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# Health and Culture

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Is culture relevant to the study of health and illness? Almost with one voice, sociologists and anthropologists affirm it is. Such a consensus is exceptional in these disciplines which have produced the bulk of systematic research on health-related behavior by applying a wide variety of approaches and conceptual perspectives. Today we know that culture is not just one of many factors associated with health but is the context within which health-related behavior unfolds. This chapter explains why culture is significant in health-related behavior. The discussion unfolds in three steps. We shall first deal with the definition of culture. Then we will consider the link between culture and health behavior. Finally, we will focus on the link between culture and healing systems.

## Defining Culture

The meaning of the term "culture" varies widely across disciplines and conceptual perspectives. To keep within the scope of this volume, the focus is on the contributions of sociology and anthropology. We begin with an historical glance at the efforts made to define and understand "culture."

### The Classics

One enduring contribution is that of Emile Durkheim, a pioneer of the discipline of sociology. In his *Rules of Sociological Method,* first published in 1895, Durkheim proposed guidelines for the study of social phenomena as *social facts*. He argued that social facts are "representations" of society in the mind of the individual. They are ways of thinking, feeling, and acting external to the person. Such "facts" include myths, popular legends, religious conceptions, moral beliefs, and social beliefs and practices in general. By treating social

values, beliefs, and customs as social facts, Durkheim promoted the systematic study of culture. Durkheim's concepts of a collective social consciousness and social solidarity also encompass culture. He saw social solidarity and, particularly, collective consciousness as reflective of culture and concurrently present within and external to the individual. Taylor and Ashworth (1987: 43) propose that these ideas are applicable to the study of medical sociology phenomena, such as attitudes toward death and the link between "changing forms of social solidarity and changing perceptions of health, disease, and medicine."

One of Durkheim's contemporaries was Max Weber. Weber's work during the first two decades of the twentieth century brilliantly marked the initiation of the sociological analysis of culture. Among his voluminous published work, two studies are particularly relevant: *The Protestant Ethic and the Spirit of Capitalism* (1905) and *Economy and Society* (published in English in 1968). Weber highlighted the importance of culture as values and beliefs coexisting and shaping social action within the micro-cosmos of the individual actor as well as at the level of collectivities, institutions, and the larger society. In particular, Weber's conceptualization of *ethnic group* and *traditional action* offers the most relevant insights to the study of culture.

Weber defined *ethnic* groups as "human groups" characterized by a "subjective belief in their common descent" given their real or perceived similarities in one or more characteristics: physical types or race, customs, language, religion, and in "perceptible differences in the conduct of everyday life" (Weber 1978: 389–90). The impact of these subjectively perceived similarities on social action is heightened by yet another crucial feature of ethnicity: "the belief in a specific *honor* of their members, not shared by outsiders, that is, the sense of *ethnic honor.*" Weber (1978: 391) explained:

> palpable differences in dialect and differences of religion in themselves do not exclude sentiments of common ethnicity . . . The conviction of the excellence of one's own customs and the inferiority of alien ones, a conviction which sustains the sense of ethnic honor, is actually quite analogous to the sense of honor of distinctive status groups.

Weber's concept of *traditional action* (one of four in his typology of social action) is similarly relevant to the link between culture and health. Weber defines *traditional* action as social action "determined by ingrained habituation." *Traditional* action, he wrote, "is very often a matter of almost automatic reaction to habitual stimuli that guide behavior in a course which has been repeatedly followed. The great bulk of all everyday action to which people have become habitually accustomed approaches this type" (Weber 1978: 4). As will be discussed, these insights into the substance of ethnicity and traditional action elucidate the pervasiveness of customs, beliefs, and practices of different ethnic or cultural communities upon their health-related behavior. Weber's analyses have inspired subsequent research and contributed to the understanding of the pervasiveness of culturally inspired and culturally sustained health practices. Probably because of the profound influence and widespread incorporation of his conceptual insights into the body of general knowledge of sociology, these

Weberian contributions are seldom cited directly in current medical sociology research. A notable exception is the analysis of Weber's legacy in medical sociology by Uta Gerhardt (1989) and his concept of lifestyles (Cockerham 1998).

The interest in culture was passed along to subsequent generations of social scientists. By 1951, Clyde Kluckhohn reported many different definitions of culture (1951) and many more have appeared since. Yet, in spite of the plurality of definitions, some common strands are found in the cumulative work of anthropologists and sociologists that make up the fundamental fabric of this important concept. Kluckhohn (1951: 86) defined "culture" in the widest sense, as a community's "design for living." He pointed out that despite the wide variety of definitions, he and A. L. Kroeber (1952) found, in their critical review of definitions, an "approximate consensus" that he (Kluckhohn 1951: 86) summarized as follows:

> Culture consists in patterned ways of thinking, feeling, and reacting, acquired and transmitted mainly by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; . . . traditional (i.e. historically derived and selected) ideas and especially their attached values.

