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ARTICLE

Making Sense of a Pandemic through Trauma-Informed Pedagogy and the Value of Medical Anthropology

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Abstract

It is difficult to describe the experience of living through the COVID-19 global pandemic while simultaneously teaching anthropology and sociology courses to undergraduates. My students and I experienced together not just the fear of sickness and death, but also social issues in the U.S. made more visible by the pandemic, such as racial tensions, challenges related to access to health care, and consequences of the social determinants of health. The "normal" that many are hoping we return to was heavily shaped by neoliberal policies that conceptualize health and illness as well as personhood in particular ways, such as through defining social problems as medical in nature and using medicine as a form of social control. The issue for us as educators, however, is that stress, depression, and anxiety are normal reactions to real conditions that we are all experiencing, albeit with strikingly different foundations and resources. In this paper I reflect on my own experiences in the classroom and discuss how I incorporated theoretical constructs of intersectional trauma, or trauma-informed pedagogy. I will showcase how I teach students these concepts through medical anthropology. I highlight how these concepts have helped students make sense of the impacts of the COVID-19 pandemic, and I argue that this framing is useful for understanding other crises for students and professors alike.

Keywords: *medical anthropology; medical sociology; COVID-19 pandemic; explanatory models; medicalization; structural violence; trauma-informed pedagogy*

Introduction

There are moments that are etched into our memories forever. That moment when I realized that the COVID-19 pandemic was real (approximately March 2020) and the fear that accompanied this realization will be etched forever in mine. I observed early in the pandemic that my students and I were struggling to make sense of everything and to stay academically present and motivated. Much of my research has focused on the mental health system in the U.S. as well as the mental health system in Ukraine. I have been

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especially interested in understanding barriers in access to care as well as the local and global forces that impact mental health and access to services. My approach gravitates towards political economy and global health. I often tell my students that stress, depression, and anxiety can be normal reactions to real conditions that we are all experiencing at the same time, albeit with strikingly different foundations and resources. The disproportionate impacts of COVID-19 are much higher, for example, among "residents of lower-income neighborhoods and among Black and Latinx populations" (Singer and Rylko-Bauer 2020, 12). In order to adapt to students' needs during a pandemic, educators had to undergo radical changes to transform education at all levels to face the COVID-19 disruption. Drawing from bell hooks' seminal work *Teaching to Transgress*, Phelps-Ward, McCloud, and Phelps (2021, 197) "argue for more educators who teach to transgress, pushing beyond the boundaries of dominating and oppressive ideologies of pedagogical practice." They write that "teaching to transgress means not only holding space for serious conversations related to power, privilege, and oppression so students have opportunities for healing through education in which they can make concrete meaning of their learning, but valuing the wholeness of all parties (students and teachers) within the learning situation" (199). Utilizing theoretical constructs of intersectional trauma to inform my teaching – and teaching students about these concepts – has provided a useful platform both for my relationships with learners in my classroom and students' relationships with themselves and others during exceedingly challenging and, indeed, even traumatic times. Making room for the recognition of trauma amongst students (and professors) is not just an "emergency" or temporary tactic; it's instead something that must be part of the fabric of the academic endeavor. In other words, this is a perspective that I will continue to carry into future semesters.

I teach a range of courses in a mixed Anthropology/Sociology program; these include Sociological and Anthropological Theory, Methods, Medical Anthropology/Sociology, Environmental Anthropology/Sociology, as well as courses in our Native American and Indigenous Studies Program. Many of the topics and examples we discuss in class revolve around social issues such as racism, the social determinants of health, mental health, structural violence, and so forth. These are the same kinds of topics that drew me to the field of anthropology because they helped me to frame the struggles that I and my family experienced as I grew up in south Georgia as part of a poor working-class family. I know that many of my students find the same value and interest in my classes because the concepts and materials help them to also frame their lived experiences. In this paper I will reflect on my own experiences in the classroom and discuss how I incorporated theoretical constructs of intersectional trauma, or trauma-informed pedagogy. I will showcase how I teach students these concepts through medical anthropology. I highlight how these concepts have helped students make sense of the impacts of the COVID-19 pandemic, and I argue that this framing is useful for understanding other crises for students and professors alike.

