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~~NEW SUMMER EDITION~~

Message from the President

Barrett P. Brenton (St. John's University)

It is with great pleasure that I welcome *NEAA Newsletter* readers to the inaugural summer issue. The idea of an additional issue was devised under the leadership of Editor-in-Chief Jessica Skolnikoff and Copy Editor Alan Hersker as a way of highlighting prize winning student papers from our annual meeting and to provide more outreach to our members. Please take the time out of your busy schedules before a new academic year begins to read through the summaries of an impressive body of research that is being undertaken by our student membership. The papers represent the richness of an anthropological approach and include the M. Estellie Smith Graduate Paper Prize winner Kathryn A. Rhine's, now an Assistant Professor at the University of Kansas, and her work on the dilemmas of diagnoses related to HIV testing in northern Nigeria; the John

Omohundro Undergraduate Paper Prize winner Erica Varlese from Drew University and her exploration of labor support and resistance in American birth; and finally the NEAA Undergraduate Poster Paper Prize winner Katelyn Rusk from UMASS-Amherst and her investigation on developing a quantitative method of aging the human skeleton using the pubic symphysis. I would like to again congratulate these winners as well as thank them for sharing their work with other NEAA members. The papers should also serve as an inspiration for future research and paper prize applicants. In closing, I want to invite everyone to the NEAA's 50th Anniversary Meeting in Buffalo, NY exploring the theme of "Borders, Margins, and Passages," March 5-7, 2010. Additional details will become available in future issues of the Newsletter and on our website. I wish everyone a prosperous and productive academic year ahead.

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Estelle Smith Graduate Paper Prize Winner
Dilemmas of Diagnoses: HIV Testing in Northern Nigeria

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Introduction

Much of what is known about the prevalence and presence of HIV in Nigeria is based upon aggregate estimations and projections. Without confirmatory tests, most individuals infected with the virus are merely sick, or – more likely – are *not* sick, but have been married to sick partners.¹ HIV dwells in the body without symptoms for an unknown period of time. Further, the illnesses that accompany HIV infection resemble those of any of a number of diseases present throughout sub-Saharan Africa. An HIV screening, consequently, is often an afterthought for patients, one considered only after a range of biomedical and traditional treatments for typhoid, malaria, or other parasitic infections have failed.² Even the most severe symptoms associated with advanced stages of HIV are so prevalent in Nigeria that patients do not necessarily suspect that the virus is at fault. HIV-related deaths are not remarkable in a country with an average life expectancy of under 50 years.³ There is more, however, to be understood about the invisibility of HIV in Nigeria than that which can be concluded by these epidemiological and demographic trends. The virus's immoral connotations entrench fears of stigmatization and abandonment among HIV-positive persons and individuals sever themselves from all potential associations with the disease.⁴ Political-economic forces contribute to the social invisibility of the virus: patients, for example, lack the resources for repeated visits to the hospital; health care providers are unable to follow the course of a patient's recovery; and infected persons often die in their homes without autopsies.⁵

An HIV test is thus not simply a tool employed to measure immunological malfunction. A diagnosis, I will argue, also illuminates a set of social facts. In this paper, I ask why ordinary Nigerians would want to know their status and why they might not want to know. What, specifically, is at stake when one receives a positive result? I focus upon how Nigerian women contemplate diagnoses in reference to their sense of social identities, as well as notions of family aspirations, obligations, and processes of marriage dissolutions. And I suggest that the virtues and fears embedded in the act of taking a test are related to larger questions of how families and relationships might be reconfigured in light of a positive result.

Diagnostic Testing in Anthropological Perspective

A classic tenet of personalistic ethnomedical models is the preeminent role of the healer in discerning the *who and why* of a disorder.⁶ Good (1994) summarizes: the naming of the source of suffering constitutes “a critical step in the remaking of the world, in the authoring of an integrated self” (128-129). For patients with chronic conditions, testing is a crucial element in the validation and legitimization of illness claims.⁷ In exploring chronic back pain, for example, Rhodes and her colleagues (1999) write, “Thus while in other conditions a positive test may be feared, for back pain patients a positive result affirms a ‘real’ problem and allows their suffering to become “an acceptable illness, one that can be handled” (1190).⁸ In psychological terms, a correct diagnosis reveals the “emancipatory” potential of a correct label. It fosters the establishment of a “therapeutic alliance” between clinicians and patients, which is considered one of the cornerstones of the healing process in biomedicine. In the public health literature

on HIV, clinicians are instructed that this relationship can facilitate patient education, improve medication compliance, and promote behavioral change among their patients. Patients, in turn, are assured they can rely upon this empathetic bond during times of crises.⁹ Studies such as these assume that biomedical practitioners are the prevailing authorities in producing and enhancing the life chances of persons infected with HIV. I propose that, in fact, there exists an array of authoritative persons in patients' lives, not limited to health professionals, who contribute to the validation of disorders and disordered identities, and who foster the alliances upon which patients depend in times of critical need.

Social theorists have also conceptualized illness diagnoses as the foundation upon which patients are enculturated into a "sick role:" one characterized by a process of accepting the terms, prescriptions, and limitations of a condition, with an aim of getting well.¹⁰ The latter of these expectations, however, present distinct challenges for those with chronic illnesses, pain, and disabilities, who cannot entirely be healed.¹¹ As physicians and patients act according to expectations surrounding these social roles, they reproduce the setting and the rules that govern their environs. "Total institutions," such as hospitals or asylums, argues Goffman (1961), strip a patient of the social context from which she comes, reinforcing her "essential" deviance, thereby creating the conditions not only for her stigmatization, but also for larger processes of social control. Specific diagnoses propel patients through particular health institutions, revealing a spectrum of forms of control, ranging from the more custodial and coercive to the more supportive and therapeutic.¹² Green and Sobo (2000) write, "A positive HIV antibody test can shatter a previously crafted sense of self, and it can mean that an individual will incorporate a new facet into his or her identity – that of being HIV positive" (2). While these scholars have explored the relationship between social identities and the interpersonal management of HIV stigma, less clear are the ways in which other social institutions – besides medical establishments – intervene in these processes. I thus emphasize not only processes of identity formation (and disintegration), but also the kinship and religious norms that shape these dynamics.