Kluckhohn proposed that the concept of culture be used as "a map" or "abstract representation" of the distinctive features of a community's way of life. This method is akin to the *ideal type*, the analytical tool introduced by Weber ([1925] 1946) to identify general characteristics, patterns, and regularities in social behavior.

A direct connection between culture and health was articulated by Bronislaw Malinowski (1944: 37) who considered culture as a functional response to satisfy "the organic and basic needs of man and of the race." He (Malinowski 1944: 36) defined culture as "the integral whole" encompassing "human ideas and crafts, beliefs and customs . . . A vast apparatus, partly material, partly human and partly spiritual, by which man is able to cope with the concrete, specific problems that face him." Malinowski saw those problems as human "needs" that prompted "cultural responses." These needs were metabolism, reproduction, bodily comforts, safety, movement, growth, and health. However, in his (Malinowski 1944: 93) view, health is implied in all the other six human basic needs, in addition to the need for "relief or removal of sickness or of pathological conditions." Malinowski (1944: 91) proposed "hygiene" as the "cultural response" to *health*. Hygiene involves all "sanitary arrangements" in a community, "native beliefs as to health and magical dangers," "rules about exposure, extreme fatigue, the avoidance of dangers or accidents," and the "never absent range of household remedies" (Malinowski 1944: 108).

Another valuable contribution to the understanding of culture was provided by sociologist Talcott Parsons. Parsons was greatly influenced as a student by Durkheim and Weber. Among his colleagues, he acknowledged the influence of Kluckhohn concerning "the problems of culture and its relation to society" (1951: xi). Parsons conceptualized social action as taking place within a three-dimensional context comprising personality, culture, and the social system

(1951: 17). He (Parsons 1951: 327) defined culture as "ordered systems of symbols" that guide social action and are "internalized components of the personalities of individual actors and institutionalized patterns of social systems." For Parsons (1951: 11), the shared symbolic systems are fundamental for the functioning of the social system and they represent "a *cultural tradition.*" Parsons argued that a cultural tradition has three principal components or systems: value-orientations, beliefs, and expressive symbols (1951: 326–7).

Parson's preoccupation with a balanced analysis of values and motives that would prevent us from falling into the extremes of "psychological" or "cultural" determinism, led him to invest considerable effort into the discussion of culture. Parsons (1951: 15) identified three main features:

> First, that culture is *transmitted*, it constitutes a heritage or a social tradition; secondly, that it is *learned*, it is not a manifestation, in particular content, of man's genetic constitution; and third, that it is *shared*. Culture, that is, is on the one hand the product of, on the other hand a determinant of, systems of human interaction.

Parsons' concepts of culture and cultural traditions and his identification of culture as transmitted, learned, and shared, together with the contributions from Durkheim, Weber, Kluckhohn, and Malinowski form the significant inheritance from the social science pioneers on the study of culture. An additional heritage of the study of culture is the cross-fertilization of insights and research from sociology and anthropology. Most current studies on culture and on the link between culture and health have built on this rich patrimony.

By identifying the fundamental components of culture, the collective wisdom inherited from the classics permit us to consider culture and ethnicity as the same phenomenon. Although Margaret Mead (1956) and Benjamin Paul (1963) proposed that cultural differences cut across racial and religious lines, these two factors are very much part of the cultural landscape within which individuals and groups operate. This idea is captured well by Stanley King (1962) who proposed that what constitutes an ethnic group is the combination of "common backgrounds in language, customs, beliefs, habits and traditions, frequently in racial stock or country of origin" and, more importantly, "a consciousness of kind" (1962: 79). It is important to keep in mind that, from the perspective of individuals and collectivities, these ethnic similarities may be factual or perceived and may include a formal religion. The sharing of the same geographical settlement is not as important as it was once thought, mainly because large migrations (voluntary or not) of people from different ethnic groups have resulted in the formation of diaspora beyond their ancestral lands and the subsequent increase of multiethnic settlements. The process of assimilation (becoming a member of the host culture) is commonly observed when individuals settle in a new country. Living in close proximity to each other leads individuals from different ethnic groups into another process, *pragmatic acculturation*; that is, the process of culture borrowing motivated by the desire to satisfy specific needs (Quah 1989: 181). Inspiration from the classics has guided the identification of these processes. Assimilation and *pragmatic acculturation*

have been found to influence health behavior significantly. These processes will be discussed in more detail later. But first, let us review some of the contemporary leading ideas on culture and health.

