CHAPTER 1

Culture and health

Multiculturalism is the only way in which the whole of humanity can be greater than the sum of its parts. If we are to avoid being churned in a monocultural ‘melting pot’ this requires us all to acknowledge, tolerate and work with different interpretations of some of the things that we hold most precious. One of these things is health. The interplay between culture and health is truly complex and invites consideration of a kaleidoscope of causes, experiences, expressions and treatments for a plethora of human ailments. However, while cultural variations are intuitively intriguing and inviting to focus in on, especially in relation to health, they can also veil equally fundamental economic, political and social differences between peoples.

This book explores the complexity of human experiences of health and illness across cultures. The complexity includes the broader social context in which minority and majority groups operate. We must resist empirically stereotyping people as though they were ‘cultural dopes’ whose behaviour will conform to an abstracted ‘cultural type’. Individuals must not be relegated to simple conduits of culture, but recognised as active sifters of the ideas presented to them through their family, community and social context, as well as their broader culture. Already we have taken as implicit some assumptions and definitions such as the meaning of the terms ‘culture’ and ‘health’. However, before proceeding to define these I want to make clear the perspective taken in this book, and how it differs from other books by seeking to integrate the contributions of the various social health sciences to understanding the interplay of culture and health.

The social health sciences and culture

Within the social health sciences of sociology, anthropology and psychology the importance of cultural differences is treated in quite different ways. Although my background is in psychology, much of my thinking in this area is influenced by ideas from related disciplines. However, differences in how these disciplines make sense of and incorporate ‘culture’ into their understanding of health can be confusing and somewhat disorienting. Although I argue for the synthesis of these differences it is nevertheless also important to understand their distinctions. We shall therefore consider each of these ‘treatments’ of culture in turn. Table 1.1 gives several definitions of each of these
Table 1.1 Some definitions of medical sociology, medical anthropology and health psychology.

**Definitions of medical sociology**
Explores ‘. . . how diseases could be differently understood, treated and experienced by demonstrating how disease is produced out of social organisation rather than, nature, biology or individual lifestyle choices’.
White (2002, p. 4)
‘The study of health care as it is institutionalised in a society and of health, or illness and its relationship to social factors’.
Ruderman (1981, p. 927)
‘. . . is concerned with the social causes and consequences of health and illness’.
Cockerham (2001, p. 1)

**Definitions of medical anthropology**
‘. . . how people in different cultures and social groups explain the cause of ill-health, the type of treatments they believe in, and to whom they turn if they do become ill . . .’
Helman (2000, p. 1)
‘. . . the cultural construction of illness, illness experience, the body, and medical knowledge . . .’
Lindenbaum and Lock (1993, p. xi)
‘A biocultural discipline concerned with both the biological and sociocultural aspects of human behaviour, and particularly with the ways in which the two interact throughout human history to influence health and disease’
Foster and Anderson (1978, pp. 2–3)

**Definitions of health psychology**
‘. . . devoted to understanding psychological influences on how people stay healthy, why they become ill, and how they respond when they do get ill’.
Taylor (2003, p. 3)
‘Health psychology emphasizes the role of psychological factors in the cause, progression and consequences of health and illness. The aims of health psychology can be divided into (1) understanding, explaining, developing and testing theory and (2) putting this theory into practice’.
Ogden (2000, p. 6)
‘. . . the aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of the etiological and diagnostic correlates of health, illness and related dysfunctions’.
Matarazzo (1980, p. 815)

disciplines, and it is apparent that there are significant differences between them, but also that definitions within disciplines vary. Different people interpret their own disciplines in different ways.

**Medical sociology**

Lupton (2003) distinguishes between three approaches within medical sociology:
1. **Functionalism** sees illness as a potential state of social deviance, e.g. a person adopting the ‘sick role’ relies on others rather than being independent of them. According to this view, the medical profession, as an institution of social control, serves to distinguish between normality and deviance.