Anthropologists have questioned how societies are reconfigured when biomedical tools, diagnostic protocols, and other forms of technical knowledge "travel" across diverse locales. These studies have elucidated the intimate ties that technologies forge with global power configurations.¹³ In a West African example of prenatal sickle cell screening, Fullwiley (2004) considered the paradoxical ways in which patients who carry sickle cell traits in Senegal enlist "traditional" interpretations of the pregnant body and the family to justify the need for these "modern" techniques. Senegalese physicians, she found, erroneously presumed these religious traditions and cultural ethics would inhibit such considerations among patients. Similar arguments have been made in ethnographic studies of HIV activism. Scholars have illustrated the role HIV-positive persons have played in making public claims for the protection of human rights and the provision of antiretroviral therapies.¹⁴ Framings of agency – especially gendered forms of agency in Africa – are often conceptualized as the ways individual interests are realized against structures of political power. Such framings risk exaggerating individual autonomy and reifying state-subject relationships. In this paper, I ground the dilemmas women face over HIV tests within hierarchies of kinship and gender relations. In other words, the expressions of and constraints upon women's agency that I have observed are not oriented so much around the issue of whether or not to seek an HIV test, but instead are intertwined with larger questions over the ways individuals negotiate power relations in their sexual and social lives.

In what follows, I begin with a case study of a widow I have called Talatu. Her story reveals the constraints upon women's agency both in their relationships trajectories and in decisions over their health. Even when women suspect that their husbands are infected with HIV, they may be unable to

demand a test. A test's association with promiscuity raises fears and further accentuates gendered power differentials within relationships, as I have observed in my conversations with members of an HIV support group. Northern Nigerian men have greater opportunities for extramarital affairs, while HIV-positive women blame themselves and "Hausa culture" more broadly for men's sexual behavior. While they fervently dismiss accusations of promiscuity, women often move into and out of numerous partnerships as they seek to fulfill their marriage aspirations and maintain their material livelihoods. I illustrate an example of these constraints through a relationship history I collected from a young non-married woman named Asama'u. While women were aware that having multiple sexual partners and unprotected sex are associated with HIV transmission, less clear to them were the ways that they might have changed these relationship dynamics to lessen their risk. At the core of women's deliberations surrounding HIV-positive diagnoses were not, in fact, the trajectories of illness, but rather their fears of being blamed by their in-laws for their husbands' deaths. Women who learn they are infected before their kin and community thus maneuver strategically in their attempts to ensure they are in a position to protect themselves when the status of their partners becomes known.

Talatu

I met Talatu, a twice-divorced Muslim woman in a support group for HIV-positive persons in the northern Nigerian city of Kano. Shortly after her first divorce, she told me, there was a man who had courted her. Although he was much older than her, Talatu felt that he could help support her children and she accepted his proposal for marriage. She noticed he was very thin and attempted to persuade him to take an HIV test before they married. He insisted on a quick marriage and paid her dowry. They set a date for the wedding, but when her persistence for screening grew, he stopped visiting her. Afraid that she would lose him, Talatu asked his friends why he was avoiding her. They told her that he was unhappy about the HIV test. Her behavior implied that she did not trust him. She sent him an apology, and they were married. Talatu expected that once they married, she would possess greater authority and would be able to convince him to be tested. For two months, she resisted moving in with her husband and refused his sexual advances. Her friends began to lecture her about a husband's right to have sex with his wife, and she ultimately relented.

Talatu knew her husband had had a number of partners before her, since friends had said they had seen him with other girlfriends. In spite of this reputation, they expected now that he was married, he would stop pursuing other women. A few months later, she began to have stomach cramps, which would not go away. Her illness became serious and she went to the hospital. Her husband then gave her divorce papers, because he could not cope with her always being sick. After the divorce, Talatu's parents took her to the hospital to have her blood tested. They knew her status then, but would not tell her. Her daughter from her first husband, whom she was still breastfeeding, soon became sick and started to lose weight. She suspected that her baby might also be sick with HIV, though her mother told her that she should not "call sickness" upon to the child. Later, her baby died. She then learned that her first husband died of AIDS, as well. Talatu returned to the hospital for an HIV test and confirmed she was positive.

As HIV is most commonly transmitted through heterosexual sex between husbands and wives, a diagnosis is intertwined with the sexual and social lives of Nigerian couples and their families. Community reputations, financial stability, and health histories are all part of the calculus employed by kin in contracting marriages. Individuals and their families – particularly those with limited resources – maneuver in strategic ways to ensure that partnerships are forged or dissolved. Despite the fact that most Nigerian women are aware of the ways HIV is transmitted, few are able to demand an HIV test of their

partners. Following marriage, they are unable to abstain from sex, even if they suspect that their partner is infected. And finally, most do not possess the power to prevent their relationship from dissolving, if their husbands seek to divorce or abandon them. There are limitations to women's autonomy both in their relationships and their decisions over their health. Ultimately, the social risk of losing a partner outweighs the risk of HIV transmission.

