recognize the interrelation existing between wider pathogenic systems based on inequality and social injustice and diseases such as diabetes. In the next paragraph I show how this can be accomplished by adopting, theoretically and methodologically, a phenomenologically inspired approach.

Diabetes as a diglossic space: speaking and sentient bodies as thrown subjectivities

Medical anthropology, more than other fields in anthropology, has recognized the importance of placing the body in sharp focus and at the center of its analysis. While earlier theoretical approaches such as functionalism and structuralism did somehow include the body in ethnographic descriptions and observations, they did so in a rather abstract way and considered it an instrument or reflection of society at large. This way of dealing with the body was largely ahistorical and deprived of temporality: the body was conceived as the universal substratum upon which culture is inscribed. This led to the later

tendency to "read" the body as a text and to bracket emotions, empathy, and the senses. As Green notices, "the body itself remained unproblematized until quite recently" (1998, pp.3-4) excepting important contributions such as those of Bourdieu (1977) and Foucault (1981, 1991). Nevertheless, despite the attention paid to biopower, forms of control, representation, and self-discipline, the body was still paradoxically rather "disembodied". Phenomenology, roughly definable as a philosophical movement or orientation, has had the merit of helping "anthropologists to reconfigure what it means to be human, to have a body, to suffer and to heal, and to live among others" (Desjarlais and Throop, 2011, p.88). From the 1980s onwards, the body has become problematic (Csordas, 1994) and an inspiring source of new theoretical orientations and ways of doing ethnographic research. Since then, new fields of study have burgeoned in anthropology, such as sensory anthropology (Classen, 1990, 1993; Geurts, 2002; Howes, 1991, 2003; Seremetakis, 1994; Stoller, 1989, 1997; Sutton, 2001), the anthropology of emotions (Lutz and White, 1986; Desjarlais, 1992; Shepard, 2002), the anthropology of violence and social suffering (Green, 1998; Scheper-Hughes, 1992; Farmer, 2003; Das, 2007; Roma, 2007), just to mention a few. They all have benefited from concepts of phenomenological inspiration such as embodiment, thrownness, being-in-the-world, intersubjectivity².

The adoption of phenomenological approaches in

² For a thorough and sound review of the phenomenological approaches in anthropology see Desjarlais and Throop (2011).

anthropology has allowed for the introduction of objects of inquiry that had been by and large overlooked. For instance, Biehl et al., (2007) have underscored the importance of including subjectivity in anthropological investigations and the urgency of defeating the fear of falling inevitably into a psychologization or universalization of subjectivity, while Kleinman and Fitz-Henry (2007) and Throop (2003) advocate for an analysis of experience, perhaps a slippery and unsatisfactory concept, but nevertheless overtly necessary.

The phenomenological attention to subjectivity, personhood, preobjectivity, and experience often suffers the critique of downplaying the social and the cultural. In my opinion, this interpretation is based on a flawed reading of phenomenologically inspired works. The contribution of the philosopher Martin Heidegger (1927) provides us with an epistemological framework that fruitfully articulates subjectivity and objectivity, intentionality and constraint, agency and structure. In fact, the profound sense of the being is ultimately its being-there, Dasein, thrown, situated in a specific context, "located" in a "non-equivalent position in a substantive web of connections" (Haraway as illustrated by Csordas, 1994). The thrown character of Dasein inevitably entails its historicity, temporality, and fluidity in contrast with a Western philosophical tradition that had identified the being as that which is permanent (Vattimo, 2011, p.11) and unconditioned. Dasein is thrown and limited, placed in the world, along with others, and always endowed with a "mood" that although ontologically different from emotion, is ontically

linked to it. Dasein is also a project, animated by a desire to change or maintain its condition (ibid., p.15). We are in the world to make a project out of ourselves: life is an array of possibilities, not infinite though. Death is the ultimate, certain, and permanent possibility which makes all the other possibilities possible. Life is, therefore, a synonym of existence which can be defined as *ex-sistere*, transcendence situated into the world (ibid., pp.56-57).

Stripped down to its essentials, phenomenology clearly involves the collapse of any sharp antinomy between subjectivity and objectivity, projectuality and constraint, transcendence and situatedness, a theoretical achievement that well suits social anthropology and even more medical anthropology. Although this account of phenomenology is not detailed in any way, I think it allows me to hint at what the adoption of this approach can contribute to an ethnography of diabetes and the formulation of a holistic model of care. In fact, the appreciation of the specificity of human experience makes ethnography a valuable instrument for exploring the lived experiences of people with diabetes, being aware that a universal model of care cannot be conceived and applied to a "variety of human conditions within which often greatly different things are at stake" (Kleinman and Fitz-Henry, 2007, p.55), even though they might be sharing the experience of suffering from hyperglycemia.

Attention to local engagements and compelling concerns (Wikan, 1990) is key to an understanding of the sweetening of the blood. Embodiment is the paradigm that best recognizes the multiple ways in which human suffering

is lived through, felt, listened to, silenced, and expressed. Several anthropological works have recognized the capacity history and macroprocesses have to inscribe themselves into the bodies (Scheper-Hughes and Lock, 1987; Stoller, 1995) and how these in turn can remember (Becker, 1997; Cartwright, 2007; Casey, 1987; Fassin, 2007; Nichter, 1981). An ethnography of diabetes which explores how indigenous peoples are engaged in this process of "bodily remembering" (Casey, 1987), i.e. body memory and memory of the body, can shed light on a set of related issues: how diabetes is experienced, understood, explained, and made sense of in specific locations; how macroprocesses "remake [the] most intimate inner processes: emotion, cognitive style, memory, [the] deepest sense of self" (Kleinman and Fitz-Henry 2007: 55) and contribute to the susceptibility of certain people to diabetes; how people with diabetes conceptualize well-being and strive to transform or maintain their lives through everyday enactments of care.