2. The **political economy** approach, on the other hand, emphasises how socioeconomic context shapes health, disease and treatment. Here health is seen not only as a state of well-being, but also as having access to the basic resources required to promote health.

3. The third approach, and the most influential in contemporary medical sociology, is **social constructionism**, which understands medical knowledge and medical practice to be socially constructed, as opposed to being an independent and scientific body of knowledge.

Medical sociology’s interests are in the structural organisation of health services in society, and how they relate to other social structures and how these contribute to or detract from health (Goldie, 1995).

The tradition within medical sociology has, however, been to focus on social structures in western societies (primarily Europe and North America – Matcha, 2000). Although, in principle, the social structure of any cultural group may be of interest to medical sociologists, it is primarily its structural component, rather than its cultural component, that is of concern here. However, another way of construing what medical sociology is about is that it is interested in the culture of healthcare within a society.

**Medical anthropology**

McElroy (1996) has identified three perspectives within medical anthropology:

1. **Ethnomedicine** is concerned with cultural systems of healing and the cognitive parameters of illness. The variety of meaningful constructions across cultures can be seen to challenge the reductionist epidemiology of biomedicine (Kleinman, 1980).

2. The **medical ecology** perspective is concerned more explicitly with the interaction of biological conditions and cultural contexts. It thus considers the interrelationships of ecological systems, human evolution, health and illness, where health may be seen as a measure of environmental adaptation. Medical anthropologists’ interest in nutrition and cultural rules about what can and cannot be eaten fit well within this framework.

3. **Applied medical anthropology** seeks directly to affect people’s health by taking account of their cultural beliefs. An example given by Helman (2000) is increasing the acceptability of oral rehydration therapy for diarrhoeal diseases by first understanding cultural reasons for it being rejected. As such, applied medical anthropology is directly concerned with intervention, prevention and health policy.
Medical anthropology is a biocultural discipline, which puts greater emphasis on understanding the meaning of events than on objectively trying to measure them. With its use of qualitative methods, medical anthropology seeks to provide an ‘insider perspective’ (Skultans & Cox, 2000), to understand the relationships between health and illness through the cultural lens of the people whom it studies. It also seeks to look beyond the ethnocentric nature of modern western biomedicine.

**Health psychology**

Health psychology is concerned with how an individual’s personal characteristics and beliefs contribute to their personal health and illness experiences. How the beliefs of different cultures contribute to these individual beliefs and characteristics is of special interest to cultural health psychologists, who explore how psychological determinants of health vary in different cultural contexts. Health psychology takes a biopsychosocial approach to health and has positioned itself at the intersection between biological and social factors in health and illness (Kazarian & Evans, 2001). However, most theories in health psychology have been derived from mainstream psychology and have therefore adopted psychology’s assumptions, methods and problems somewhat uncritically (Marks, 1996). This approach can therefore have an individualistic bias and broadly reflects western values. Furthermore, although health psychology claims to reject the biomedical approach, in clinical practice it rarely departs from traditional medical agendas (Marks, 1996). There have, however, been attempts to overcome these limitations by, for example, integrating health psychology and cultural psychology (Kazarian & Evans, 2001). The advent of a critical health psychology has also recently challenged and sought to depart from the limitations of health psychology, and has been argued as central to an emerging cultural health psychology (MacLachlan, 2004).

Cultural psychology is concerned with the cultural environment of individuals (Marsella, Thorp & Ciborowski, 1979) and how they interact with it as individuals. As we noted, cultural health psychology recognises that people are not simply empty vessels with ‘thinking spaces’ filled by the flows of their culture, but rather people reflect on and make their own interpretations of cultural understandings and these are influenced by individual differences in, among other things, emotion and cognition. Health psychology is particularly concerned to measure these variables in as valid and reliable a way as possible.