Perceptions of Promiscuity

The women with whom I worked in a support group in Kano had much to say about the problems of adultery among men and the relationship between extramarital affairs and the HIV epidemic. One of our meetings together focused on this concern. Adultery, they argued, was unambiguously immoral. Hafsat, for example, explained, "Islam has made provision for cheating men. According to *shari'a*, death is the penalty one pays for adultery. Religion also provides for punishment in the hereafter, if [adulterers] are not caught. Also, there are repercussions on society because adultery leads to the spread of sexually transmitted diseases, as infections are transferred to women. Men are indebted to whosoever they infect and their punishment is certain."

"But is promiscuity only a problem among men?" I asked members of the group. The women agreed. "Hausa women," Hauwa pointed out, "are 99% shy, while men are only 1% shy. So men's desire overwhelms them, and that is what gets them into the trouble." Another responded to her, "Because men get more desires, God has made provision for them to marry four wives, is that not so? But some men have four wives and still seek other women outside. Women, on the other hand, once married love and honor their husbands. It is not possible to seek another man except yours." Most of the women concurred, "We [women] could see a neat, good-looking man but not be moved. Men, however, would not hesitate to follow a well-dressed woman, even though he is knowledgeable, informed, and might have just finished preaching in the mosque. He will see and follow a woman, and that's why we keep seeing all sorts of problems. It is because we digress from God's teachings." Statements such as these naturalize sexual drive, attraction, performance, and satisfaction into defined gender roles. Men innately need more sex than women.

At fault, women suggested, was "Hausa culture," which propagates women's ignorance and feelings of shame about sex. Further, Hausa Muslim women, who are not able to appear beautiful, neat, and "cultured," risked losing their husbands to "outside women" [non-Hausa] who possessed these attributes. I asked this woman to elaborate and she said that it is due to wives being "dirty, unfaithful, and not looking after herself properly":

If the man comes to her and finds her smelly and the bed un-welcoming, he tends to be drawn to someone else who is neat, looks and smells nice. There still exist men with beautiful, neat, cultured, obedient and sensible wives, but because they are like goats, they will seek others. Especially there is a problem if a woman cannot sexually satisfy her husband. That will lead him to seek a second or a third wife, or sex workers. Some women do not know the art of love making, so by mistake, or stroke of fate, the husband finds himself in the company of an experienced woman, and that's it. He would prefer going to that one. Usually infidelity in men is because the woman is not good in bed.

In order to meet these virtuous ideals, however, women must possess material resources, which – not coincidentally – men were responsible for providing. Men neglect their wives and thus have the

justification for pursuing new girlfriends. At the same time, women blame themselves for their lack of culture, when it is larger social inequalities driving patterns of sexual behavior.

Asama'u

While misdirected accusations of promiscuity drive women's fears of learning their status, most Nigerian women have had multiple sexual partners over their life course. Premarital and extramarital sex is common among women, as well as among men. Adolescent women, particularly those in the north, are pursued by older men and often marry at a young age. One of the support group members I met, Asama'u, was 26 years old and had never married. At age 13, she had a boyfriend whom she desired to marry, but her parents insisted that she remain in school. In recent years, the importance of "girl child education" has become increasingly recognized in northern Nigeria, and likely, her parents' refusal was in part a reflection of this shift in attitudes. While her education may have delayed her plans for marriage, it did not prevent this couple from initiating sex.

I asked Asama'u to describe the first time she had sex. Though she was fearful at first of visiting her boyfriend in his room, her resistance soon gave way:

We continued to meet after my lessons, and then one day he fell ill. When I told my friend, she advised that I visit him and take oranges with me. He was seriously sick. After that, I continued to check on him until he became well. I would meet him in his room and we would chat. Gradually, he deceived me into having sex. For example, we would watch American movies and I would ask him questions about what couples were doing -- Why is he touching and holding her, and so on. And he would explain. So things went on until I became totally infatuated and we had sex.

Though most women assured me that they had never had sex before marriage – whether it was true or not – given that Asama'u had HIV and had never married, it would have been difficult to lie about her sexual experience. She stressed, however, that she was "tricked" into having sex the first time, and it was because she loved him and expected to marry him that she continued to have sex.

My parents still insisted they did not want him to marry me, and they sent me away for a few months. As soon as I got back I went straight to his place only to be met by a friend of his. He asked me "Have you not been around?" Your boyfriend has gotten married. I could not believe it so I went back home and cried... Anyway, before we had separated, I had suitors whom I never paid any attention to, so I simply moved on with one of them. Although this new boyfriend was no match for my first, I simply forgot my previous and moved on. This time, I was wiser and did not love like I did before. I thought about my carelessness and scolded myself. With this boyfriend, we were together for a year. We had a good relationship and were in fact in love. But I discovered he was not interested in marrying me so I ended it...It was when I was with my third boyfriend – and about to marry – that he began to fall sick. When he did not get better, I went to a counseling center and that was where I learned I had HIV. Before I could tell him, he had died.

Young women's relationships do not always result in marriage and they are cognizant of this. Like Asama'u, women frequently have numerous suitors concurrently and men, in turn, vie for their consideration. Sequential partnerships illuminate the fundamental importance of marriage in northern Nigeria, even in the face of high rates of partnership dissolutions. They further highlight the roles these

partners play in supporting a woman's material livelihood. Gifts of money, jewelry, clothes, and other tokens, for example, reflect vital affective and material exchanges between men and women.