The main challenge in such an anthropological project is to interpret diabetes as a "diglossic"³ context where corporality and bodily memory coexist, in a continuum, with language and memory of the body. This explains why my attempt is to reconcile the perceiving and the speaking body, the realms of emotions, feelings, and sensations and the realms of storytelling, praying, singing, talking, conversing. If we adopt a gestural theory of language (Leonard, 2013) drawn from Merleau-Ponty's (1945) philosophy then there is no substantial opposition between

embodied practices and language. Human suffering becomes accessible by listening to people's words but also by accessing their sensations and resonating with their experiences. Empathy, a key element for any ethnographic work, reemerges as a methodological and heuristic tool (Wikan, 1992; Hollan and Throop, 2008; Hollan, 2008, 2012; Gieser, 2008).

The anthropological literature on diabetes has largely emphasized the narrative dimension of inquiry, partly overlooking the sensory aspect of lived experiences. The seriousness with which anthropologists have approached and listened to the lay discourses on diabetes has led them to highlight the special relationship existing between stress and diabetes. The recognition of this link has been indicated as one of the distinctive contributions of anthropology to the study of diabetes. As Schoenberg et al. (2005, p.174) write:

'With some exceptions (Hinkle and Wolf 1952), attention to life history and circumstances has fallen outside the purview of biomedical research and practice but has been a defining characteristic of anthropological inquiry into diabetes (Walrath 2003)'.

The most challenging claim of the researchers dealing with this theme is the bidirectional nature of diabetes and stress and/or depression (Cabassa, et al., 2008; Ferreira and Lang, 2006; Iwasaki, et al., 2004, 2005; Mendenhall, et al., 2012; Mendenhall and Jacobs, 2012; Mendenhall, et al., 2010; Rock, 2003; Schoenberg, et al., 2005). This means that not only the chronic condition suffered by people with diabetes can lead them to depression, but also the other

³ In linguistics, diglossia refers to two varieties of the same language, usually spoken in different sets of circumstances. Here the term is used metaphorically.

way round, namely that harsh and prolonged conditions of stress can contribute to the development of diabetes. I argue that this finding would benefit from the integration of stories on diabetes with the ways bodies are experienced, felt, interpreted, perceived, lived through. We need to include sensory categories and perceptions, emotions, and the processes through which people with diabetes distinguish 'fine' from 'sick' (Hay, 2008).

The reconciliation of the speaking and the perceiving body naturally binds together phenomenology with political economy. For instance, an exploration of the local indigenous sensorium and of the sensorium of people with diabetes can help to tease out both lived food experiences (Ferzacca, 2004) and the food policies that have changed Mexican tables and palates (Pilcher, 1998). Dasein is always thrown within a historical, cultural, political horizon. As Thompson and Gifford's (2000) ethnography on Melbourne Aborigines shows, "When Melbourne Aborigines talk about trying to manage their diabetes, it is not only their sugar that is out of balance, it is their whole life" (2000, p.1458). Aborigines' narratives about balance and diabetes display a lucid and conscious understanding of the historical (past and present) politics that have boosted the epidemic. They describe "sugar" as something introduced from outside, from the "white man", and they link its presence to a series of disruptive occurrences, including the loss of land and the consequential severance of connections between land and kin (ibid., p.1462). For this reason, diabetes cannot be separated from a history of dispossession, colonization, and marginalization. The struggle to keep a

balance (mirrored in the outcome of the glycemic values) stands as a wider metaphor that speaks about the struggle to survive as a community in the face of threatening forces. "The unpredictability of sugar levels" mirrors "the unpredictability of life in general" (ibid., p.1465) which in turn explains why Aborigines give more attention to the present than to the future. The way Aborigines are able to link their illness with wider circumstances that involve family, community, society and environmental ties, openly challenges scientific approaches that deal with diabetes through an individual risk factor paradigm.

Again, the study of narratives of people with diabetes, especially if integrated with an exploration of bodily memory and lifeworld, reveals what a strong contribution ethnography can bring to health studies and why a mere account of lifestyles cannot be regarded as sufficient to stem diabetes. Ethnographies of diabetes have the potential to disclose the possible connections between health, identity, ethnicity (not as a reified entity), place, land, and the dispute over natural resources. They propose an integrated perspective of culture (Campbell, 2010) that captures the imponderabilia of actual life (Malinowski, 1922, p.18) while critically "seeing the entire situation in a given community" (Campbell, 2010, p.78). They also reaffirm the need of moving towards ethno-epidemiological models, or what Nancy Scheper-Hughes indicates as "Indigenous models and understandings" (2006, p.xxi).