**Integrating social health sciences**

To some extent the three social sciences outlined above have each responded to limitations inherent in the biomedical model, including neglecting the socioenvironmental context of health and illness, treating patients as passive objects, denying them their own interpretations of their experiences, and being intolerant of competing or pluralistic explanations and of alternative
forms of healing (Nettleton, 1995). Conrad (1997) talks of ‘parallel play’ in the way that the disciplines of anthropology and sociology continue side by side without interacting with each other, and the same can be said for psychology. Figure 1.1 schematically represents the interrelationship of these three health social sciences, which all have a legitimate claim to contribute to understanding health in a broader cultural context.

Health psychology focuses on the smallest unit in society, the individual, and how the individual’s life experience and characteristics influence health. This experience is seen as central to, but not independent of, structural and cultural factors. Medical sociology provides a wider, societal frame of reference, one that addresses why certain groups are more vulnerable and less well treated than others in a given social system. As a result of medical sociology’s interest in the structure and inequalities of a society’s health system, I have represented this as a ‘vertical’ oval, which indicates that a particular health culture may be stratified at different levels. Medical anthropology’s perspective allows for comparison of the cultural systems that construct differing social and health systems, and I have therefore represented this as a ‘horizontal’ oval, looking across societies. Although some might question the centrality that I, a psychologist, have given to psychology, I feel that it is justified on the grounds that, whatever one’s structural or cultural context, individuals operate according to their own health psychology. In fact, to put it more emphatically – everybody is entitled to their own health psychology!

Culture forms the implicit backdrop to many of the variables studied in psychology, sociology and anthropology, and requires that our understanding of them be presented in a ‘joined-up’ fashion. In order for us to be able to provide any given individual from whatever cultural background with the optimal care, we have not only to appreciate this backdrop but also to embrace
it in the most conducive manner – from the perspective of the person seeking healthcare.

**Culture, race and ethnicity**

Paddy: ‘Good morning Mick.’
Mick: ‘Good morning Paddy.’
Paddy: ‘Ah, but it’s a great day for the race!’
Mick: ‘And what race would that be?’
Paddy: ‘Why the human race, of course!’

Ahdieh and Hahn (1996) reviewed the way in which the terms ‘race’, ‘ethnicity’ and ‘national origin’ have been used over a 10-year period in articles published in the influential *American Journal of Public Health*. Their motivation for doing this was to determine the extent to which authors were complying with an objective set by the US public health service, for researchers explicitly to refer to racial or ethnic differences in health status. They found that researchers used such categories in their samples, either specifically (e.g. ‘black’, ‘Chinese’ or ‘Hispanic’) or more generically (e.g. ‘race’ or ‘ethnicity’), only in half of the studies; in less than 1% of all the studies were ‘race’ and ‘ethnicity’ examined independently. Furthermore, less than 10% of those studies that did use terms relating to race, ethnicity or national origin explicitly defined what they meant by the term. Often the terms were used in combinations or interchangeably. It is also interesting to note that in those articles that did describe their samples using these terms, most did so only to control for their possible ‘confounding’ effects. Less than 10% of all the articles treated these categories as potential risk factors in themselves. Ahdieh and Hahn concluded that there was little consensus in the scientific community regarding the meaning or use of terms such as race, ethnicity or national origin.

The idea of different human ‘races’ is something that many people are uncomfortable with. This is probably because it is seen as suggesting that differences between human beings can be reduced to tiny biological variations in nucleic acid. Furthermore, these genetic differences are understood to determine human behaviour in a relatively immutable fashion. It is assumed that, if genetic differences exist, they must influence behaviour. These possible differences are at their most controversial when they are used to explain variations in antisocial behaviour, intelligence or health, between members of different cultural groups, i.e. when cultural differences are explained as resulting from different genetic constitutions. There seems to be an irresistible drive towards evaluating any possible differences in terms of them being ‘good’ or ‘bad’.