Protecting Privacy

Mercy, a Christian widow with two young daughters, had suspected her husband was HIV-positive for a number of years before he passed away. These suspicions were raised, in part, from "the way [she] married him," as she described. Soon after they married, he had found employment with UniPetrol in the urban center, Lagos, while she remained in her village in Plateau State. He told her that once he found a place to live, he would come and get her. Over a year passed, and she began to hear from her family that he was living with another woman. They had suggested it was because she did not give birth to a son. "If I don't have a male child in the house, forget it." Her mother-in-law told her she was nothing and they were advising him to marry another woman. He came home one weekend, and she became pregnant again. But then to her surprise, he denied the baby was his and wanted her to abort it. They fought and he left her. Finally, she went to Lagos on her own. He tried to divorce her, but she said, "It cannot work. I married you when you had nothing. Now you are something, you want me to leave. Where do you want me to go? I cannot go back to my parents' house. I'll stay even if you want to remarry. I'll stay." He found her a room, but gave her no money to pay for her to attend antenatal clinic or even food. Her husband had packed up his things from her house and was living with a girlfriend. She delivered her baby at home with the help of a relative. The baby was constantly falling sick. Soon after, her husband returned to her apartment. He too was severely ill. It was at this point that he was admitted to the hospital.

She began:

When [my husband] started his job, his illness became serious. He was then admitted in one hospital called Abimbola Hospital in Lagos. The way I looked at him, I began to suspect what was wrong. I was thinking of the way I married him. I had never seen him sick. I saw him with tuberculosis medicine and I asked him why he was taking the drug. He said he did not know -- that they just gave it to him. So I went and met the doctor and asked him, "What is the problem with my husband?" He said that there was nothing wrong -- that he will soon be ok. "Just tell me, I insisted, "I am a medical personnel. No matter how serious the case is." So he said, "You are a medical personnel?" I told him, "Yes we do work on these cases. That is why I came to ask." So I told him I am going to leave my husband with him. If anything happened to him, he should contact his family and tell them. "...Because I don't want to try to answer questions that I don't know anything about. If he dies, his family will ask me questions. If he dies, don't ever look for me because I'll sue you." The doctor was scared. He said, "Madam, I am sorry but your husband is HIV-positive. Don't tell him I told you. He warned me that I should never tell you; he didn't know how you'd take it."

At stake when one receives an HIV test result is not only the question of whether or not one is infected, but also, who caught the virus first? Who is to blame? Even when a woman's virtuous reputation is well established among her in-laws, the suspicion of being responsible for infecting one's partner with HIV is grounds for her abandonment. While many women know when their partners have extramarital affairs, not all seek to dissolve their relationships. In fact, suspicions of affairs often motivate women to intensify their efforts to make claims for their husbands' economic support and affective commitment. Their ability to make claims upon their in-laws and broader social networks, however, is less secure. A

woman has a greater chance of maintaining her reputation if she learns of her husband's status before he informs his family or he passes away. Without a husband's confirmation that she has been a respectable, faithful wife, a positive result in the hands of his kin and community jeopardizes more than her health. His family may take her children, or they may leave them without any support. They may also take away her possessions and deny her the inheritance she is due. Her relatives may broadcast her status to the larger community, potentially spoiling her chances of remarrying. *From whom* and *when* one receives an HIV test result are as consequential as what a screening actually reveals.

Conclusion

In 2003, the World Health Organization issued a document entitled, "The Right to Know: New Approaches to HIV Testing and Counseling." The report outlines the benefits of HIV testing both on the individual level and the community level. HIV tests, according to the WHO, enable individuals to change their behaviors; to protect themselves as well as their partners; gain early access to treatment and care, including PMTCT services; "better cope with HIV infection;" and "plan for the future." On the community level, HIV testing decreases stigma and discrimination and mobilizes support for "appropriate responses." *Knowledge is power.* The most evident risk for contracting HIV is – accordingly – not knowing. To make this point, however, is to abstract HIV knowledge and HIV "non-knowledge" out of context. In this paper, I have shown that being unaware of one's status is not always a sign of ignorance, nor is it necessarily *disempowering*.

For the vast majority of my informants, at the time they finally obtained a test, they already knew or suspected they were infected. By its very definition, HIV is a shared disease. Most women have witnessed the illnesses of their partners and children. They know the virus's symptoms and they know that it is spread most commonly through sex. An HIV-positive test result reveals the social fact that both men and women have multiple partners over the life course – a fact that does not bode well in a moral economy where brides are valued for their chaste, virtuous dispositions. A positive diagnosis thus invites accusations of immorality, not only from one's partner, but also one's extended family. These accusations are the bases upon which marriages may be dissolved and social reputations may be destroyed. The social risk of losing this partner, I have argued, is often greater than the risk of contracting the virus. In their efforts to circumvent these threats, women seek to learn their husbands' status before they learn their own. Women have told me that the course of HIV is analogous to pregnancy: while one is able to hide their condition early on, it will inevitably show as it advances. That status of one's partner will ultimately be revealed to his family. Women maneuver strategically within this uncertain period of time in order to ensure that they can protect their reputations and social relations. Nevertheless, they often confront insurmountable challenges in their efforts to intervene in these relationship – and viral – trajectories.

Footnotes

¹ For example: Clark 2004

² For example: Busch and Satten 1997; see also Lipman et al. 2004.

³ United Nations Population Division 2007.

⁴ For example: Herdt 2001.

⁵ For example: Farmer 1999, Biehl 2007

⁶ Foster 1976.

⁷ For example: Kleinman 1992, Rhodes et al 1999.

⁸ see also: Coulehan 1985:370.

⁹ For example, Proctor et al 1999, Safran and Muran 2003, Pound et al 2005

¹⁰ Parsons 1951, compare with: Gallagher 1976, Segall 1976, Levine and Kozloff 1978, Meile 1986, Arluke 1988.