A holistic model of care

The anthropological project outlined above has important implications on a practical level which suggest new paths in health policies and programs. The integration of a phenomenological and a political economy approach inevitably entails the assumption of a holistic model of care that does not limit itself to the therapeutic encounter but tries to address both the proximate and ultimate causes of suffering by identifying what Wikan (1990) calls people's "compelling concerns". In this section I aim at establishing the ontological and philosophical basis for a culturally and socially grounded strategy of care. I contend that to contribute to the definition of medical models capable of responding to people's concerns and ideals of well-being, and reformulate ideas of medical efficacy we need a philosophical reconceptualization of "care". Only by exploring the ontological and ontic dimensions of care, can we hope to contribute to a better, more comprehensive, and collective view of health and health-seeking processes. I shall argue that this can be done through an analysis of Martin Heidegger's reflection on Dasein and care. Although I will draw directly on his widely interpreted work "Being and Time" (1962 [1927]), I have to point out that I am not a philosopher, nor am I concerned with the philosophical hermeneutic debate on Heidegger's heritage. Suffice it to say that the discussion that follows is creatively personal and its *raison d'être* lies in the belief that an exploration of his work can provide us with a new epistemological horizon within which promising approaches to care come to the forefront.

The philosophical endeavor undertaken by Heidegger aims at going back to the primordial question of Ancient Greek philosophers, namely the study of Being in itself. Heidegger's approach also manifests an aspiration towards "totality" that resembles Hegel's concern with the Spirit and its phenomenological unraveling in history. The necessity to re-establish the primacy of ontology over the ontic is what makes Heidegger wonder about the primordial totality of Dasein's structural whole (1962, p.225). As said before, according to Heidegger, Dasein is characterized by its "thrownness", Being-in-the-world, and its being always ahead of itself, projected in its possibilities. The reconciliation of these existential dimensions of Dasein is intrinsically reconstituted by care, which is its very pre-ontological condition. Care is at the basis of any other state of being, or mood; it is their precondition, therefore the primordial dimension of Dasein. Heidegger also suggests that Dasein is "fallen" and is caught in an "inauthentic life" that closes its horizons within the boundaries of the "presence-at-hand" ('Reality', 'world actuality'). This divide between inauthenticity and authenticity, ontical and ontological, can easily be misunderstood as the replication of a Western dichotomy between the empirical and the ideal, the phenomenon and the noumenon. This is not so, since the act of consciousness that reveals the fallen character of Dasein and leads to the ontological discovery of Dasein's authenticity brings us back to the existential acknowledgment that Dasein is Being-in-the-world, and Dasein's Being is care. Thus, the divorce of facticity and Being in itself is only apparent and is solved by care, which is

both the precondition and the ultimate station of Dasein's journey: "This lies in demonstrating that no sooner has Dasein expressed anything about itself to itself, than it has already interpreted itself as care (*cura*), even though it has done so only pre-ontologically" (*ibid.*, p.227).

Even though care is the totality that brings unity to Dasein, other states-of-mind can reveal the nature of Dasein. Anxiety, fear, concern, and solicitude are states-of-mind that, depending on care, facilitate Dasein's own disclosing. According to Heidegger, anxiety is a sense that derives from our acknowledgment that "[W]hat oppresses us is not this or that, nor is it the summation of everything present-at-hand; it is rather the possibility of the ready-to-hand in general; that is to say, it is the world itself." (*ibid.*, p.231). So, anxiety reveals Dasein's Being-possible character (*ibid.*, p.232). In this sense, anxiety is a pervasive state directed towards no threat as such but towards what Kierkegaard had called the "dizziness of freedom" (1980, p.61). Thus, anxiety is the state-of-mind that discloses Dasein's projection towards its ownmost possibilities and its "being-ahead-of-itself" (1962, p.236). Anxiety reveals projection but also thrownness into a world (*ibid.*, p.236), thus disclosing that Dasein is "ahead-of-itself-in-already-being-in-a-world" (*ibid.*). Ontologically, these features are reconstituted into the unity of care. Ontically, they find expression in concern, i.e. being-alongside-things-ready-to-hand; solicitude, i.e. being-with-the-others (*ibid.*, p.237); and willing, i.e. the act by which Dasein commits itself to be concerned with an entity (*ibid.*, p.239).

All these phenomena constantly bring together a threefold existential pattern: being-ahead-of-itself; being-already; potentiality-for-Being (*ibid.*). Throughout his work, Heidegger mentions a number of moods such as will, wish, addiction, urge, worry, grief, devotedness, etc., all of which founded upon care, namely thrown projection.

The importance and significance of Heidegger's contribution for a reconceptualization of care in medical anthropology lies in the fact that care is recognized as the ontological premise of Being and that the world is meaningful as long as it is care-full. As Michael Inwood explains, "[O]nly if Dasein is care can it dwell in a significant world, and only if it dwells in a significant world can Dasein be care" (2000, p.59). By saying and appreciating this, care ceases to be a practice confined to particular and limited conditions and times of one's life (for example disease), and becomes an ontological precondition for life itself, shared by humans, non-humans, things, and the environment, as well as engaged and enacted personally and collectively on a daily basis. In this sense, my conceptualization of care is close to that of Fisher and Tronto (1990) who define it as:

'a species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life sustaining web. (cited in Tronto 2006)'

Therefore, we can say that care has a total and existential character that calls for a more conscious recognition of its

role and a phenomenological engagement that takes issue with objectifying definitions of care and encourages intersubjective disclosures of it. Furthermore, this approach makes us sensitive to the manifold modalities and aspects of care that risk disappearing into the shadows of the fabric of everyday life, while they have "already been disclosed in an ontico-existential manner" (1962, p.241) and ask for their being included into medical models of care and cure. This is a very important point, for it confers dignity on experiential knowledge, everyday enactments of care, and what Aristotle defined as *phronesis*, "the cautious intelligence that, context by context, evaluates which aspect of practical knowledge to activate in relation to a certain circumstance"⁴ (Tommasi, 2011, p.1).