Student and Instructor Experiences During the Pandemic

Yurchak (2006, 2), writing about the breakup of the Soviet Union, wrote that many felt as if there was a "break in consciousness" and "stunning shock," as well as "excitement and readiness to participate in the transformation." This description resonates well with my own experiences as an educator during the COVID-19 pandemic. In my observations, I would argue that a similar "break in consciousness" was felt and even heard. In my memory, the beginning of the pandemic serves as an "index fossil," the way an Irish Elk found in strata lets us know that fossils in that strata are relatively older than 10,600 years (approximately the time the Irish Elk became extinct). For example, in my own speech I often refer to time generally as either what happened before or after the beginning of the pandemic. Felix Ringel (2020) calls this "Corona time," an experience that is shared globally, yet specific to each individual situation. The shared experience he speaks of, however, is the "feeling of being stuck in the present, combined with the inability to plan ahead" (Ringel 2020); this feeling is akin to what Guyer has previously termed "enforced presentism" (Guyer 2008). In the classroom, my students have reported a similar feeling of being "lost," "disrupted," or "stuck." As time has passed, that initial "Corona time" has morphed into some kind of "new normal," filled with even more traumatic events. A few years after it began, the pandemic is still with us, as are the social issues that came to the forefront and a few new ones, such as the invasion of Russia into Ukraine, and in the U.S. several high-profile mass shootings, the reversal of *Roe vs. Wade*, and the erasure of tenure at many colleges and universities. This is not to romanticize the "pre-pandemic" time, since parallel to the "break in consciousness," the pandemic brought to the forefront the many social issues that had already been plaguing the U.S. and causing immense emotional and mental strain, including racism, the lack of access to health care, and the social determinants of health, to name a few.

My own experiences and struggles teaching at a regional university in relatively rural south Georgia are also being felt in other departments and exacerbated by the COVID-19 pandemic. The department I teach in, which combines programs in Sociology, Anthropology, and Criminal Justice, has grown smaller and smaller over the last 8 years. The department has been "greying" and almost every year a faculty member retired. Unfortunately, each time an individual retired, the line would also be "retired." Our department is significantly smaller than when I first started, and faculty are asked to do more with less; I understand this is a common trend in other universities and departments. Colleges and universities around the country have been eliminating majors, furloughing faculty, pausing admissions, or even eliminating entire programs (Hubler 2020; Hyer, Landau, and Workman 2020). Mitchel and colleagues (2019) describe how cuts to funding for higher education are greatly impacting not just faculty, but also students. These cuts translate into raised tuition as well as reduced faculty lines and the elimination of courses or even entire departments. These trends especially impact low-income students and students of color, as the rise in the price of tuition leaves students with the options of exorbitant debt or forgoing college altogether. Due to the COVID-19 pandemic, our

university dropped the SAT as a requirement for entrance and many students who probably would not have been able to attend were admitted. This led to the largest first-year class in recent history – ironically at the same time that faculty are being asked to do more with less. More recently, however, enrollment is tracking in the opposite direction, with extreme declines being reported across the state of Georgia at just about every institution.

The impacts of the COVID-19 pandemic on students has been a little difficult to assess since at the beginning of the pandemic we immediately went to online instruction. As a result, and ever since, student participation in the classroom has not been the same. I understand that exactly when professors and students returned to in-person instruction varies, and that my university's return was significantly earlier than others'. In the fall of 2020, for example, no COVID-19 vaccines were available yet. At my institution, we were to return to in-person instruction, however there were a number of modalities that professors could choose. Over the summer of 2020, I had taken part in several trainings to learn these modalities. I decided on the "hy-flex" model. Lectures would be recorded asynchronously for students to watch on their own, while class time was dedicated to discussion and answering questions. A limited number of students could be in the classroom at one time, so students would rotate in. For example, several of my courses are taught on Tuesdays and Thursdays. In those classes, half the students were able to attend in person on Tuesday, while the other half would be able to attend on Thursday. When not attending in person, students were expected to attend synchronously through an online platform. What ended up happening, however, is that most students decided to just attend virtually. I was receiving notices from the University on students' behalf almost every day that they would not be able to attend class – the assumption is that these students either had COVID-19 or were in quarantine. For fall 2020, the way that I accounted for attendance and participation had to be much more flexible. I realized that students were managing a lot: they may be sick with COVID-19, caring for family that had COVID-19, or working extra jobs because of COVID-19, so it made sense to give students the tools to fit the coursework into their lives in the way that worked best for them. That meant recording my lectures and making those available asynchronously. It also meant some flexibility for assignment due dates. For example, in my *Introduction to Anthropology* classes, I would give students a window of a week, sometimes much longer, to complete each week's assignment. During class time I would be available to meet in the classroom for students who wanted to meet face-to-face, but I would also have Teams (a videoconferencing platform) open and recording for students who wanted to attend virtually but synchronously. Since these meetings were recorded, students also had the option to watch at a later time. If a student was not completing assignments and not showing up virtually or in the classroom, then I would reach out to these students via email. This classroom design seemed to work well but only because I was constantly providing feedback to my students. I spent several hours every day giving feedback on assignments, sending out emails, and creating recorded lectures. I kept a discussion board in every class. For every class I made one discussion board a reflection piece asking students what worked well and what didn't; I read

overwhelming posts discussing how the flexibility and the communication in my classes was what students found most helpful. Despite this positive feedback from students, I really only heard the perspective of a minority of students. I don't know about the students who dropped out, the students who failed the course, or the students who decided to not even pursue college. Looking back at those early days of the pandemic, I realized my students and I were experiencing burnout and apathy, in addition to trauma.