The term ‘ethnicity’ is often used to remove the pejorative use of ‘race’ and in recognition that different ‘races’ may share a similar culture. Thus, members of an ethnic group are seen as sharing a common origin and important aspects of their way of living. The word ‘ethnicity’ is derived from the
Greek *ethnos*, meaning nation. Essentially, it refers to a psychological sense of belonging that will often be cemented by similar physical appearance or social similarities. This sense of belonging to a group can either stigmatise individual members or empower them through consciousness raising. Black consciousness in some countries can be seen as an attempt to empower members of a stigmatised minority group. Although it is tempting to gloss over the sensitive issue of race, its association with heredity makes it especially important to consider in relation to health.

Rushton (1995, p. 40) suggests that, in zoological terms, a race refers to a ‘geographic variety or subdivision of a species characterised by a more or less distinct combination of traits . . . that are heritable’. He argues that differences in body shape, hair, facial features and genetics distinguish three major human races: Mongoloid, Caucasoid and Negroid. He further suggests that modern humans evolved in Africa some time after 200,000 years ago, with an African/non-African split occurring about 110,000 years ago and the Caucasoid split occurring about 41,000 years ago. Rushton suggests that the different evolutionary pressures produced by different geographical environments resulted in genetic differences across a number of traits. Through genetic drift, natural selection and mutation, particular characteristics were selected for in certain environments but not in others (e.g. white skin, large nostrils) and, as they gave individuals some advantage over those who did not have these characteristics, such characteristics later predominated in relatively geographically isolated gene pools. Thus, populations in diverse geographical areas came to differ in their physical appearance.

Variation in gene frequencies may affect health in very specific ways, e.g. bone marrow transplantations are used in the treatment of leukaemia and other haematological illnesses. National registers of potential bone marrow donors in Britain and North America consist primarily of, so-called, ‘Caucasian’ donors. Similar to blood, bone marrow comes in different types – human leukocyte antigen (HLA) types – that appear to be genetically determined. Only roughly a third of potential recipients of a bone marrow transplant find a good match among their relatives, the rest being dependent on unrelated donors who are identified through large-scale registries. Within the British and American registries the chances of finding a match for ‘non-Caucasian’ patients are considerably lower than they are for ‘Caucasian’ patients. Consequently, it has been argued that different ethnic groups should establish their own registries in order to improve the success rate for finding a matching donor (Asano, 1994; Liang et al., 1994).

There are of course numerous such links between genetic constitution and health. Another example is research suggesting that genetics may be relevant to the prevalence of seasonal affective disorder (SAD), which is usually taken to refer to the higher incidence of depression during winter months. It has been reported that descendants of Icelanders living in the Northern Territories of Canada have a lower incidence of SAD than descendants of either the indigenous population or other settlers. In seeking to explain this finding Magnusson and Axelsson (1993) have suggested that, in extreme
northern latitudes, such as Iceland, the propensity not to get depressed during the dark winter months may have been positively selected for through reproduction. Therefore the indigenous Icelandic population would have evolved with a lower incidence of SAD in northern latitudes. Further south, in Canada, descendants of these Icelanders would therefore be less susceptible to SAD than the indigenous population or settlers whose ancestors originated from lower latitudes.

This is a particularly interesting argument for us because it concerns genetic variation within a particular ‘racial’ group – being ‘Caucasians’. It also suggests that genetic variations are not synonymous with the traditional anthropological distinctions of Caucasoids, Negroids and Mongoloids. In other words, genetic variability is not a distinguishing feature of this classification. Furthermore, Haviland (1983) has also argued that genetic variation appears to be continuous rather than discontinuous. By this is meant that, although people from different parts of the world may differ in physical appearance, no one group differs to the extent that different gene frequencies are found. Instead there appears to be a continuum of phenotypic expression, with different ‘racial’ groups found at different points along a continuum. Thus bodily shape does not change abruptly as we move across the globe, but gradually with neighbouring peoples resembling each other.