¹¹ Hahn and Kleinman 1983; compare with: Murphy 1990.

¹² Horwitz 1982; compare with: Sadowsky 1999.

¹³ For example: Inhorn and Birenbaum-Carmeli 2008.

¹⁴ For example: Epstein 1996, Rose and Novas 2005, Nguyen 2005, Fassin 2007, Biehl 2007.

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SAVE THE DATE
NEAA's 50th Anniversary Meeting
in Buffalo, NY
March 5-7, 2010

John Omohundro Undergraduate Paper Prize Winner
Birth Junkies: Labor Support and Resistance in American Birth

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Home of the highest cesarean rate, a 60 percent higher than average maternal mortality rate, and a 7.8 percent vaginal birth after cesarean (VBAC) rate, New Jersey provides a unique case for studying American birth practices. As of 2008, the rate of cesarean section in the United States was 31.1 percent; in New Jersey, that figure reached an average of 38.9 percent in 2007 (Grady 2008; ICAN 2007). As such, over one in every three women in New Jersey entering a hospital to give birth will have a cesarean section. This figure appears in stark contrast to the World Health Organization's recommendation that the cesarean rate for any country, and hospital, settle between 10 and 15 percent (ICAN 2007). While the subject has received relatively little attention from popular media, a small subset of American women have taken it upon themselves to reinstate the traditional support role of women aiding women in childbirth. These women are attempting to counter the highly medicalized hospital protocol through a variety of means that, in many cases, support the hegemony of American obstetrics, but primarily resist and subvert dehumanizing birth practices. Enter the doula.

Doulas are non-medical professionals who have been trained to provide emotional and physical support for women in labor. Labor support, i.e. verbal encouragement or "healing" touch, is both a novel American commodity and hailed as a traditional role for women in the birth process. The study of doulas incorporates a mix of politics, feminism, and humanism that provides an interesting cross-section for a variety of women's issues in America. For example, while families across America are hiring private doulas to ease them through their labor, other doulas may provide reduced rates or volunteer doula services for women whose husbands are serving in Iraq through Operation Special Delivery and support women receiving abortions or who are delivering while incarcerated.

In this study, I attempt to situate the role of the doula within the larger framework of American birth through participant observation, content analysis, and interviews. In particular, I hope to shed light on power relations between medical caregivers, patients, and third-party actors within the hospital system. To achieve this, I interviewed 40 respondents, including 25 doulas, five midwives, five clients, three chiropractors, and two obstetricians, all of whom operated within the Northern New Jersey area. These one- to three-hour long interviews were conducted either in person, in a mutually convenient meeting place, including the informant's home, as well as over the phone. In addition to these semi-structured interviews, I attended a two-day, 18-hour doula training workshop in which I participated in the first step toward becoming a doula. Lastly, I attended three birth education courses taught by doulas involved in this study. The birth education courses included the three most commonly taught by the doulas interviewed, namely Lamaze, Bradley, and pre-natal yoga.

Because I will be examining the role of the doula from a critical-medical perspective, I hope that this study will show the dire position in which we currently find American obstetrics, in addition to highlighting issues of power, privilege, and agency within American childbirth culture. Despite the discovery that the majority of standard procedures for a hospital birth are detrimental to labor progression (Sakala and Corry 2008), these practices continue. Both common sense and scientific studies tell us that walking during labor aids dilation; squatting, as opposed to the supine position, helps a woman push her

baby out by opening the pelvis. In the hospital system of birth, there is a reproduction of cultural values that are often enmeshed in issues of patriarchy and capitalist social structures, which, as many anthropologists have argued before me (Davis-Floyd 1992; Jordan 1993; Martin 1992; Jordan and Irwin 1987), leads to the continual use of detrimental hospital procedures and protocol.

While anthropology is not new to the study of gender issues or even childbirth, a considerable gap exists regarding the literature of American childbirth and, in particular, doulas. Only Barbara Katz Rothman and Bari Meltzer Norman, City College of New York and Miami-based sociologists, respectively, have conducted an academic study focusing on doulas. In their research, Rothman and Norman interviewed 30 doulas based in both the tri-state and Miami area. Their analysis led to a negative conclusion as to the effectiveness of doulas. Because doulas do not directly challenge doctors and, as Rothman and Norman state, the role is predicated on a “deeply gendered role play,” they conclude that doulas provide very little concrete help in an increasingly dehumanized birth system (Rothman and Norman 2007: 265).

While I agree that working within the system may hinder the doula’s effectiveness in terms of concretely changing numbers, i.e. reducing the national cesarean rate, I also believe that doulas both define their success via the contentment of their clients and also participate in more subliminal resistance tactics. In this paper, I attempt to look at “success” from a more insider/emic perspective in which the doula’s definition of a satisfactory childbirth takes precedence over statistics and figures that emphasize objective markers of progress. Therefore, while doulas *do* work within the medical system, they also resist it. Resistance, subversion, and power plays are often elusive and intertwined. If a doula empowers a woman to decide that she needs a cesarean, has she failed to advocate? Or, has she subverted the discourse of power, enabling a woman to have control over her body, coincidentally choosing a highly medical procedure? I attempt to show the ways in which doulas resist the predominant birth system and how they are changing birth culture, “one woman at a time.”

The primary theoretical viewpoint from which I will interpret American childbirth states that the medicalization of birth has led to the obstetrical paradigm of “birth as pathology.” Doctors, in this analysis, view pregnancy as a disease. Other researchers, in particular anthropologists Robbie Davis-Floyd (1992), Brigitte Jordan (1993), and Emily Martin (1992), explain the “birth as pathology” construct as bound to Western notions of femininity and an historical emphasis on “American core values” of science, technology, patriarchy, and institutions (Floyd 1992: 47).

