Cultural Perspective

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Why think about health from a cultural perspective?

How to define culture?

“Classic” anthropologic definition of culture

“A framework of beliefs, symbols, and values used to define one's world, express feelings, and make judgments.”

Clifford Geertz, The Interpretation of Cultures

A socio-biologic view of culture

- Humans are a knowledge-using, cooperative species
- Our brains are “wired” to:
  - Infer other people’s goals and understand the behavior relative to those goals
  - Learn and copy behaviors that will allow us to function in collaboration with others

A sociobiologic view of culture

- Culture as an “epidemiology of mental representations” (Sperber)
  - “a pool of technological and social innovations that people accumulate to help them live their lives” [together] (Pinker)
  - A group of “shared arbitrary practices” that help guide daily behavior and serve to regulate interpersonal behavior (ie, make the intentions of others more predictable)

A sociobiologic view of culture

- Cultures differ when groups of people evolve in isolation from each other
  - Isolation may be physical or voluntary
- Differences preserved when:
  - Need for “behavioral identity badges”
  - High cost for individuals to make change
- Cultures change when people see advantage in what others are doing

Reasons to consider culture

To understand more about ourselves

- Cultural knowledge is “overlearned” - accepted as objective reality until confronted by contrast or crisis (let’s pause to think about some examples of “overlearned”)

Necessary to provide services

- Obvious examples: differences in modesty, trust, expectations for care
- Other examples?

Dimensions of culture that may be related to health interventions

- Individual versus collective orientation as a determinant of how resources allocated
  - Family versus collective orientation as determinant of how information is transmitted or accepted
  - Culturally-sanctioned or prohibited behavior related to health risk or health promotion

Culture-bound conditions

- Salience or meaning of an illness varies across cultures (schizophrenia)
- Some illnesses appear not to occur across cultures (anorexia, menopause)

Disease versus illness

- Disease: abnormality of structure or function of body organs and systems (Kleinman)
- Illness: individual's *experience* of *disvalued* bodily abnormalities or changes in social function
  - Experienced: abnormality may be real or presumed
  - Disvalued: real abnormalities may or may not be seen as problematic

The interaction of illness and culture

- ...the subjective experience of illness is culture-bound...
- ...the cognitive and linguistic categories of illnesses characteristic of any culture constrain the interpretive and behavioral options available in response to symptoms

The illness process

Perception of a symptom → Label as ill

Inputs

Individual

Family

Community

Event	**Cognitive Process**	**Culture**
A “change”	Is it noticed?	Degree of attention to internal states Available labels
Interpretation	Is it a symptom? Is the person ill?	Prevalence/past experience Knowledge Social implications
Action	Seek help	Hierarchy of helpers Community-specific barriers

Social construction of illness

Example: A “cold” in a school-aged child

- family tradition determines whether this is recognized as a pathologic state or part of normal life experience
- family tradition and constraints dictate to what extent sick role is available and accommodations that are required

Interpretation of symptoms

Example: Flathead reservation (Montana) (O'Nell)

- Study of individuals meeting DSM criteria for major depression
- Have core symptoms of low energy, appetite, sleep disturbance, thoughts about death
- How are symptoms described?
  - *loneliness* rather than *sadness* the main idiom
  - loneliness related to social relationships, which are a core value in the culture

Three clusters of depressed feelings

- Aggrieved - chastised, jilted, ignored
- Bereaved - grief for things that are gone, missing people, lost tribal values
- Worthless - feeling as if one would be abandoned, unworthy, reproachful of self for not living up to responsibilities to others

Pathologic?

- Only “worthless” is seen as pathologic within the culture, associated with suicidality, something to be treated.
  - aggrieved and bereaved not seen as illness by person or peers
  - to be bereaved is seen as a sign of maturity, attitude befitting an elder
  - to be aggrieved is natural condition after certain situations

Acculturation

- Process of adaptation to living in a culture different from one's own
- Many definitions and proposed “endpoints” (Hunt, 2004)
- Often conceptualized as adoption of language, values, tastes, behaviors of “host” cultures
  - Early views pre-supposed a hierarchy from primitive to civilized; traditional to modern

What are possible endpoints?

- Assimilation to various degrees
  - Sufficient adoption of new behaviors and attitudes to the point where identification with culture of origin no longer create a difference “life chances” relative to others (Richard Alba)
- Polarity with “multiculturalism”
  - Parallel existence of disparate groups
- Neither obviously good or bad
  - Neither likely to exist in pure form

What is cultural competence?