## Main Contemporary Research Trends

The contributions of the classics are the foundation of our understanding of culture and of its impact on behavior. As we shall see, the research conducted over the past five decades have supported their interpretation of culture. The corpus of contemporary sociological and anthropological research on culture is expanding rapidly and in different directions. Some "neoclassical approaches" have sprang out of the work of Weber, Durkheim, and Marx but have taken a life of their own as, for example, interpretations of religion, studies of social control, and feminist perspectives of the body and gender (Alexander 1990).

Attention to the body as an important subject of social analysis was brought up by Michael Foucault's work on *The Order of Things* (1970), *The Birth of the Clinic* (1973), and *Discipline and Punish* (1977). He eschewed research in favor of formulating assumptions, but his effort at awakening alertness to the symbolic and perceived meaning of the body is, to me, his vital contribution. Research findings over the past decade show that the symbolic meaning of the body in relation to health and illness, manipulation, completeness and mutilation, varies substantially across cultures. One of the most recent and dramatic illustrations of this finding is the cultural interpretation of female genital cutting (FGC) by western groups advocating the eradication of FGC as opposed to the symbolic meaning of FGC held by some African communities that are struggling to preserve it (Greer 1999).

On the effort to elucidate how culture affects the individual's behavior, the work of Erving Goffman (1968a, 1968b) using the symbolic-interactionist perspective is important. Goffman focuses on the person's subjective definition of the situation and the concept of stigma. He proposes a three-stage stigmatization process (1968b): the person's initial or "primary" deviation from a normative framework; the negative societal reaction; and the person's "secondary" reaction or response to the negative reaction that becomes the person's "master-status." It is clear that Goffman's "normative framework" is socially constructed based on the community's predominant culture. Disability and disease, particularly mental illness (1968a), are typically perceived as stigma and trigger the stigmatization process. Unfortunately, Goffman and many of his followers have neglected to apply his conceptual approach fully to their own studies: they overlook cross-cultural comparisons (see for example Strauss 1975; Locker 1983; Scambler 1984).

The preceding discussion might lead some readers to believe that there is consensus on what is culture and how to study it. Drawing a sketch of the current situation in cultural studies, Jeffrey Alexander (1990) indicates that one point of agreement is "their emphasis on the autonomy of culture from social structure." On the other hand, he finds in the contemporary literature on culture "extraordinary disagreement over what is actually inside the cultural system itself." Is it symbols, or values, or feelings, or metaphysical ideas? He proposes

that culture might embrace all these because culture cannot be understood "without reference to subjective meaning" and "without reference to social structural constraints." For the same reason he favors a multidisciplinary approach to the study of culture (1990: 25–6).

The multidisciplinary approach is indeed one of two main trends in contemporary research on the link between culture and health. Focusing on the understanding of culture and health behavior, the disciplines of sociology and anthropology have produced research findings confirming that culture or ethnicity influence health behavior and attitudes significantly. The research work advanced over the second half of the twentieth century is characterized by a second main trend: although several conceptual perspectives on the influence of culture are discussed and explored, no dominant theory has yet emerged to explain that influence systematically.

Rene Fox (Parsons and Fox 1952a, 1952b; Fox 1976, 1989), has contributed to the advance in the search for evidence on the impact of values and beliefs on health behavior at the micro-level through her analysis of individuals and at the macro-level by focusing on institutional aspects of medical care such as the medical school and the hospital. She demonstrated the advantages of close collaboration between sociology and anthropology in the study of health-related behavior, particularly on the aspect of culture. Some of her contributions will be discussed in the subsequent sections.

A final note before moving on to culture and health: The inclusion of ethnicity has become fashionable in medical research in the past two decades but it appears that little is learned from social science research. Reviewing the uses of the ethnicity concept in articles published in the *American Journal of Public Health* from 1980 to 1989, Ahdieh and Hahn (1996) found that "there was little consensus in the scientific [medical] community regarding the meaning or use of terms such as race, ethnicity or national origin" (1996: 97–8). Efforts have been made to assist health care practitioners to appreciate the complexity of culture (LaVeist 1994; Williams 1994). The social sciences and, in particular sociology and anthropology, remain the disciplines most dedicated to the study of culture or ethnicity *per se* and of its association with health and illness phenomena.

## Culture and Health Behavior

The conceptual insights of the classic and contemporary sociologists and anthropologists on the significance of culture are confirmed by research on health behavior over the past four decades. A complete review of the vast body of sociological and anthropological literature dealing with the influence of culture upon the individual's health behavior is a formidable task beyond the scope of this chapter. Instead, I will highlight the nuances and significance of cultural variations in health behavior by discussing relevant findings within the framework of three types of health-related behavior: namely, *preventive health behavior, illness behavior*, and *sick-role behavior*. The two former concepts were proposed by Kasl and Cobb (1966). The concept of *sick-role* behavior was formulated by Talcott Parsons (1951: 436–8).