Intersectional Trauma-Informed Teaching

Individual trauma, as defined by the Substance Abuse and Mental Health Services Association (SAMHSA), "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA 2014, 7). Intersectional trauma, however "refers to the psychosocial marginalization of individuals across multiple axes of identity, including race, ethnicity, gender, nativity status, religion, sexual orientation, mental health status, and so forth" (Di-Capua 2015 as cited in Ezell et al. 2021, 79). Intersectional trauma recognizes that trauma is not evenly distributed across a society, nor is it evenly felt amongst individuals in a group, but instead is mediated by inequities within the society. A "trauma-informed" or intersectional trauma-informed approach to teaching takes this into account. Darryl Stephens (2021, 9) writes that this recognition and understanding of trauma has opened up a different way to address the manifestations of trauma in the classroom, where educators shift from "confrontation to care." The effects of trauma in the classroom tend to manifest as "difficulty focusing, attending, retaining, and recalling, tendency to miss a lot of classes, challenges with emotional regulation, fear of taking risks, anxiety about deadlines, exams, group work, or public speaking, anger, helplessness, or dissociation when stressed, withdrawal and isolation, involvement in unhealthy relationships" (Stephens 2021, 12-13). Marquart and Báez (2021, 63) write that COVID-19 provided a "catalyst for faculty to adopt trauma-informed teaching and learning (TITL) practices, as educators across disciplines have shifted their teaching to be more compassionate, flexible, consistent, and predictable in response to the worldwide trauma and distress … to mitigate the effects of trauma in order to support student success." They discuss several trauma-informed strategies, such as sharing power in the classroom with students, recognizing and celebrating student success, as well as allowing choices for students (Marquart and Báez 2021, 64).

I saw the effects of trauma in my students, and I continue to see the effects of trauma. Early in the pandemic, students would explicitly tell me that they were unable to focus or find the motivation to complete assignments. They would describe their fears, or that their family members were sick, or that they were sick, or that family members had passed, or worse, that their peers had committed suicide. Students would not attend class, or if they did attend, they would not participate. Not all students had this experience, but regardless of students' experiences, the academic task remained. I found that teaching core concepts

from medical anthropology, when combined with a trauma-informed approach that was flexible, sympathetic, and incorporated "care" into the classroom experience, helped students better navigate academic life during a pandemic.

In my reflections on teaching and students' learning, I am often drawn to O'Brien's (2008) "Compass" model. She uses the analogy of a compass, or four points of reference, to help guide the design of pedagogy. Each point of the compass points to a different question guiding learning-focused pedagogy: "What will my students learn and why is it worth learning? Who are my students and how do students learn effectively? What can I do to support students to learn effectively? How do I know if my teaching and my students' learning have been effective?" (O'Brien 2008, 4). Using O'Brien's work as a model, I collaborated with a faculty-librarian on a project (before the pandemic) to understand student perceptions of research and writing in Anthropology and Sociology (Bowers and Yankovskyy 2019). In my classes, I generally teach both Anthropology and Sociology majors/minors. My goals for student learning are often a blend of both disciplines' threshold concepts. For example, understanding the biocultural or biosocial approach to health is a core learning goal of *Medical Anthropology*. This was an especially poignant concept to teach during the COVID-19 pandemic. This approach stresses the interconnectedness of both culture and biology in determining our health – in other words, our health is not determined by biology alone. In addition, the notion that different cultural belief systems impact the way health is understood – what Kleinman, Eisenberg, and Good (1978) call explanatory models – is another core concept. Other concepts that bridge anthropology and sociology well are medicalization, structural violence, and the social determinants of health, or the way that inequalities and socio-economic status (SES) impact health outcomes.

My own positionality coming from a working-class family as a young child, then as a "welfare kid," and being the first in my family to get an education, means that I've always been especially mindful about the baggage, struggles, and trauma that students bring to the classroom. I was drawn to particular literature and topics in anthropology because of my positionality and experiences, and I share these literatures with my students. Let me show you what I mean through three specific examples: explanatory models, medicalization, and structural violence.

Making Sense of Trauma through Medical Anthropology

In this section, I argue that medical anthropology concepts helped students make sense of their own experiences in ways that recognized intersectional trauma and supported their learning. Many students were parents of small children, taking care of their parents, or were working jobs in the service industry while attending classes and therefore were considered "essential workers" during the pandemic. These students were both living through and learning about intersectional trauma.