Culturally specific studies of care and everyday practice can be anchored in this ontological framework that simultaneously recognizes the fundamental character of care to human life and its historical, social, and cultural specificity. An ethnography of diabetes would, therefore, explore the ways in which well-being is locally conceptualized and nourished in everyday life.

Another important point that Heidegger's exploration of care raises, is that of temporality. Care is embedded in the temporal dimension, given the fact that Dasein's Being is a thrown projection, constantly ahead of itself and already there. "Temporality gets experienced in a phenomenally

primordial way in Dasein's authentic Being-a-whole, in the phenomenon of anticipatory resoluteness" (1962, p.351). The temporal dimension of Dasein has to do with the consciousness of death, or Being-towards-death, something Ancient Romans summarized in the Latin reminder *memento mori*. Death is not conceived as an episode that concludes life but as a constitutive omnipresent condition. In Heidegger's (ibid., p.354) words:

'Death is not 'added on' to Dasein at its 'end'; but Dasein, as care, is the thrown (that is, null) basis for its death. The nullity by which Dasein's Being is dominated primordially through and through, is revealed to Dasein itself in authentic Being-towards-death'.

Resoluteness lies in this certainty which is incessantly anticipated. The projection towards the end molds the sense of selfhood and permits one to give sense to life. The mortal condition of Dasein is what confers to life the impulse to make projects and forge the self in conjunction with the world it is thrown into. This explains the within-time-ness of the Being-in-the-world; Dasein discloses and uncovers itself by projecting itself "upon that uttermost possibility which lies ahead of every factual potentiality-for-Being of Dasein" (ibid., p.349). This clearly means that the idea of the self is something that does not take shape from a vacuum that allows unconditioned freedom and random possibilities but that the "already-there" character of Dasein provides the ontological and ontical dimension that anchors the self within a net of relations. Not only Dasein's Being is "Being-already-there", but is also

⁴ "l'intelligenza prudente che sa valutare caso per caso quali aspetti del molteplice ed eterogeneo bagaglio del sapere pratico siano da attivare in relazione a quella particolare circostanza".

"Being-with-others" and "Being-alongside-entities-within-the-world". This is why, as Ricoeur highlights, no possibility exists without memory of the past. "Retrospection is reconnected to anticipation, and anticipation is rooted in retrospection" (1981, p.178). The structural dimension of death and its pervasiveness make any act an act of care, both in the sense of caring about something and taking care of something (Inwood, 2000, p.58). Again, care is not an activity performed by certain actors at certain times, but, rather, a collective ongoing process that looks ahead and back in order to take action in the present. In this perspective, care implies the repairing as well as the crafting of the self and the world towards ideals of good that are grounded in memory and are projected into the future. Care has to do with the idea of who we want to be (possibility) and how we can accomplish it with what is ready to hand. "When fully conceived, the care-structure includes the phenomenon of Selfhood" (1962, p.370) which is never isolated, sovereign, and permanent. The constancy of the self finds a place only in Dasein's Being as care (ibid., p.369). And care brings us back to the dimension of temporality which works insofar as the being-ahead-of-itself character is interwoven with the already-there and the being-alongside (ibid., p.375).

What are the implications of these speculations to a reconceptualization of care? First of all, the critique to the isolated subject reminds us that the self "is enfolded ab initio within a web of relationships" (Dunne, 1995, p.144) and that only from this web of relations can the self become aware of its ongoing engagement in taking care of and caring

about something/someone. Thus, relatedness becomes the center of any act of care, even when directed to the self. This openly challenges individualistic logics of care that, for instance, conceptualize cure in terms of punctual interventions offered or sold to patients who are either free (bounded) citizens or customers (Mol, 2008). Care should not be seen as an activity urgently needed at times of crisis but as an ongoing process that not only repairs but also crafts. Secondly, in this light, care and the need for it become the duty and right of all individuals, thus blurring the divides between those who consider themselves or are considered able and the unable, the strong and the weak, the healthy and the ill. As Tronto duly points out: "The presumption that only the vulnerable need care, [...], belies our common human fate of depending upon others" (2006, p.17). Thirdly, once the ontological dimension of care is fully acknowledged, then it becomes easier to look at the ontical dimension of it and identify (valorize) all those daily acts of care that go overlooked in the flow of life. In particular, all those gestures that do not make themselves tangible in discrete ever-lasting products but attest to care demand attention. As Italian feminist Carla Lonzi wrote, these practices of care are "gestures in the air, as those of the equilibrists, gestures done of air. Upon these gestures with no final concretization, our life is built"⁵ (2010 [1978], p.614). These words recall those of anthropologist Anderson who defined food history as a "history without names" (2005, p.2). Food preparation is

⁵ "[Gesti] che non diventano un prodotto, ma solo un accadere. Gesti nell'aria come quelli degli equilibristi, gesti fatti d'aria. Su questi gesti senza seguito è costruita la nostra vita".

a primordial act of care that does not leave names in history; the product of care, food, disappears, therefore, cooking albeit corporeal is ultimately a gesture in the air. Fourthly, the experience of worry, will, wish, concern, fear, anxiety, solicitude, etc. reveals the projection of the self upon the world and discloses what merits affection and the idea of good. Care becomes enmeshed in the making of personal and social realities, and reveals its transformative power. This allows us to bring into focus more complex forms of care and cure. Although not all therapeutic interventions are considered transformative by patients and healers, and some only aim at restoring a previous state of perceived well-being (Waldrum, 2013), they all entail a vision and the active accomplishment of the self. During therapies, patients, healers, and all the actors involved in the process bring their concerns, worries, and ideas of well-being. The therapeutic encounter becomes inhabited and experienced by ideas of the good that have been molded throughout time and enacted through the ontical dimension of care.