*Preventive health behavior* refers to the activity of a person who believes he or she is healthy for the purpose of preventing illness (Kasl and Cobb 1966: 246). Kasl and Cobb labeled this "health behavior" but the term *preventive* differentiates it clearly from the other two types of health-related behavior. Kasl and Cobb (1966: 246) defined *illness behavior* as the activity undertaken by a person who feels ill for the purpose of defining the illness and seeking a solution. In the sense intended for this discussion, *illness behavior* encompasses the time span between a person's first awareness of symptoms and his or her decision to seek expert assistance or "technically competent" help (to borrow Parsons' [1951: 437] term). *Illness behavior* thus defined includes activities such as initial self-medication or self-treatment, and discussion of the problem with non-expert family members and others within one's primary or informal social network. *Sick-role behavior* is the activity undertaken by a person who considers himself or herself ill for the purpose of getting well (based on Parsons 1951: 436–8). *Sick-role behavior* is typically preceded by *illness behavior* and encompasses the sick person's formal response to symptoms, that is, the seeking of what he or she perceives as "technically competent" help. The sick person may seek technically competent or expert advice from whoever he or she perceives as or believes to be an expert including traditional healers, modern medical healing practitioners, or a combination of these. *Sick-role behavior* also includes the relations between patient and healer, and the subsequent activity of the person as a patient.

## Culture and Preventive Health Behavior

Preventive health behavior refers to the activity of a person who believes he or she is healthy for the purpose of preventing illness (Kasl and Cobb 1966: 246). In addition to the study of healthy individuals, relevant research on preventive health behavior also covers studies on substance addiction or abuse (drugs, alcohol, cigarettes) that seek to understand the path toward addiction and to identify the factors involved. The subjective evaluation of one's own health status may propel or retard preventive action against disease. Many studies on preventive health behavior report data on self-health evaluation but it is not common to report variations in the cultural meaning attached to health status. As health status is in many respects a value, cultural variations are commonly found in people's evaluation of their own health status and the way in which they evaluate it.

The study by Lew-Ting, Hurwicz, and Berkanovic (1998) illustrates this phenomenon in the case of the Chinese. The Chinese use the traditional idea of "ti-zhi" or "constitution" to denote "a long-term, pervasive characteristic that is central to their sense of self" and clearly different from the western concept of health status. The latter is "a more temporal, fluctuating state" that varies with "the experience of illness" (1998: 829). This is an illustration of the cultural similarity in the definition of constitution among people of the same ethnic group (Chinese elderly) living in two different parts of the world. In contrast, residing in the same geographical location does not secure a common meaning of health status. For example, significant cultural differences in self-evaluated

health status were observed among three cultural groups living in close proximity of each other in south-central Florida (Albrecht, Clarke, and Miller 1998).

Among the latest studies relevant to the prevention of substance abuse, in this case of alcohol, is the work of Gureje, Mavreas, Vazquez-Baquero, and Janca (1997). People in nine cities were interviewed by Gureje and his colleagues on their values and perceptions concerning the meaning of drinking alcohol. The nine cities were Ankara (Turkey), Athens (Greece), Bangalore (India), Flagstaff (Arizona), Ibadan (Nigeria), Jebal (Romania), Mexico City, Santander (Spain), and Seoul (South Korea). These authors reported a "remarkable congruence" in the practitioners' criteria to diagnose alcoholism. But they found significant variations among people across the nine cities concerning "drinking norms, especially with regard to *wet* and *dry* cultures" (1997: 209). A *wet* culture, they stated, is that where alcohol drinking is permitted or encouraged by the social significance attached to the act of drinking and to the social context within which drinking takes place. In a *dry* culture alcohol drinking is discouraged or prohibited altogether. They cited two of the earliest alcohol studies by Bunzel (1940) and Horton (1943) which suggested the strong influence of culture on alcohol drinking. Their own study adds to the increasing body of research findings showing that the difficulties encountered in the prevention of alcoholism are greater in some cultures than in others.

The investigation into the relative influence of culture upon alcohol abuse was found by Guttman (1999) to be equivocal in situations where acculturation takes place. Guttman refers to the common definition of acculturation that is, "the process whereby one culture group adopts the beliefs and practices of another culture group over time" (1999: 175). His study of alcohol drinking among Mexican immigrants in the United States highlighted several problems. He found it difficult to identify clearly the boundaries between cultures sharing the same geographical area. This problem has been overcome in some studies by following the symbolic-interactionist postulate of the importance of subjective definition of self and of the situation and correspondingly accepting the subjects' self-identification as members of a given culture (see Quah 1993). Some researchers assume that the length of time spent in the host country leads to acculturation and thus use other indicators, such as the proportion of the immigrant's life spent in the host country (cf. Mandelblatt et al. 1999).