Explanatory Models

The explanatory models perspective is quite helpful for understanding the distinction between "illness" and "disease" and how both are cultural constructions. This distinction is especially helpful also for those navigating the COVID-19 pandemic. For example, "illness behavior" is governed by cultural values – we learn "approved" ways of being "ill." Kleinman, Eisenberg, and Good (1978) argue that despite the great strides being made in biotechnical medicine, there is a crisis in healthcare because physicians tend to pay little attention to people's "explanatory models" of illness and doing so can help (at least partially) explain patient noncompliance and dissatisfaction. Their argument, while a little over 40 years old, continues to be relevant. For example, the authors list several case studies to showcase issues that arise as a result of differences between a patient's explanatory model and the professional's medical model. One case in particular resonated well with my students during the COVID-19 pandemic. The authors discuss a "60-year-old white Protestant grandmother recovering from pulmonary edema secondary to atherosclerotic cardiovascular disease and chronic congestive heart failure" (254). They go on to describe how the patient was presenting with "bizarre behavior": she was "inducing vomiting and urinated frequently into her bed" (254). It turns out what had motivated this behavior was a misunderstanding of the mechanics of the body. She has been told that she had "water in the lungs" and so she was using her knowledge of household plumbing as an analogy for the way her own body worked. She was trying to get rid of as much fluid as she could. The authors used this case study to illustrate how a person's explanatory model can be very different from the professional medical model, and just how common a problem this is (254).

I usually assign this reading during the fifth week of class, and students are expected to discuss the article during class time. Students are then expected to respond to an online discussion prompt, as well as reply to other students in the online discussion board. Early in the COVID-19 pandemic, in class and in the discussion boards, students related this situation to friends, relatives, or even famous individuals who misunderstand how COVID-19 works. For example, students brought up how many do not understand how masks work to curb COVID-19 transmission. Students would mention people who might wear a mask but not cover their nose or people who refuse to wear a mask because they believe COVID-19 is not real. Other students related this to people who use drugs to treat COVID-19 such as Ivermectin, despite not being approved or authorized by the FDA. Once vaccines were made available, students would describe examples of family members' or even their own fear of vaccines. Some described their and others' vaccine hesitancy originating out of distrust of pharmaceutical companies, out of conspiracy theories that COVID-19 doesn't exist, or out of concerns that it is a way for the government to track and control individuals. Vaccine hesitancy is a complex issue and is not a new phenomenon. Sorrell and Butler (2022, 347) discuss the role especially by social media in contributing to the spread of views relating to COVID ranging from "ultra-right-wing racist and antisemitic conspiracy theories; antiglobalist conspiracy movements of both the left and right; suspicion of big pharma; left-wing and libertarian suspicion of routine government overreach; and 5G

conspiracy theories that draw adherents from both the right and from the ecological movement." The authors describe these views as ultimately religious and political, and originating from a breakdown between citizens and traditional political authorities (Sorrell and Butler 2022). There are several take-aways here, but I especially highlight the idea that illness is a social construction, and that illness behavior is governed by cultural values. In other words, this example highlights the connection between cultural beliefs/values and behavior. As students described their inability to understand why someone would go out in public without a mask or refuse to get vaccinated, they were able to think about how these behaviors might relate back to cultural beliefs and values. Students were further able to apply these same insights into understanding their own experiences, such as a student who was an "essential worker" but had to engage with people in the workplace who were not complying with COVID-19 prevention protocols. Of course, while being able to critically analyze this experience is helpful, it does not curb the very real predicament of having to show up for work despite the risks. Another theme that I saw in my student's responses to this case study was concern for the doctor/patient relationship and how they felt this grandmother was not being properly taken care of. I interpret this analysis as saying just as much about my students' own experiences with the healthcare field.

This also relates to another case study described in the reading. A second case study that stood out to students was that of a 26-year-old Guatemalan woman who was being treated for inflammatory bowel disease. The patient was very "angry, withdrawn, and uncooperative" (Kleinman, Eisenberg, and Good 1978, 254) because she was not allowed food by mouth (she was receiving nutrients intravenously), and because she was not able to "regulate her hot/cold balance of nutrients" (Kleinman, Eisenberg, and Good 1978, 254). The authors explain that the root of the problem was the difference between the cultural beliefs driving her explanatory model and the professional clinical reality. She understood her issue as originating with witchcraft and she interpreted the care she was getting as indicating that the doctors believed she was unlikely to live. Once the differences in etiology were understood by both the physicians and the patient, they were all able to move forward with a medical treatment. The authors did not discuss whether the threat from witchcraft was addressed, however. It's important to understand that these differing etiologies are both valid ways of understanding health and illness; however, in this case, the patient's cultural beliefs needed to exist in the same space as the biomedical treatment for any kind of treatment to move forward (in a similar fashion to the previous case study). This case study in particular is an example that relates to content in another course that I teach, and usually there are students that have taken some of my other courses, or that take this other course concurrently. I usually teach *Magic, Religion, and Witchcraft* in the fall semester and have students read the ethnography *Mama Lola: A Vodou Priestess in Brooklyn* by Karen McCarthy Brown (1991). Through the reading, discussion, and essay assignments with this reflexive ethnography students are able to understand how those who practice Haitian Vodou may have very different explanatory models around health and healing than their own. These lessons are carried over into