In this light, the project of anthropologists (Cabassa, et al., 2008; Ferreira and Lang, 2006; Iwasaki, et al., 2004, 2005; Mendenhall, et al., 2010; Mendenhall, et al., 2012), who are committed to a "liberation medicine" (Scheper-Hughes, 2006, p.xxi), investigates and proposes "culturally relevant empowerment-oriented diabetes management strategies to promote mastery and life quality among Aboriginal peoples with diabetes" (Iwasaki, et al., 2005, p.978) and should be endorsed. The central idea of this project is the identification of indigenous people's coping strategies, everyday

practices of care, and conceptualizations of well-being in order to incorporate them into models of care. Although I believe this is the most promising approach to diabetes prevention and treatment, I also feel it is important to mention the risk of unproblematizing indigenous "traditions" and medical knowledge. As recent studies have highlighted, the very concepts of "indigenous" (McIntosh, et al., 2002), "traditional", and "authentic" (Theodossopoulos, 2013) are not conflict-free. If, for example, we look at traditional ways of preparing and consuming food we might find that certain commodities considered unhealthy from a biomedical point of view have been adopted and are considered important for the maintenance of social cohesion and well-being. Tastes, as well as concepts of health and well-being, can be uncertain and ambivalent (Holtzman, 2009). Facing these ambiguities, anthropologists as much as physicians might fall into the temptation of assuming the authority of arbiters of healthy and unhealthy indigenous habits, a practice that too closely resembles the twentieth-century indigenist policies of Mexico and Latin America we all consider part of a past and obsolete project of nationhood. The attempt to formulate a holistic model of care calls into question the political position of medical anthropologists, often hesitating between a cultural broker or a critical role, especially when "the interests and goals of doctors and their patients do not always coincide" (Scheper-Hughes, 1990, p.190). This paper, therefore, concludes in a two-fold way: proposing directions for a socially complex understanding of diabetes and the

crafting of a holistic model of care, but also posing unsolved questions and challenges for the future of medical anthropology and health care strategies in general.

Conclusion

Indigenous peoples worldwide are experiencing the burden of noncommunicable diseases and diabetes. The unequal distribution of illness demands explanations and sense making. The ways in which diabetes is framed, addressed, and described have crucial implications in terms of research agendas and health care strategies. A vast array of discourses is being produced from a variety of actors placed on a continuum where no clear-cut distinction can be traced between the popular and the scientific. Medical anthropologists are participating in this enterprise and should therefore interrogate themselves about their roles in and their contributions to an understanding of diabetes. My initial question was concerned with whether or not, and the ways in which, an ethnography of diabetes can provide unique insights into the lived experiences of people with diabetes and into both the proximate and ultimate causes of it. My answer is that anthropologists are well-equipped to give a significant contribution towards an understanding of diabetes and the crafting of medical models of care. However, this statement is not sufficient. In order to substantiate it, it behooves us to clarify the ontological and epistemological premises of our investigation and political contribution.

I have argued that a socially complex approach to hyperglycemia,

human suffering, and care can be theoretically grounded in a framework that integrates a phenomenologically inspired approach with a political economy one, thus obviating the possible flaws of both standpoints. In particular, I have shown that the attention paid by phenomenology to subjectivity and lived experiences inevitably leads to the consideration of larger socio-political forces: political economy is the "natural" completion of any phenomenologically inspired analysis. This is particularly evident when dealing with bodily memory, both in its incarnate fashion and linguistic expression. Bodies are lived through and listened to, constantly pre-objectively and intentionally experienced, loci from which experience is arrayed (Desjarlais and Throop, 2011, p.89), receivers and providers of care. This is why an ethnography of diabetes cannot be focused only on the speaking body but also on the perceiving body, although they should not be dealt with in a dichotomized way, given that speech is incarnate as much as the senses are spoken.

One of the strongest contributions of anthropologists to the study of diabetes has been the recognition that "racial" and ethnic differences are relevant only insofar as they mirror social disparities and structural inequalities. In this sense, the epidemiological map of diabetes can trace the lines of social suffering. Diabetes is therefore the embodiment of social, political, and economic stratification. This is a broad hint that diabetes cannot be successfully tackled unless the social, political and economic inequalities are reduced. Anthropologists can look at history at work at the global

level and history as lived in local space, the state policies and the politics of subjects (Fassin, 2007, p.xvii). In this light, bodies remember as much as they feel and they become objects of reflection and subjects of political (in its broader sense) action.

Thus, any ethnography of diabetes should integrate an exploration of historical processes with consideration for the lived experiences of suffering and distress.