To understand the doula’s importance in buffering the often competing desires of the hospital and the individual, birthing woman, one must understand the interplay between medicine and culture. The materials of a culture, i.e. ritual tools and photographs shown in popular settings, provide an excellent vantage point from which researchers and academics can see these larger metaphors. In Emily Martin’s *The Woman in the Body* (1992), she analyzes birth literature to expose a larger cultural construct of the body as machine. Because the process of birth implicates a discussion of the “female machine,” Western core values suggest that the female body is inherently broken or malfunctioning because it is not the norm, it is not the male body. Furthermore, a woman’s labor is thus “managed” by an attending obstetrician, a word that differs greatly from the, typically, midwife stance of “guiding.” It is within this management role that a doctor performs the delivery. It is not the mother who is laboring to birth her baby. As such, the cesarean section, arguably the epitome of medical intervention in birth, is the ideal means through which doctors can control birth. Birth then becomes a highly-controlled, male-centered experience, rather than a powerful, feminine one.

For anthropologist Robbie Davis-Floyd (1992), birth and death are emotionally-charged and highly unpredictable “rites of passage” within any culture. Therefore, those who are culturally sanctioned to guide individuals through these life events are likely to rely on strict, ritualistic procedures. She argues that this is especially true in the case of American childbirth, despite obstetrics’ vocalized emphasis on science and technology. When hospital protocol diverges from helpful procedures to almost purely superstitious rituals, women’s health suffers while predominant paradigms flourish. For doulas, their liminal position allows them to question the ritual devices of the doctor, while also guiding women through this transformative event in a slightly, albeit not commonly recognized, socially sanctioned way.

The most extreme example of the lack of authority and agency given to women over their bodies and the cultural power of biomedicine can be found in cases of court-ordered cesareans. Brigitte Jordan and Susan Irwin (1987) studied nine cases of court-ordered cesareans to document the ways in which power was maintained in instances of individual resistance. Six of the nine cases resulted in cesarean sections, and, the authors note, the majority of the cases involved women outside of the “mainstream,” i.e. immigrants, women of color, and religious women (Jordan and Irwin 1987: 327). Ultimately, in these cases, the lesson learned is that biomedicine, and subsequently, American core values, are correct and further legitimized through the state on a very personal level. When a doula “holds the space” for one of her clients, I maintain that she is directly refuting this lack of authority typically given to laboring women.

Such forms of resistance occur on many levels, both in terms of mass politics and in the realm of the politics of everyday life. Whereas some doulas are devoted to the political aspects of birth activism, such as fighting for paternity leave or post-partum care, other doulas seek to change the culture of birth “one woman at a time.” In these instances, they follow John Fiske’s interpretation of resistance as “the art of making do (Fiske 1989: 4),” which he uses originally in reference to the construction of popular culture.

Fiske develops this idea of resistance by defining two competing groups in any given culture: that of social force, which includes those who lack power, and the power-bloc, which he defines as “a welding together of different components for a specific purpose (Fiske 1993: 10)” and thus cannot be seen as a category or group, but a “disposition and exercise of power to which certain social formations, defined primarily by class, race, gender, and ethnicity, have privileged access (Fiske 1993: 10).” The social force carries out its own struggle for control over individual livelihoods through a variety of means that can be both highly visible, such as protests, or discrete, such as the creation of new meanings for words that originate in the lexicon of the power-bloc. Furthermore, resistance can incorporate the construction of locales, in which people localize larger forces of power by claiming control of their space. The doula concept of “space,” or “holding the space” again becomes an example of such an effort.

The primary challenge to similar forms of doula resistance is that doulas may not directly confront the medical establishment while on their “turf,” so to speak. The primary reason for this deference to hospital hierarchy is because doulas are *not* medical professionals, though their knowledge and role does confer them a certain amount of localized authority. Thus, there are many tactics and means by which doulas subvert and/or re-appropriate medical technologies and protocol on behalf of their clients. It is the art of making do in which meanings, tools, and personal relationships empower women to remain in control of their birth experience. These methods can take on a variety of forms, such as loopholes, education, and semiotic changes.

A doula's central concern is her client's contentment with her birth experience. This concern is directly tied to control and self-determination. Because a woman who uses a doula will have one to three prenatal visits in which she can discuss her birth preferences, doula clients are more likely to be informed about the variety of interventions and medications that can be used in a difficult birth. While doulas are labor support persons, they are also educators. Fifteen of the 25 doulas I interviewed taught some form of birth education, and all emphasized preparing their clients for any complications that may occur in the delivery room. There is a pragmatism to the doula approach toward birth education that can be defined, as Emily Martin stated, as "self-defense in the hospital (Martin 1992: 140)." Because medical professionals cannot and do not always have the ability to offer genuine informed consent, doulas view it as their priority to educate women so that they can make informed decisions during labor.

By providing full and accurate information, doulas challenge the birth system in which they operate. Though doulas are not theoretically able to contradict a medical professional's plan of action, they can ask a doctor to better explain a procedure or provide more options. One doula I interviewed, Ellen, explained an incidence in which her client's water had broken early and she had agreed to try to speed up the labor. Knowing that her client had hoped to avoid Pitocin, synthetic oxytocin that speeds labor, Ellen asked the medical team if it was possible to use the alternative Cytotec, which would allow her client to continue to be ambulatory with only intermittent monitoring. Pitocin, on the other hand, requires constant fetal monitoring and, thus, confinement to the hospital bed. While she genuinely did not know some of the answers to the questions she asked about Cytotec, Ellen felt that it was important for the medical team to pause, stating, "Let's get some information on this. Is this another option she might have?"