A second and more critical difficulty in the study of preventive and other types of health behavior involving alcoholism and other health disorders among immigrants is their concurrent exposure to multiple cultural influences. In this regard, Guttman's finding in the United States is similar to findings from immigrant studies in other countries. He observed that immigrants "are participants not only in the dissolution of older cultural practices and beliefs but are also constantly engaged in the creation, elaboration, and even intensification of new cultural identities" (Guttman 1999: 175). However, the presence of multiple cultural influences does not necessarily lead to the creation of new identities. Other outcomes are possible. A significant outcome is what I label *pragmatic acculturation*: the borrowing of cultural elements (concepts, ways of doing things, ways of organizing and planning) and adapting them to meet practical needs. Pragmatic acculturation is practiced in the search for ways to prevent

illness, or trying different remedies to deal with symptoms (illness behavior), or seeking expert help from healers from other cultures (Quah 1985, 1989, 1993). Individuals "borrow" healing options from cultures other than their own, but they may or may not incorporate those options or more aspects of the other cultures into their lives permanently. The borrowing and adapting is part of the ongoing process of dealing with health and illness. Solutions from other cultures tend to be adopted, or adapted to one's own culture, if and for as long as they "work" to the satisfaction of the user.

Yet another angle of analysis in the study of culture and health is the identification of cultural differences in health behavior among subgroups of a community or country assumed to be culturally homogeneous. Such is the case of differences commonly found between "rural" and "urban" ways of life and ways of thinking in the same country. One of the numerous illustrations of this phenomenon is the study on preventive health education on AIDS in Thailand by Lyttleton (1993) that documented the urban–rural divide. The message of public preventive information campaigns designed in urban centers was not received as intended in rural villages. The concept of promiscuity that was at the center of the Thai AIDS prevention campaigns was associated by the villagers with the visiting of "commercial sex workers" only and not with the practice of "sleeping with several different village women" (1993: 143). The misperceptions of preventive public health campaigns occur between the rural, less educated, and dialect-speaking groups on the one hand, and the urban, educated civil servants and health professionals who design the campaigns, on the other hand. The misperception of the campaign message is not the only problem. An additional serious obstacle to reach the target rural population is the medium used to disseminate preventive health information. The Thai villagers perceived new technology including television broadcasts from Bangkok as "belonging to a different world – both physically and socioculturally" and, consequently, "increased exposure to these messages simply reinforces the [villagers'] perception that they are not locally pertinent" (Lyttleton 1993: 144).

## Culture and Illness Behavior

As mentioned earlier, illness behavior refers to the activity undertaken by a person who feels ill for the purpose of defining the illness and seeking a solution (Kasl and Cobb 1966). What people do when they begin to feel unwell, the manner in which people react to symptoms, and the meaning they attach to symptoms have been found to vary across cultures.

Reviewing the work of Edward Suchman (1964, 1965) on illness behavior and ethnicity, Geertsen and his colleagues (1975) concluded that there was indeed an association between the two phenomena. They found that "Group closeness and exclusivity increases the likelihood" of a person responding to a health problem "in a way that is consistent with his subcultural background" (1975: 232). Further detailed data on the correlation between ethnicity and illness behavior was reported by, among others, Robertson and Heagarty (1975); Kosa and Zola (1975); and by Sanborn and Katz (1977) who found significant

cultural variations in the perception of symptoms. In fact, the relative saturation of the literature regarding the ethnicity-illness behavior link was already manifested in Mechanic's observation in the late 1970s: "Cultures are so recognizably different that variations in illness behavior in different societies hardly need demonstration" (1978: 261).

Nevertheless, the number of studies documenting the association between culture and illness behavior has increased continuously. One of the most common research themes is mental illness, given that mental illness symptoms are primarily manifested through alterations in what is culturally defined as "normal" or "acceptable" social interaction. A prominent contributor to the study of culture and mental illness is Horacio Fabrega (1991, 1993, 1995). Summarizing the crux of current research in sociology and anthropology, Fabrega states that "empirical studies integral to and grounded in sound clinical and epidemiological research methods . . . have succeeded in making clear how cultural conventions affect manifestations of disorders, aspects of diagnosis, and responses to treatment" (1995: 380).

The reaction of others, particularly the family and people emotionally close to the symptomatic person, plays an important part in determining how the affected person reacts, that is, how he or she defines and handles symptoms. Such reaction varies across cultures. McKelvy, Sang, and Hoang (1997) found that, in contrast to Americans, "the Vietnamese traditional culture has a much more narrower definition of mental illness." They are more tolerant of behavioral disturbance triggered by distress. The Vietnamese define someone as mentally ill only if the person is "so disruptive" that he or she "threatens the social order or the safety of others"; even then, the family is the first source of care that may include "physical restraint." The person is taken to the hospital if the family is unable to control him or her (1997: 117).