Phenomenology, especially an Heideggerian inspired one, provides a challenging but promising approach that permits us to establish the ontological premises of care while taking into consideration culturally specific ideals and enactments of well-being, health, and illness. The conceptualization of Dasein as thrown projection reminds us how each life is engaged in an existential struggle towards the everyday nourishment of an authentic self project, and how this process is always and at any time grounded, limited, and contextually specific. The self is, therefore, an oxymoron: a situated transcendence. The acknowledgment of this ontological premise is theoretically, methodologically, and politically relevant for medical anthropologists: the movement towards a "liberation medicine" (Scheper-Hughes, 2006, p.xxi) entails the assumption of a role that should aim at facilitating indigenous peoples' projection towards their ownmost possibilities, or authenticity. This project resonates with Mexican anthropologist Guillermo Bonfil Batalla's idea of "etnodesarrollo" (ethno-development strategy), which is the right of indigenes to decide autonomously about their own destiny (Bonfil Batalla, 1970). In this endeavor, the

anthropologist is called to abide by the indigenous decisions and to be at the service of human liberation, assuming a militant and politically active role in favor of the dis-alienation of cultures. Perhaps, the first step towards such a project is a reconceptualization of care that is attentive to people's concerns (being-alongside-things-ready-to-hand), solitudes (being-with-the-others), and willingness. The result is a holistic model of care that is conceived as a collective ongoing process, expressed in a manifold modality, and through everyday gestures, including "gestures in the air". If we considering well-being in its wider sense, then human suffering and potentiality for Being cannot be severed from the broader pathogenic circumstances in which they are thrown, such as the dispossession of aboriginal land and violations of indigenous rights.

The main challenge of this project lies, therefore, in the ways we decide to look critically at diabetes prevention and treatment. Although this article does not provide any ultimate answer, it does clarify the philosophical and anthropological basis for a liberation medical model that goes beyond race and ethnicity and aims at illuminating culturally specific features of care, which are projected towards indigenous peoples with diabetes' ownmost possibilities and thrown into specific historical contexts marked by political economic forces and trajectories.

Bibliography

Aime, M., 2004. *Eccessi di Culture*. Torino: Einaudi. Anderson, E., 2005. *Everyone Eats: Understanding Food and Culture*. New York: New York University Press.

- Becker, G., 1997. *Disrupted Lives: How People Create Meaning in a Chaotic World*. Berkeley ; Los Angeles ; London: University of California Press.
- Biehl, J., Good, B. and Kleinman, A. eds., 2007. *Subjectivity: Ethnographic Investigations*. Berkeley: University of California Press.
- Bonfil Batalla, G., 1970. Del indigenismo de la revolución a la antropología crítica. In: Warman, A., et al., 1970. *De eso que llaman antropología mexicana*. Mexico: Nuevo Tiempo, pp.39-65.
- Borovoy, A. and Hine, J., 2008. Managing the Unmanageable: Elderly Russian Jewish Émigrés and the Biomedical Culture of Diabetes Care. *Medical Anthropology Quarterly* 22(1), pp.1-26.
- Bourdieu, P., 1977. *Outline of a Theory of Practice*. Cambridge ; New York: Cambridge University Press.
- Cabassa, L.J., Hansen, M.C., Palinkas, L.A. and Ell, K. 2008. Azúcar y Nervios: Explanatory Models and Treatment Experiences of Hispanics with Diabetes and Depression. *Social Science & Medicine*, 66(12), pp.2413-2424.
- Campbell, D., 2010. Anthropology's Contribution to Public Health Policy Development. *Mcgill Journal of Medicine*, 13(1), pp.76-83.
- Cartwright, E., 2007. Bodily Remembering: Memory, Place, and Understanding Latino Folk Illness Among the Amuzgos Indians of Oaxaca, Mexico. *Culture, Medicine and Psychiatry*, 31, pp.527-545.
- Casey, E., 1987. *Remembering: A Phenomenological Study*. Bloomington: Indiana University Press.
- Classen, C., 1990. Sweet Colors, Fragrant Songs: Sensory Models of the Andes and the Amazon. *American Ethnologist*, 17(4), pp.722-735.
- Classen, C., 1993. *Worlds of Sense: Exploring the Senses in History and across Cultures*. London; New York: Routledge.
- Csordas, T.J., 1994. *Embodiment and Experience: The Existential Ground of Culture and Self*. Cambridge ; New York: Cambridge University Press.
- Das, V., 2007. *Life and Words: Violence and the Descent into the Ordinary*. Berkeley ; London : University of California Press.
- Desjarlais, R. and Throop, J.C., 2011. Phenomenological Approaches in Anthropology. *Annual Review of Anthropology* 40, pp.87-102.
- Desjarlais, R.R., 1992. *Body and Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas*. Philadelphia: University of Pennsylvania Press.
- Dunne, J., 1995. Beyond Sovereignty and Deconstruction: The Storied Self. In: D. Rasmussen, ed. 1995 *Philosophy and Social Criticism*, 21(5/6), pp.137-157.
- Farmer, P., 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley, CA ; London: University of California Press.
- Fassin, D., 2007. *When Bodies Remember: Experiences and Politics of AIDS in South*

Africa. Berkeley: University of California Press.

Fee, M., 2006. Racializing Narratives: Obesity, Diabetes and the 'Aboriginal' Thrifty Genotype. *Social Science & Medicine*, 62(12), pp.2988-2997.

Ferreira, M. and G. Chesley Lang, eds., 2006. *Indigenous Peoples and Diabetes: Community Empowerment and Wellness*. Durham, N.C.: Carolina Academic Press.

Ferzacca, S., 2000. 'Actually, I Don't Feel That Bad': Managing Diabetes and the Clinical Encounter. *Medical Anthropology Quarterly*, 14(1), pp.28-50.

Ferzacca, S., 2004. Lived Food and Judgments of Taste at a Time of Disease. *Medical Anthropology*, 23(1), pp.41-67.