More commonly, however, are doulas who attempt to create a safe space in which their clients can demand more information from their caregivers. Ideally, a doula client will have been previously informed to know when to ask questions regarding her care. She will also be able to recognize that her inquiries and concerns are valid and should be vocalized in the hierarchical setting of the hospital.

Client empowerment thus plays a large role in a doula attended birth. Doulas recognize that level of control effects a client's satisfaction with her birth. A woman who feels out of control and that things passively happened *to* her is more likely to be disappointed in her birth experience. One informant stated poignantly that in "handing over complete responsibility you're also handing over the potential of complete blame." If a woman is an active participant in the decision making process, she is less likely to "point fingers" if, indeed, there is a poor outcome. By asking questions and stating her preferences, which is enhanced and more likely with doula support, a client can better maintain control over her birth experience. The reaffirming phrases and presence of the doula can often push a scared and vulnerable mother to demand such attention.

The most obvious and concrete form of physical resistance is finding loopholes in the hospital system. Most hospitals expect women to be on the electronic fetal monitor, which often requires patients to remain bed-ridden during labor. Because walking is incredibly helpful for dilation and pain-management, for women seeking natural birth, remaining mobile is crucial. For women who are required to stay in bed because of EFM, doulas suggest frequent bathroom trips. Caregivers do not deny women the ability to use the restroom and it requires that women unhook themselves from the external monitors, stand, and walk to the restroom. In the restroom, women are alone and thus can try any position change they would like. Doulas attempt to keep women in restroom until the nurses suggest that they return to bed. If these trips occur often enough, they will aid in a woman's pain management in labor.

Other times, doulas believe in utilizing technology to their advantage, as opposed to simply evading invasive, medical technologies. One informant spoke of an incidence in which the electronic fetal monitor was giving an abnormal read. She offered her knowledge of internal monitoring in a way that both refuted the medical establishment's preference for constant EFM, yet also supported possible intervention by recommending the internal monitor. She stated:

I've seen it used about 7 times, so in all the cases where the external monitor says the baby's having a problem and they're starting to think they might need a cesarean, and they put in the internal monitor instead, the internal monitor has said the baby's perfect... And those women then go on to have an unmedicated, natural, vaginal birth, which is what they want.

Thus, in this instance, if the ultimate goal for the mother is an unmedicated, natural birth, some interventions may prevent the ultimate in that which is unnatural: the cesarean. The doula was able to take a possibly negative situation, offer her knowledge, and change the likely course of events for her client, in a way that would *appear* to support, though it actually subverts, medical hierarchies.

Doulas also advise their clients to labor at home, in a normal birth. What is often dubbed the "cascade of interventions" is seen to begin when a client arrives at the hospital. In most hospitals, a woman is given 24 hours from the time her water breaks to when she gives birth. When laboring at home, women wait until they are closer to the active stage of labor so as to avoid any interventions that can occur along the way in a hospital or to buy time under the 24-hour protocol. All of the doula clients interviewed for this study said they waited at home as long as they could, with the doula meeting them in their homes to help them through the early stages of labor. This effectively removed them from the medical system for as long as possible, further encouraging a natural, woman-centered birth experience.

At the hospital, doulas often subvert medical norms by suggesting position changes and techniques that may be unfamiliar to most obstetricians who are generally not exposed to natural childbirth in their obstetrical training (Davis-Floyd 1987). As such, from time to time, a doula will suggest pain management methods to her client who will then either succeed in convincing the doctor to allow her to continue the method, or who is told to return to the supine position, as is standard. Periodically, doulas have introduced doctors to a new technique or method that is more natural birth friendly than standard hospital procedures.

Providing an excellent example of John Fiske's definition of "semiotic power" in which members of the social force appropriate the power to make meanings out of the power-bloc's lexicon (Fiske 1989: 10), Dianna was the only non-white doula that I interviewed. As a Puerto Rican woman who worked in primarily immigrant communities, she was in the unique position of acting as both doula and translator and often translated and softened the words of the doctors she worked with. "The doctors, a lot of times, did not speak Spanish, so they could say everything they wanted that was mean or horrible and I could just translate it and make it sound a lot better." During training, it was recommended to doulas that they speak to their clients in their primary language, if possible, because labor and primary language are processed in the same part of the brain. For Dianna, she took the recommendation a step further. Rather than translating directly any words or phrases that could be disempowering or "mean," she offered her clients positive words and buffered them from any negative comments on the part of the medical establishment.

However, one of the most powerful and intimate ways doulas resist medical norms is by reclaiming their own negative birth experiences. It is not uncommon for a doula to enter the profession after being “awakened” to the natural birth world after a personally traumatic birth experience. Susan’s story of her three births offers a prime example of the ways in which women with negative birth experiences can proceed to becoming a doula. For all three of her births, Susan had cesareans. During her first birth, Susan felt she and her medical staff were both too “uneducated in natural birth” and, after a *pro dromo* labor, had a cesarean at the suggestion of her doctor. For her second birth, however, after planning an elective cesarean, Susan arrived at the hospital in labor a day early. Rather than allowing her to attempt vaginal birth, her doctor discouraged her efforts, telling her that “[she] would just end up with a cesarean later.” Unable to get on top of her contractions, Susan found that she could not progress and the doctor’s predictions came true.