another course I teach titled *Culture and Personality*. This course is an overview of the history of psychological anthropology. Students read the ethnography by Theresa O'Nell (1996) titled *Disciplined Hearts: History, Identity, and Depression in an American Indian Community.* O'Nell's work more directly deals with explanatory models when she discusses the nuances of the meaning of the idiom of distress "loneliness," used by Flathead Indians. While this is a word many might relate to, she warns us that "Flathead loneliness entails moral meanings and social forces that are probably not entailed in the loneliness of non-Flathead readers" (O'Nell 1996, 179). While some of the students in these courses are majoring in anthropology, the majority are majoring in other disciplines, such as sociology, history, biology, premed, or nursing. Learning about the diversity of "explanatory models" is especially useful for students in any discipline. Learning that there is a diversity of "explanatory models" or ways of understanding one's trauma, distress, health, and so forth exemplifies why this is a core concept in medical anthropology. All students, but especially future healthcare providers will be able to better understand the importance of considering culture when engaging with others in the workplace, not just during the COVID-19 pandemic, but always.

Medicalization

Medical anthropology can help us frame our understanding of the COVID-19 pandemic in other ways. For example, in my own research on mental health I have argued that the "normal" that many are hoping we return to was heavily shaped by neoliberal policies that conceptualize health and illness as well as personhood in particular ways, such as through defining social problems as medical in nature and using medicine as forms of social control (Singer and Baer 2007, 92). This "medicalization" (Zola 1971) shifts attention away from the ways in which larger social arrangements (structures), such as poverty, racial/ethnic disparities, citizenship, etc. are impacting the origins of these social problems (such as the COVID-19 pandemic and it's impacts across societies generally). In the U.S. we tend to rely heavily on biological explanations for the origins of illness, which leaves little space for moral and political critique. In other words, we "medicalize our suffering" by defining social and physical problems as medical in nature and use medicine as forms of social control (Singer and Baer 2007, 92). This places the responsibility for illness on the individual and in so doing diverts attention away from the structural dimensions of suffering. Arthur Kleinman (1988) directly tackles the medicalization of social problems. He uses the example of dysthymic disorder from the Diagnostic and Statistical Manual (DSM) 3, also known as Neurotic depression in the International Classification of Diseases (ICD)-9, and says this may be an example of a category fallacy. He says that "dysthymia would seem to be an instance of the medicalization of social problems … where severe economic, political, and health problems create endemic feelings of hopelessness and helplessness, where demoralization and despair are responses to actual conditions of chronic deprivation and persistent loss, where powerlessness is not a cognitive distortion but an accurate mapping of one's place in an oppressive social system, and where moral, religious, and

political configurations of such problems has coherence for the local population but psychiatric categories do not" (Kleinman 1988, 15). In other words, chronic demoralization – a response to real and actual conditions such as poverty and loss – is not "abnormal behavior" but actually quite a normal reaction. Kleinman (1988, 8) writes that "a psychiatric diagnosis implies a tacit categorization of some forms of human misery as medical problems." Because stress, depression, and anxiety – which can be normal reactions to real conditions (and I'm not saying that this is the case in all situations) – have become so medicalized in our society, culturally psychological idioms have become an appropriate way to understand and display suffering, and this fits with the neoliberal rhetoric that runs alongside medicalization.