Ferzacca, S., 2012. Diabetes and Culture. *Annual Review of Anthropology*, 41, pp.411-26.

Fisher, B., and J. Tronto, 1990. Toward a feminist theory of caring. In: F. Abel and M. Nelson, eds. 1980. *Circles of care*. Albany: State University of New York, pp.35-62.

Foucault, M., 1981. *The History of Sexuality*. Harmondsworth: Penguin Books.

Foucault, M., 1991. *Discipline and Punish: The Birth of the Prison*. London: Penguin.

Geurts, K.L., 2002. *Culture and the Senses: Bodily Ways of Knowing in an African Community*. Berkeley: University of California Press.

Gieser, T., 2008. Embodiment, Emotion, Empathy: A Phenomenological Approach to Apprenticeship Learning. *Anthropological Theory*, 8(3), pp.299-318.

Good, B., 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge; New York: Cambridge University Press.

Green, L., 1998. Lived Lives and Social Suffering: Problems and Concerns in Medical Anthropology. *Medical Anthropology Quarterly*, 12(1), pp.3-7.

Hamington, M. and Miller, D. eds., 2006. *Socializing Care*. Oxford: Rowman and Littlefield.

Hay, C.M., 2008. Reading Sensations: Understanding the Process of Distinguishing 'Fine' from 'Sick'. *Transcultural Psychiatry* 45(2), pp.198-229.

Heidegger, M., 1962 [1927]. *Being and Time*. Translated from German by J. Macquarrie and E. Robinson. Oxford: Blackwell.

Hollan, D., 2008. Being There: On the Imaginative Aspects of Understanding Others and Being Understood. *Ethos* 36(4), pp.475-489.

Hollan, D., 2012. Emerging Issues in the Cross-Cultural Study of Empathy. *Emotion Review* 4(1), pp.70-78.

Hollan, D. and Throop, C.J., 2008. Whatever Happened to Empathy?: Introduction. *Ethos* 36(4), pp.385-401.

Holtzman, J., 2009. *Uncertain Tastes: Memory, Ambivalence, and the Politics of*

Eating in Samburu, Northern Kenya. University of California Press.

Howes, D., 1991. *The Varieties of Sensory Experience: A Sourcebook in the Anthropology of Senses.* Toronto: University of Toronto Press.

Howes, D., 2003. *Sensual Relations. Engaging the Senses in Culture and Social Theory.* Ann Arbor: The University of Michigan Press.

Inwood, M., 2000. *Heidegger: A Very Short Introduction.* Oxford: Oxford University Press.

Iwasaki, Y., Bartlett, J., and O'Neil, J., 2004. An Examination of Stress among Aboriginal Women and Men with Diabetes in Manitoba, Canada. *Ethnicity and Health*, 9(2), pp.189-212.

Iwasaki, Y., Bartlett, J. and O'Neil, J., 2005. Coping with Stress among Aboriginal Women and Men with Diabetes in Winnipeg, Canada. *Social Science & Medicine*, 60(5), pp.977-988.

Joe, J.R., and Robert, S.Y., 1993. *Diabetes as a Disease of Civilization: The Impact of Culture Change on Indigenous Peoples.* Berlin ; New York: Mouton de Gruyter.

Kierkegaard, S., 1980. *The Concept of Anxiety: A Simple Psychologically Orienting Deliberation on the Dogmatic Issue of Hereditary Sin.* Translated and edited by R. Thomte and A.B. Anderson. Princeton, N.J.: Princeton University Press.

Kleinman, A. and Fitz-Henry, E., 2007. The Experiential Basis of Subjectivity: How Individuals Change in Context of Societal Transformation. In: J. Biehl,

Good, B., and Kleinman, A., eds. 2007. *Subjectivity: Ethnographic Investigations.* Berkeley: University of California Press, pp.52-65.

Leonard, S.P., 2013. Phenomenology of Speech in a Cold Place: The Polar Eskimo Language as 'Lived Experience'. *International Journal of Language Studies*, 7(1), pp.151-174.

Lieberman, L.S., 2003. Dietary, Evolutionary, and Modernizing Influences on the Prevalence of Type 2 Diabetes. *Annual Review of Nutrition*, 23, pp.345-377.

Lonzi, C., 2010 [1978]. *Taci, anzi parla. Diario di una femminista.* Milano: Rivolta Femminile.

Lutz, C. and Geoffrey, M.W., 1986. The Anthropology of Emotions. *Annual Review of Anthropology*, 15, pp.405-436.

Malinowski, B., 1922. *The Argonauts of Western Pacific: An Account of Native Enterprise and Adventure in the Archipelagoes of Helanesian New Guinea.* London: Routledge.

McGarvey, S.T., James R.B., Douglas E.C., and Schendel, D.E., 1989. Modernization and Adiposity: Causes and Consequences. In: M. Little and J. Haas, eds. 1989. *Human Population Biology.* London: Oxford University Press, pp.263-280.

McIntosh, I., Colchester, M., Bowen, J. and Rosengren, D., 2002. Defining Oneself, and Being Defined as, Indigenous. *Anthropology Today*, 18(3),pp.23-25.

Mendenhall, E., and Jacobs, E.A., 2012. Interpersonal Abuse and Depression Among Mexican Immigrant Women with Type 2 Diabetes. *Culture, Medicine and Psychiatry*, 36(1), pp.136-153.