Research conducted from the perspective of psychiatry tends to put a stronger emphasis on the importance of culture: the cultural definition of symptoms is seen as determining the disease outcome. Hahn and Kleinman (1983) proposed that beliefs in the etiology and prognosis of disease are as important to disease causation as microorganisms or chemical substances. Adler (1994) found this premise evident in the case of the sudden nocturnal death syndrome or SUNDS among the Hmong refugees in the United States. Adler explains "in the traditional Hmong worldview the functions of the mind and the body are not dichotomized and polarized" (1994: 26). Consequently, Adler identified a series of pathological circumstances leading to SUNDS. As refugees, the Hmong lost their traditional social support and were pressed to adapt to a different culture. The "severe and ongoing stress related to cultural disruption and national resettlement" as well as "the intense feelings of powerlessness regarding existence in the US," and their "belief system in which evil spirits have the power to kill men who do not fulfill their religious obligations" together led "the solitary Hmong male" to die of SUNDS (1994: 52).

Illness behavior typically involves a "wait-and-see" attitude as the first reaction to symptoms, followed by self-medication; if the problem is judged to have worsened, then the person might be prepared to seek expert advice. In this process, cultural patterns of behavior may be superseded by formal education.

In a comparative analysis of Chinese, Malays, and Indians, I found that education explains the practice of self-medication with modern over-the-counter medications better than culture. There was a significant difference among the three groups in the keeping of non-prescription and traditional medications at home. Yet, education served as an "equalizer" for self-medication with modern (i.e. western) medicines. The more educated a person is the more inclined he or she would be to practice self-medication with "modern" over-the-counter medicines before (or instead of) seeking expert advice, irrespective of his or her ethnic group (Quah 1985). A similar finding is reported by Miguel, Tallo, Manderson, and Lansong (1999) in the treatment of malaria in the Philippines.

## Culture and Sick-Role Behavior

To recapitulate what was discussed in the first section, *sick-role behavior* is the activity undertaken by a person who considers himself or herself ill for the purpose of getting well (based on Parsons 1951: 436–8). Sick-role behavior encompasses the sick person's response to symptoms, in particular, the seeking of what he or she perceives as "technically competent" help (to borrow Parsons' term), as well as doctor–patient or healer–patient interaction. Lyle Saunders (1954) was among the first sociologists to observe that cultural differences in medical care manifested in the problems encountered when the physician and the patient were from different ethnic groups.

One of the earliest and most significant investigations on the actual influence of culture on sick-role behavior was Mark Zborowski's (1952, 1969) analysis of cultural differences in responses to pain. Investigating differences among war veterans warded in an American hospital, he observed that the Italian-American and Jewish-American patients differed significantly from the "old American" and Irish-American patients in their expression of pain and description of their symptoms. Zborowski proposed that cultural differences such as socialization, time-orientation, and the array of values outlining what is appropriate behavior in cultural communities explained the differences he observed among the four groups of patients. Along the same line of investigation, Irving Zola (1966) pursued the analysis of how culture shapes the subjective perception of symptoms. His research confirmed the findings reported by Zborowski on the presence of cultural differences in perception of, and reaction to, symptoms and pain. Zola continued his probe into the impact of cultural differences on the doctor–patient relationship, the perception of illness and the importance given to health matters in different cultural communities (1973, 1983). Andrew Twaddle (1978) conducted an exploratory replication of Zborowski's study, comparing 26 American married males who classified themselves as "Italian Catholics," "Protestants," and "Jewish." Twaddle found that Parsons' configuration of "sick role" varied among these groups.

Recent studies continue to confirm the impact of culture on the doctor–patient relation and, correspondingly, on patient outcomes. Nitcher (1994) observed the use of the traditional term "mahina ang baga" (weak lungs) by doctors and lay persons in the Philippines. Nitcher found that doctors use the term when diagnosing tuberculosis in an effort to spare the patient the social stigma of the

disease. However, "weak lungs" is a very ambiguous term in everyday discourse, thus, the unintended consequence is a negative patient outcome. Nitcher states "the sensitivity of clinicians to [the] social stigma [of tuberculosis] is laudatory." But he correctly points out that "the use of the term *weak lungs* has [serious] consequences" for public health because the diagnosis "*weak lungs* is not deemed as serious as TB" and thus people, especially the poor, do not comply with the prescribed treatment which is a "six-month course of medication" (Nitcher 1994: 659).