One assignment I have students complete in a course I teach called *Medical Sociology* is to listen to a podcast of their choice where individuals recount what it's like to have an illness, in other words their "illness narratives." This assignment is an alternative to having students interview individuals about their illness, something that was sometimes problematic even before the pandemic. Students are able to choose any illness or disease they like as their topic and to see if they are able to identify the individual's explanatory models. Additionally, I have the students use at least two concepts they have learned from the class to analyze/understand the narrative and students quite often gravitate towards the concept of medicalization. To understand this concept, I have the students read and discuss two articles, Irving Zola's (1971) original introduction of the concept and a more recent review of the concept by Peter Conrad (2005). These articles, combined a little later in the course with the introduction of Helena Hansen's (2015) work on the opioid epidemic in the U.S., really resonate with students. Students begin to understand with this work concepts such as social constructionism and how so much of what we take as "natural" or "normal" are really crafted and designed. For example, students will often feel comfortable at this point in the course disclosing their own struggles with mental health issues or past and current diagnoses with attention-deficit/hyperactive disorder (ADHD). It's not necessarily that they think they were misdiagnosed, but that there were environmental, cultural, and other elements that were contributing to their distress, and instead of addressing these situations they were just prescribed medications. Their misery was "medicalized," as if the problem originated within them instead of outside of them. In the case of the COVID-19 pandemic, I discuss with students how so much of our focus in the U.S. is on individual responsibility – the responsibility to get vaccinated, to wear a mask, etc. While on the one hand this is important, on the other it is to some extent detracting from the very real structural issues that continue to put people in harm's way. This discussion provides a segue in the classroom to discussing structural violence.

Structural Violence

Structural violence is a useful concept in the classroom, but it's also useful to frame the issues related to COVID-19 and teaching during COVID-19. Structural violence is a term coined by Johan Galtung which "describes social structures – economic, political,

legal, religious, and cultural – that stop individuals, groups, and societies from reaching their full potential" (Farmer et al. 2006). Another useful definition is: "the violence committed by configurations of social inequalities that, in the end, has injurious effects on bodies similar to the violence of a stabbing or shooting… organized along the fault lines of class, race, citizenship, gender, and sexuality" (Holmes 2013, 43). This concept is quite useful for helping students understand how "structure" directly impacts individuals, and helps answer questions such as: "who gets sick and why?"

Many of my students are immediately drawn to issues such as police brutality, racism, poverty, and mental illness, because these issues are so commonplace in their everyday lives and pervade their communities. These are themes that come up time and time again when students chose topics to research for their own research papers. After the pandemic began, these continued to be the topics students were drawn to except that they now were seeing these topics in a new way, thanks to living through a pandemic. Structural violence is a concept that comes up in multiple classes, however it is most pronounced in the *Medical Sociology* course that I teach. I have had my students read Paul Farmer and colleagues' (2006) work as well as Seth Holmes's (2013) ethnography *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. We then consider the various ways the concept of structural violence could be applied. For example, after introducing this concept we continue to build onto this with examples such as Robert Saplosky's (2004) *Why Zebras Don't Get Ulcers: The Acclaimed Guide to Stress, Stress-Related Diseases, and Coping* as well as the film *Stress: Portrait of a Killer* (Heminway 2008). In a more sociological sense, we know that inequality leads to health problems generally, but it's not just the unequal access to resources, medical care, etc. that is doing the damage, it's also the experience of inequality and hierarchy (Wilkinson and Pickett 2009). The stress of inequality can impact the body in various ways. Robert Sapolsky's (2004) research on baboons shows us that this "stress" of living with inequality has very real biological implications for both those with higher and lower social rank and is "bad for your brain," at least for the majority who have lower social rank in society. I ask students to discuss these examples of structural violence in classroom and online discussions. In the *Medical Sociology* course, I have students write a final research paper on the social construction of disease. Students are able to pick any disease of their choice, with common diseases being diabetes, HIV/AIDs, schizophrenia, and anxiety, to list a few. In the paper they must pick at least two of the concepts we have learned and apply them in their analysis, and many pick structural violence.

In these discussions and assignments, students are learning concepts that are helpful for understanding various ways that social structure impacts individuals and groups, but also their own lived experiences. These lived experiences are often traumatic ones that they are analyzing and also living through. The students' own precarity is often discussed with regards to structural violence and how it relates to COVID-19. For example, in class discussions, students will disclose the hardships they are dealing with, such as taking a full load of courses while also being employed part time or parenting small children. At my

university, 49% of the undergraduate student body identifies as non-white, 59.1% as "female," and approximately 90% of incoming first-year students receive some type of financial assistance; these students are vulnerable to the racism, mental illness, oppression, and so forth that they are learning about. Their lived experiences add multiple layers of examples that illustrate structural violence in their lives and the impact that COVID-19 has added to that. With this particular concept, then, students are provided with compelling framing and analysis in which to understand their own situations. Ezell and colleagues (2021) describe this structural violence, inequality, and stress as "intersectional trauma," and argue that the COVID-19 pandemic will be the "signature mental health crisis of this generation" (79).