Elements of a cultural formulation

- Cultural reference group(s)
  - Self-described, includes groups to which individual feels belongs or is distinct from
  - Degree of certainty about membership
- Language
  - Degree to which speak/understand language identified with cultural reference group

Elements of a cultural formulation

- Involvement with cultural reference group
  - Participation in activities, structures, degree of knowledge
  - Degree of pride/shame associated with membership

Elements of a cultural formulation

- Involvement with other (possibly “host” culture)
  - Competency in language, knowledge of activities, structures
  - Experience of acceptance/power relationships
  - Relative amount of time spent in referent vs. host culture
  - Comfort functioning in other cultures

When meet across cultures:

- Transactions between explanatory models
- Need for mutual respect
- Both “sides” fear disrespect of their model
- Getting both models “on the table” is the beginning of the transaction
- Professionals can’t always articulate their model in comprehensible ways

To elicit explanatory models (Kleinman)

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is this sickness? How long will it last?

To elicit explanatory models

5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to get from the treatment?
7. What are the chief problems your sickness has caused you?
8. What do you fear most about your sickness?

What approaches work?

- For clinicians and public health professionals
  - Start with awareness that differences possible
  - How to sensitize to differences without stereotyping?
    - Consider cultural patterns as hypotheses not generalizations
    - Know the history of interactions with other cultures
      - Conditions in the country of origin (if immigrants)
      - Experiences of oppression or discrimination
  - Remedy barriers to communication
    - Availability of translators and written materials
    - Great undersupply of trained translators
    - Outcomes clearly better in encounters where clinicians and patients speak same language

What approaches work?

- For professionals and public health educators
  - Allowing sufficient time in clinical encounter, educational session, or program development to develop a mutual understanding
  - Make the setting less strange: objects, pictures from all participating cultures create common ground

What approaches work?

- For educating, informing, motivating
  - Use spokespersons from the culture
    - The verbal message is not the whole message
- Consider problems the population has in encounters with other institutions
  - Schools, government agencies, etc.

Differences in American Indian versus "Western" help-seeking patterns (over-generalizations)

Attitude	**American Indian**	**"Western**
Orientation toward prevention	Framed as maintaining harmony, countering or avoiding exposure to certain general influences	Identifying undesired outcome
Willingness to talk about possible harm	Talking about bad things can make them happen	Awareness of possible harm seen as motivating
First source of care	Home/folk remedies; advice from family and friends	Same

Differences in American Indian versus "Western" help-seeking patterns (over-generalizations)

Attitude	**American Indian**	**"Western**
Choice of sources	Choose traditional or "Western" based on problem	biomedical
Need for appointment	"don't care enough"	Like order; "my time"
Expectation of provider	Should know what is wrong; should be person of stature	Questions expected; partnership but also authority

Differences in American Indian versus "Western" help-seeking patterns (over-generalizations)

Attitude	**American Indian**	**"Western**
Expectation for diagnosis	Events/actions that threaten intra or interpersonal equilibrium	Biological hypotheses
Expectation for healing	Treatment brief but intense; expect and need involvement of community	Extended treatment accepted; expect privacy
Expectation for prescription	Expect behavioral treatment	Expect medication

Culture and public health

- Degree to which individuals feel responsible for family and community
  - Generally higher among African-Americans and Latinos than Whites in US
- Attitudes toward sexuality
  - What happens if you abstain
  - Is touching yourself ok?
  - Is sexual knowledge the same as experience (and thus bad)?

Culture and public health

- Mobilizing individuals and communities
  - faith in ultimate “reward” among African-Americans
    - great perseverance but fatalism toward adversity
  - “justice” orientation among US Whites
    - easily frustrated when short-term fixes fail
- Willingness to seek help
  - the strong are silent
    - talking it out is a sign of weakness

Culture and public health

- Orientation toward family
  - Many cultural groups make decisions either involving extended family members or giving authority to a particular member
  - Different standards may apply for men and women within the family
    - Gail Wyatt: “We raise our daughters and spoil our sons.”

Culture and public health

- Orientation toward outside authority
  - Different ideas about what information is privileged
  - Different concerns about loss of control or harm at the hands of outsiders

Native American Breast Health Project

- Focus groups to understand attitudes toward breast health
- Art contests to develop ideas for appropriate illustrations
  - Focus on health not cancer
  - Not appropriate to have a breast on the brochure
  - Models on existing brochures looked like “Barbie”
  - Illustrations of tribal art and symbols on brochures gave women a sense that materials created for them