A major direct implication of the concept of role is the symbolic, perceived or actual presence of others. Sick-role behavior implies the presence of the healing expert (irrespective of what healing system is at work). A large body of research into the doctor–patient relationship has produced interesting information confirming the relevance of culture. An expected finding is that cultural similarities, such as physical appearance and language, among other characteristics, between doctor (or healer) and patient facilitate the relationship and increase the possibility of positive patient outcomes (Kleinman 1980: 203–58; Cockerham 1998: 168–81). A note of caution: similarities in culture do not secure success in the doctor–patient relationship. Many other aspects come into play, from ecological factors (Catalano 1989) to the differential understanding of metaphors (Glennon 1999). The structural features of the healer–patient relationship, such as how is the interaction conducted and who is involved, also vary across cultures. Haug and her colleagues (1995) found interesting differences in the manner in which the doctor–patient interaction develops in Japan and the United States. Kleinman (1980: 250–310) shows that the relationship is not always a dyad as in some communities the patient's family is often directly involved. In some communities the quality of the interpersonal relationship built between patient and healer is paramount and may become as significant to the patient as "the technical quality" of the medical care received (Haddad, Fournier, Machouf, and Yatara 1998).

Recent publications have addressed the need of physicians and other health care personnel to be informed on the importance of cultural differences that may affect the doctor–patient interaction. Three of the latest works will suffice as illustrations. *The Cultural Context of Health, Illness and Medicine* by Martha O. Loustaunau and Elisa J. Sobo (1997) introduces the role of culture in an easy style devoid of conceptual arguments and thus suitable for health care practitioners who simply wish to improve their interaction with patients. Using a similar approach, the *Handbook of Diversity Issues in Health Psychology* edited by Pamela M. Kato and Traci Mann (1996) offers basic information for practitioners on the impact of ethnicity on health. The third example is Malcolm MacLachlan's (1997) book on *Culture and Health* that covers the analysis of culture in more detail and introduces some conceptual discussion. His book is also addressed to the medical profession but, compared to the other two, MacLachlan's is more suitable for health care practitioners interested in a social science analysis of culture and health. It is relevant to note that MacLachlan is a clinical psychologist but follows (albeit without citations) the sociological and anthropological conceptualization of ethnicity discussed earlier in this chapter:

that ethnicity encompasses a way of life and common origin as well as a consciousness of kind (1997: 3).

Following the same premise on the significance of the presence of others, another important aspect of sick-role behavior is the availability of an informal, social support network for the sick individual. The emotional, social, and instrumental support received from one's informal network of family and friends tend to guide the attitudes and actions of the ill person before, during, and after consulting experts. Just as cultural variations are observed among sick people searching for help from healing experts (whether traditional or modern), the seeking of emotional and social support and the presence and quality of informal social support from family and friends also vary across cultures. A recent example of studies supporting these assumptions is the study conducted by Kagawa-Singer, Wellisch, and Durvasula (1997). They compared Asian-American and Anglo-American women's situations after breast cancer diagnosis and found that the subjective meaning of the disease and the presence and use of family as the first source of social support varied between the two groups of patients.

## Culture and Healing Systems

The options available to people seeking health care vary greatly across countries and cultures. As Cockerham explains (1998: 128), even in a modern, developed country like the United States, people may not look at modern medicine as the only or right option. In the discussion of culture and health, reference must be made to the wide range of healing options found in most societies today. For the sake of clarity and expediency, it is useful to consider all healing options as falling into three general categories: the modern or *western biomedicine* system; *traditional* medicine systems; and *popular* medicine. A medical system is understood as "a patterned, interrelated body of values and deliberate practices governed by a single paradigm of the meaning, identification, prevention and treatment of . . . illness and/or disease" (Press 1980: 47). Traditional medical systems flourished well before western biomedicine and their history goes back more than one millennium. Three ancient healing traditions are considered to be the most important: the Arabic, Hindu, and Chinese healing traditions (Leslie 1976: 15–17). However, there is a revival of interest in cultural traditions today around the two best-known traditional medicine systems: traditional Chinese medicine (Unschuld 1985) and Hindu or Ayurvedic medicine (Basham 1976). Popular medicine refers to "those beliefs and practices which, though compatible with the underlying paradigm of a medical system, are materially or behaviorally divergent from official medical practice" (Press 1980: 48). Popular medicine is also labeled "alternative" medicine or therapies (Sharma 1990).

In contrast to the modest attention given by researchers to power and dominance in the traditional healing system, the intense concern with the preponderance and power of western biomedicine is evident in the work of Foucault (1973) and Goffman (1968a, 1968b), and has been documented and analyzed in detail by Freidson (1970), Starr (1982), and Conrad and Schneider (1992)

among others. These authors have referred to western biomedicine as practiced in western industrialized countries mainly in North America and western Europe. Interestingly, however, by the end of the twentieth century the predominance of western biomedicine is apparent in other countries as well (Quah 1995).