Of course, in the same way that the students are learning about concepts to frame their lived experiences, university faculty are also being impacted by structural violence. For example, the University System of Georgia (USG) recently made changes to post-tenure review, making it possible to fire faculty without a dismissal hearing (AAUP 2022). This led the American Association of University Professors (AAUP) to censure the USG for removing "the protections of tenure and academic freedom from the system's post-tenure review policy" (AAUP 2022). Next door in the state of Florida, Governor Ron DeSantis has prioritized changes to public higher education, proposing changes such as banning specific majors and minors, subjecting tenured professors to post-tenure review at any time and for any cause, and prohibiting "diversity, equity, and inclusion statements" (Florida House of Representatives 2023, 13). Amanda Reinke (2022), writing about higher education, describes these kinds of working conditions as "institutional betrayal and bureaucratic violence" (Reinke 2022, 39). She says this kind of violence found in higher education constrains pedagogical choice. In the state of Georgia, she describes the impact for anthropologists as "limitations on the strength of tenure, post-tenure review and 'improvement plan' requirements, and political appointments throughout the BoR [Board of Regents]" (Reinke 2022, 42). This bureaucratic violence in the state of Georgia is not limited to higher education, as it is also supported through legislation through Georgia Bill 377 which "stipulates that elementary and secondary education should not teach so-called 'divisive concepts'" (Reinke 2022, 43). While these are not necessarily topics that I brought up with my students, teaching in this kind of political climate does directly impact teaching and learning. This kind of political climate for example, could greatly constrain a professor's ability to apply trauma informed pedagogy in the classroom. As Reinke (2022, 44) concludes, "we cannot discuss teaching and learning effectively without addressing the working conditions of faculty, staff, and graduate students … [and] without attending to the forms of bureaucratic violence and institutional betrayal that implicitly or explicitly restrict, constrain, and depersonalize the educational experience."

Conclusion

I introduced and discussed the previously-described concepts in my courses prior to the COVID-19 global pandemic. However, I found that they are especially poignant for

students living through intersectional trauma. It is difficult to conceptualize and even describe the weight on students who are also trying to be academically present, critical, and productive during a pandemic. To adapt to the changing needs of my students, I incorporated trauma-informed teaching and learning (TITL) practices into my style of teaching. I have continued to incorporate these kinds of practices into my style of teaching and plan to do so into the foreseeable future. In addition to this teaching style, I am able to provide examples and concepts that students can relate to and that help them to frame their own research interests and lived experiences. Those in higher education are and have been under threat from several vantage points, and new ones continue to arise. Student mental health issues are on the rise, enrollments are down, and societal social problems abound. Yet, when I engage with the anthropological literature discussed here, I am reminded that we have powerful conceptual tools that can help us move forward.

References

AAUP. 2022. "AAUP Censures University System of Georgia." *AAUP Updates*, March 5, 2022. https://www.aaup.org/news/aaup-censures-university-system-georgia#.ZDhIFnbMKUk.

Bowers, Catherine, and Shelly Yankovskyy. 2019. "Using O'Brien's 'Compass': A Case Study in Faculty-Librarian Partnerships and Student Perceptions of Research and Writing in Anthropology and Sociology." In *The Grounded Instruction Librarian: Participating in the Scholarship of Teaching and Learning*, edited by Melissa Mallon, Lauren Hays, Cara Bradley, Rhonda Huisman, and Jackie Belanger, 187-199. Chicago, IL: American Library Association.

Brown, Karen McCarthy. 1991. *Mama Lola: A Vodou Priestess in Brooklyn*. Berkeley, CA: University of California Press.

Conrad, Peter. 2005. "The Shifting Engines of Medicalization." *Journal of Health and social Behavior* 46 (1): 3–14. https://doi.org/10.1177/002214650504600102.

Di-Capua, Y. 2015. "Trauma and other historians." *Historical Reflections/Refléxions Historiques* 4 (3): 1–13. https://doi.org/10.3167/hrrh.2015.410301.

Ezell, Jerel M., et al. 2021. "Intersectional Trauma: COVID-19, the Psychosocial Contract, and America's Racialized Public Health Lineage." *American Psychological Association* 27 (1): 78–85. https://doi.org/10.1037/trm0000302.

Farmer, Paul, et al. 2006. "Structural Violence and Clinical Medicine." PLoS *Medicine*. 3 (10): e449. https://doi.org/10.1371/journal.pmed.0030449.

Florida House of Representatives. 2023. *HB 999: Postsecondary Educational Institutions*. https://www.flsenate.gov/Session/Bill/2023/999/BillText/Filed/PDF.

Guyer, Jane. 2008. "Prophecy and the near future: Thoughts on macroeconomic, evangelical, and punctuated time." *American Ethnologist* 34 (3): 409–421. https://doi.org/10.1525/ae.2007.34.3.409.

Hansen, Helena. 2015. "Pharmaceutical Prosthesis and White Racial Rescue in the Prescription Opioid 'Epidemic.'" *Somatosphere*, December 14, 2015. http://somatosphere.net/2015/pharmaceutical-prosthesis-and-white-racial-rescue-in-the-prescription-opioid-epidemic.html/.