During her last birth experience, however, Susan was living abroad and found a doctor that was willing to do a VBAC, even after she had had two cesareans. She opted, however, for an elective cesarean, on certain conditions. Her stipulations were that she watch her birth, immediately have the child laid on her chest, and have no separation, to which the doctor replied that they would slow down or go fast according to her desires and that no one would speak over her. Indeed, Susan considered this her most positive birth experience and believes that because she and her third child were never separated, they are closer than her other children. Thus, though all of her births were highly medicalized, rather than feeling disempowered, she fought back. She found a way to make her cesarean her own and remained in control throughout the whole experience. As such, she offers her unique background and history to other women who come to her for labor support. By having had an epidural and a c-section, she understands what both of those experiences feel like and she is able to validate any of her clients that go through the same experiences. Though she does not consider herself an activist, she proactively altered her final birth experience and crafted a positive memory for her and her daughter.

Though the primary criticism of the doula is that she is not radical enough, it would be less effective for doulas to work outside of the system. The primary doula perspective on working within the medical system is, as one doula put it, “to do the most good with every bit of effort I put out.” There are many instances in which doulas defer to the hierarchy of the hospital system, allowing their clients to fall into the non-personal, non-women-centered protocol of the typical, American maternity ward. In particular, doulas are required to never block a suggested procedure or refute the advice of a medical professional, according to DONA’s “Standards of Practice (DONA 2008).” To some, it may seem like making concessions, but this requirement is not without reason. Doulas are, as stated earlier, non-medical professionals. While they may have vast resources of experiential and evidence-based knowledge, ultimately a woman’s caregiver is trained in the biophysical aspects of childbirth. The doula, however, adds emotional support and the space needed to reintroduce women-centered practices into the maternity ward.

Thus, though the doula may not be resisting in highly visible ways, it is clear that labor support persons offer unique strategies in attempting to divest complete authority from the patriarchal, biomedical system. In Lila Abu-Lughod’s *The Romance of Resistance* (1990), she states that it is important to understand that resistance and power operate on a variety of levels. While it may seem like “boxes within boxes within boxes,” she argues, “That is the wrong image. A better one might be fields of overlapping and intersecting forms of subjection whose effects on particularly placed individuals at particular historical moments may vary tremendously (Abu-Lughod 1990: 332).” Thus, when a doula suggests that her client ask if there are other options when advised to be induced a week after her due-date, outside of earshot of

a medical professional, she is still resisting or, rather, enabling the resistance of other birthing women. And it is within this space that changes to inhumane birth practices can gestate and come to fruition.

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Poster Prize Winner:
Quantifying Age-Related Morphological Changes in the Human Pubic Symphysis

By Katelyn Rusk, University of Massachusetts Amherst

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At the 2009 NEAA Conference, I presented preliminary results of my undergraduate senior honors thesis research. The goal of this research is to develop a quantitative method of aging the human skeleton using the pubic symphysis. Results from this research so far indicate a number of variables that correlate the surface morphology of the pubic symphysis with chronological age. Since the most widely used methods of aging the pubic symphysis are qualitative and highly subjective in nature, a more objective, quantitative method of aging the human skeleton would be very advantageous for the entire process.

To develop this method, I am applying a method originally developed to quantify dental topography to the pubic symphysis surface. This method, developed by Evans et al. (2007), quantifies surface complexity with a series of variables: Orientation Patch Count, Mean Patch Size, and Patch Diversity. These values represent different aspects of the dental surface as manifested in “patches” of similarly oriented contiguous points on the teeth, which can also be found on the pubic symphyseal surface. These measures were previously found to correlate with diet in mammal dentition, so I applied this method to the pubic symphysis in order to correlate surface complexity with age. In addition to these variables, I also measured Grade, or average slope; Relief, or 3-D Area divided by 2-D Area; and Contact Area Percentage, which compares the total area of a pubic symphysis to the specific area of contact with the joint.

In order to measure these variables, in collaboration with Redding Industries, Inc., I obtained 3-Dimensional laser scans of 55 known-aged human pubic symphyses curated at the Cleveland Museum of Natural History in the Hamann-Todd Osteological Collection. The results presented on this poster reflect a subset of 20 of these laser scans. The scanned images were manipulated (interpolated, cropped, and oriented) and analyzed using Geographic Information Systems (GIS; Surfer 8, Golden, CO). The surface complexity values were calculated with these images in a program created by A. R. Evans for the original method. The images were also interpolated and cropped using MFworks to calculate grade, relief, and contact area percentage. Each of these values was analyzed using SPSS to assess the most practical and accurate means of estimating chronological age from these variables.

Using a multiple regression analysis, the grade, relief, and contact area percentage variables represent the best model of overall age prediction across age groups ($R = .76$; $p < .01$). Previous analyses of these variables display a U-shaped pattern, with highest values in young individuals, low values in the middle, and higher values in older individuals, which prompted a split between young (≤ 35) and old (> 35) individuals in an effort to increase accuracy. With this differentiation between overall morphology patterns, age prediction becomes markedly more accurate using other variables; in young individuals, age was highly significantly correlated with Mean Patch Size ($r = .98$, $p < .001$), and in older individuals, age was significantly correlated with Patch Diversity ($r = .6$; $p < .05$). Thus, with the differentiation between age groups and the corresponding regression analysis, these variables represent a quantitative means of predicting age from the pubic symphyseal surface.

With the remainder of this current sample and additional research, it is my goal to develop this new method further into a more accurate aging method to be used in bioarchaeological, forensic, or other

applicable contexts. In addition to the application of this method on other surfaces for aging purposes, factor analyses on this sample subset have also indicated that factors other than age are affecting pubic symphysis morphology, so this research represents a significant base for a number of other studies.

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