Healing systems are constantly evolving and two features of their internal dynamics are relevant here: divergence and pragmatic acculturation. Divergence in a healing system is the emergence of subgroups within the system supporting different interpretations of the system's core values. The comparative study of medical schools by Renée Fox (1976) serves as a good illustration of cultural divergence. She investigated the assumed resilience of six value-orientations (in Parsons' sense) at the core of western biomedicine: rationality, instrumental activism, universalism, individualism, and collectivism, all of which comprise the ethos of science and detached concern, a value she assigned specifically to western biomedicine practitioners. Fox observed that these values of biomedicine are subject to reinterpretations across cultures. She found "considerable variability in the form and in the degree to which they [the six value-orientations] are institutionalized" (Fox 1976: 104–6) even within the same country as illustrated by the situation in four major medical schools in Belgium in the 1960s representing basic cultural rifts: "Flemish" versus "French," and "Catholic" versus "Free Thought" perspectives.

A manifestation of pragmatic acculturation in a healing system is the inclination of its practitioners to borrow ideas or procedures from other systems to solve specific problems without necessarily accepting the core values or premises of the system or systems from which they do the borrowing. To illustrate: some traditional Chinese physicians use the stethoscope to listen to the patient's breathing, or the sphygmomanometer to measure blood pressure, or the autoclave to sterilize acupuncture needles, or a laser instrument instead of needles in acupuncture (see Quah and Li 1989; Quah 1989: 122–59). The study by Norheim and Fonnebo (1998) illustrates the practice of pragmatic acculturation among young western biomedicine practitioners in Norway who learned and practiced acupuncture. Norheim and Fonnebo reported that general practitioners were more inclined than specialists to use acupuncture with their patients, and that the majority of all 1,466 practitioners interviewed had "already undergone acupuncture or indicated that they would consider doing so" (1998: 522). Pragmatic acculturation has also facilitated the provision of western biomedical services to peoples from other cultures. Ledesma (1997) and Selzler (1996) studied the health values, health beliefs, and the health needs of Native Americans. These researchers stressed the importance of taking the cultures of Native Americans into consideration for the provision of relevant western biomedical services to their communities. Adapting the type and mode of delivery of modern health care services to serve the needs of traditional peoples is not a new preoccupation but it is now receiving more serious attention from health care providers. In today's parlance the process is called making the medical services more "user-friendly." Although pragmatic acculturation requires the western biomedicine practitioners to change or adapt their usual practices and assump-

tions, it is deemed worthwhile if it attains the objective of delivering health care to communities in need.

The presence and relative success of groups and institutions (for example, the medical profession, hospitals, and other health care organizations) involved in the provision of health care unfold in the context of culture. Arthur Kleinman (1980) highlights the relevance of the "social space" occupied by health systems. He identified significant differences among ethnic communities and the subsequent impact of cultural perceptions of mental illness upon the structure of mental health services. The influence of culture on the provision of mental health services has been studied widely. In the recent investigation on mental health in Vietnam by McKelvy, Sang, and Hoang (1997), cited earlier, they found that "There is no profession specifically dedicated to hearing the woes of others. Talk therapy is quite alien to the Vietnamese" (1997: 117). The Vietnamese's traditional perception of child behavior and their "narrow" definition of mental illness help to explain their skepticism on the need for child psychiatric clinics.

## The Pervasiveness of Culture

The conclusion of this chapter is that culture has, does, and will continue to influence health-related behavior. There is a wealth of social science and, in particular, medical sociology research demonstrating the pervasiveness of cultural values and norms upon preventive health behavior, illness behavior, and sick-role behavior among individuals and groups as well as at the macro-level of healing systems.

The preceding discussion has highlighted three additional features of the study of culture in health and illness. The first of these features is the remarkable confluence of different and even opposite schools of thought in sociology concerning the need to analyze culture as an independent phenomenon, and the influence of culture upon agency and structure. The affective nature and subjectivity of one's perceived identity as member of an ethnic group and the permeability of cultural boundaries, are ideas found implicitly or explicitly in Durkheim, Weber, Parsons, as well as Goffman, Foucault, and Habermas, among others. The second feature is the divergence of healing systems. Healing systems are not always internally consistent; different interpretations of the core values or principles of the system may be held by subgroups within the system. The third feature is pragmatic acculturation, that is, the borrowing from other cultures of elements, ways of thinking and ways of doing things, with the objective of solving specific or practical problems. This borrowing is very prevalent and is found in all types of health-related behavior.

Finally, a comprehensive review of the relevant literature is not possible in this chapter given the enormous body of medical sociology research on health and culture. Instead, illustrations and the list of references are offered for each main argument in this discussion in the hope that the reader be enticed to pursue his or her own journey into this engaging research topic.

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