Heminway, John, dir. 2008. *Stress, Portrait of a Killer*. Los Angeles, CA: National Geographic Television, 20th Century Fox, November 18, 2008. DVD.

Holmes, Seth. 2013. *Fresh Fruit Broken Bodies: Migrant Farmworkers in the United States*. Berkeley, CA: University of California Press.

Hubler, Shawn. 2020. "Colleges Slash Budgets in the Pandemic, With 'Nothing Off Limits.'" *New York Times*, November 2, 2020. https://www.nytimes.com/2020/10/26/us/colleges-coronavirus-budget-cuts.html.

Hyer, M. C., J. Landau, and J. L. Workman. 2020. "Recovering from burn-out and budget cuts by cultivating faculty writing communities." *Journal on Centers for Teaching and Learning* 12: 149–168.

Kleinman, Arthur. 1988. *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: The Free Press.

Kleinman, Arthur, Leon Eisenberg, and Byron Good. 1978. "Culture, Illness, and Care: Clinical lessons from Anthropologic and Cross-Cultural Research." *Annals of Internal Medicine* 88: 251–258. https://doi.org/10.1176/foc.4.1.140.

Marquart, Matthea, and Johanna Creswell Báez. 2021. "Recommitting to trauma-informed teaching principles to support student learning: An example of a transformation in response to the coronavirus pandemic." *Journal of Transformative Learning* 8 (1): 63–74.

Mitchel, Michael, Michael Leachman, and Matt Saenz. 2019. "State Higher Education Funding Cuts Have Pushed Costs to Students, Worsened Inequality." Washington, D.C.: Center on Budget and Policy Priorities. https://www.cbpp.org/research/state-budget-and-tax/state-higher-education-funding-cuts-have-pushed-costs-to-students.

O'Brien, Mia. 2008. "Navigating the SoTL Landscape: A Compass, Map and Some Tools for Getting Started." *International Journal for the Scholarship of Teaching and Learning* 2 (2). https://doi.org/10.20429/ijsotl.2008.020215.

O'Nell, Theresa DeLeane. 1996. *Disciplined Hearts: History, Identity, and Depression in an American Indian Community*. Berkeley, CA: University of California Press.

Phelps-Ward, Robin, Laila McCloud, and Erin Phelps. 2021. "Teaching to Transgress During COVID-19 and Beyond for Racial Justice and Decolonization." *Journal of the Professoriate* (12) 1: 195-216.

Reinke, Amanda. 2022. "The Institutional Betrayal and Bureaucratic Violence of Higher Education." *Teaching and Learning Anthropology Journal* 5 (1). https://doi.org/10.5070/T35156489.

Ringel, Felix. 2020. "Coronavirus: how the pandemic has changed our perception of time." *The Conversation*, May 28, 2020. https://theconversation.com/coronavirus-how-the-pandemic-has-changed-our-perception-of-time-139240.

SAMHSA. 2014. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

Sapolsky, Robert. 2004. *Why Zebras Don't Get Ulcers: The Acclaimed Guide to Stress, Stress-Related Diseases, and Coping*. 3rd ed. New York: Henry Holt and Company.

Singer, Merrill, and Hans Baer. 2007. *Introducing Medical Anthropology: A Discipline in Action*. United Kingdom: Altamira Press.

Singer, Merrill, and Barbara Rylko-Bauer. 2021. "The Syndemics and Structural Violence of the COVID Pandemic: Anthropological Insights on a Crisis." *Open Anthropological Research* 1 (1): 7–32. https://doi.org/10.1515/opan-2020-0100.

Sorrell, Tom, and Jethro Butler. 2022. "The Politics of Covid Vaccine Hesitancy and Opposition." *The Political Quarterly* 93 (2). https://doi.org/10.1111/1467-923X.13134.

Stephens, Darryl. 2021. "What is Trauma? What is a Trauma-Informed Approach?" In *Trauma-Informed Pedagogies in the Religious Studies Classroom: Spotlight on Teaching*, edited by Jessica L. Tinklenberg, 9–18. American Academy of Religion.

Winkinson, Richard, and Kate E. Pickett. 2009. "Income Inequality and Social Dysfunction." *Annual Review of Sociology* 35: 493–511. https://doi.org/10.1146/annurev-soc-070308-115926.

Yurchak, Alexei. 2006. *Everything Was Forever, Until It Was No More: The Last Soviet Generation*. Princeton, NJ: Princeton University Press.

Zola, Irving Kenneth. 1971. "Medicine as an Institution of Social Control." *Ekistics* 41 (245): 210–214. https://www.jstor.org/stable/43618673.