Mendenhall, E., Fernandez, A., Adler, N., and Jacobs, E.A., 2012. *Susto, Coraje*, and Abuse: Depression and Beliefs About Diabetes. *Culture, Medicine and Psychiatry*, 36(3), pp.480-492.

Mendenhall, E., Seligman, R.A., Fernandez, A., and Jacobs, E.A., 2010. Speaking through Diabetes: Rethinking the Significance of Lay Discourses on Diabetes. *Medical Anthropology Quarterly*, 24(2), pp.220-239.

Merleau-Ponty, M., 1945. *Phénoménologie de la perception*. Paris: Gallimard.

Mol, A., 2008. *The Logic of Care: Health and the Problem of Patient Choice*. London: Routledge.

Montoya, M., 2011. *Making the Mexican Diabetic. Race, Science, and the Genetics of Inequality*. Berkeley ; Los Angeles ; London: University of California Press.

Neel, J., 1962. Diabetes Mellitus: A 'Thrifty' Genotype Rendered Detrimental by 'Progress'?. *American Journal of Human Genetics*, 14, pp.353-362.

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

Ocampo, M., 2013. Genes indígenas, solución a la diabetes, *Sin Embargo.MX*, [online]16 April. Available at:

<http://www.sinembargo.mx/16-04-2013/588062>, [Accessed 17 April 2013].

Pilcher, J.M., 1998. *¡Qué Vivan los Tamales! Food and the Making of Mexican Identity*. Albuquerque: University of New Mexico Press.

Ricoeur, P., 1981. Narrative Time. In: W.J.T. Mitchell, ed. 1981. *On Narrative*. Chicago ; London: University of Chicago Press, pp.165-186.

Rock, M., 2003. Sweet Blood and Social Suffering: Rethinking Cause-Effect Relationships in Diabetes, Distress, and Duress. *Medical Anthropology*, 22(2), pp.131-174.

Roma, C., 2007. *Living with Violence: An Anthropology of Events and Everyday Life*. New Delhi ; Abingdon : Routledge.

Scheper-Hughes, N., 1992. *Death Without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.

Scheper-Hughes, N., 2006. Foreword. In: M. Ferreira and G. C. Lang, eds. 2006. *Indigenous Peoples and Diabetes: Community Empowerment and Wellness*. Durham, N.C.: Carolina Academic Press, pp.xvii-xxi.

Scheper-Hughes, N., Lock, M., 1987. The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly*, 1(1), pp.6-41.

Schoenberg, N.E., Drew, E.M., Palo Stoller, E. and Kart, C.S., 2005. Situating Stress: Lessons from Lay Discourses on

- Diabetes. *Medical Anthropology Quarterly*, 19(2), pp.171-193.
- Shepard, G.H., 2002. Three Days for Weeping: Dreams, Emotions, and Death in the Peruvian Amazon. *Medical Anthropology Quarterly*, 16(2), pp.200-229.
- Seremetakis, N., 1994. *The Senses Still: Perception and Memory as Material Culture in Modernity*. Chicago ; London: The University of Chicago Press.
- Stoller, P., 1989. *The Taste of Ethnographic Things: The Senses in Anthropology*. Philadelphia: University of Pennsylvania Press.
- Stoller, P., 1995. *Embodying Colonial Memories: Spirit Possession, Power and the Hauka Movement in West Africa*. New York: Routledge.
- Stoller, P., 1997. *Sensuous Scholarship*. Philadelphia: University of Pennsylvania Press.
- Stunkard, A.J., and Sorensen, T., 1993, Obesity and Socioeconomic Status: A Complex Relation. *New England Journal of Medicine*, 329, pp.1036-1037.
- Sutton, D., 2001. *Remembrance of Repasts: An Anthropology of Food and Memory*. Oxford: Berg.
- Theodossopoulos, D., 2013. Laying Claim to Authenticity: Five Anthropological Dilemmas. *Anthropological Quarterly*, 86(2), pp.337-360.
- Thompson, S.J. and Gifford, S.M., 2000. Trying to Keep a Balance: The Meaning of Health and Diabetes in an Urban Aboriginal Community. *Social Science & Medicine*, 51(10), pp.1457-1472.
- Throop, C.J., 2003. Articulating Experience. *Anthropological Theory*, 3(2), pp.219-241.
- Tommasi, W., 2011. *Oggi è un altro giorno: Filosofia della vita quotidiana*. Naples: Liguori Editore.
- Treichler, P.A., 1987. AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification. *October*, 43, pp.31-70.
- Tronto, J., 2006. Vicious Circles of Privatized Caring. In: M. Hamington and D. Miller, eds., 2006. *Socializing Care*. Oxford: Rowman and Littlefield, pp.3-26.
- Vattimo, G., 2011. *Gianni Vattimo racconta Heidegger e la filosofia della crisi*. Rome: Gruppo Editoriale L'Espresso.
- Waldram, J.B., 2013. Transformative and Restorative Processes: Revisiting the Question of Efficacy of Indigenous Healing. *Medical Anthropology*, 32, pp.191-207.
- Wikan, U., 1990. *Managing Turbulent Hearts. A Balinese Formula for Living*. Chicago ; London: The University of Chicago Press.
- Wikan, U., 1992. The Power of Resonance. *American Ethnologist*, 19(3), pp.460-482.
- World Health Organization, 2008. *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases*. WHO.
- Zimmet, P., Alberti, K.G., and Shaw, J., 2001. Global and Societal Implications of the Diabetes Epidemic. *Nature*, 414, pp.782-787.