The idea of a continuum must not, however, blind us to important health-related differences that do exist between people from different parts of the world. For example, why is it that diabetes is much more prevalent, and colorectal cancer much less prevalent, among Indian immigrants to Britain than it is among the British population as a whole (Bhopal, 2004)? Answers to such questions may provide vital insights into understanding such diseases. However, although the term ‘race’ offers an important perspective on health problems because it derives from genetics, it is increasingly important to recognise the existence of ‘mixed race’ and people’s increasing inclination to describe themselves as ‘other’, under the ‘race’ category in many surveys. People may use a broad range of factors in defining whom they are and what they identify with, including ancestry, geographical origin, birthplace, language, religion, migration history, name, the way they look, etc. Bhopal (2004) suggests that a variety of forces will stimulate increasing interest in the issues of culture, ethnicity and race, including the new genetics, a focus on healthcare inequalities, globalisation, migration and increased movement of refugees and asylum seekers – all issues addressed in this book.

Interestingly, while concluding that there is no convincing biological or scientific basis for the actual existence of ‘races’ LaVeist (2002a, p. 120) states: ‘even though race may be a biological fiction, it is nevertheless ... a profoundly important determinant of health status and health care quality’. By this is meant people discriminate as if there were race-based differences between people and, in doing so, they create actual differences. Thus whether or not you are impressed by evidence for biological difference implying the existence of ‘race’, the idea of race is a reality that we need to take account of in healthcare.
Ultimately, the way in which people conceptualise the relationship between ‘race’ and health is important because it affects their ideas about health policy. If, for instance, they adopt a ‘biological determinist’ viewpoint they may believe that there are relatively few interventions that will reduce race-related health differentials. On the other hand, a strongly behavioural perspective might suggest that interventions focus only on modifying an individual’s health-related behaviours. Alternatively, understanding at a purely societal level might suggest that appropriate interventions should all be beyond the engagement of individuals (LaVeist, 2002b).

Folk taxonomies

Physical differences can be observed in people from diverse geographical areas and these differences may have adaptive value. In the tropical regions of Africa and South America populations developed dark skins (densely pigmented with melanin which blocks sunlight), presumably as protection against the sun, whereas populations in the colder areas, such as northern Europe, which are dark for long periods of time and where people cover their skin for warmth, developed lighter skins (less densely pigmented with melanin), presumably because they did not require the same degree of protection from sunlight. Fish (1995) argues that in some ‘folk taxonomies’ (local ways in which people classify things) light versus dark skin is considered a racial difference. However, Fish also emphasises that other physical features that we associate with ‘whiteness’ or ‘blackness’ do not necessarily coincide with a black versus white distinction. He writes (1995, pp. 44–5):

There are people, for example, with tight curly blond hair, light skin, blue eyes, broad noses, and thick lips – whose existence is problematic for our racial assumptions.

Ironically the white versus black distinction is not seen as reliable enough to distinguish between people of different ‘race’, because each ‘race’ has a huge (and overlapping) spectrum of skin colours.

‘Inter-racial’ marriage further increases the overlap between the skin colour of ‘blacks’ and ‘whites’ (or ‘browns’ and ‘pinks’!) and so, to overcome this problem, in North America ‘race’ has been administratively defined according to the ‘one-drop rule’. If you are an offspring of one black and one white parent then you are black; in fact, if you have ‘one drop’ of ‘black blood’ in you, you are black, even if your skin is white! This identification of ‘race’ with blood is not a universal assumption. Different societies construct different definitions of ‘race’. For example, in Brazil racial categorisation draws equally on skin colour and hair form, but may also be influenced by an individual’s wealth and profession. This means that a person can have a different racial identity, not only from his siblings, but also from either of his parents too.
‘Black’ versus ‘white’ is simply one way of describing the variation observed between people. ‘Tall’ versus ‘short’ could be another, with accompanying ‘secondary’ physical and psychological features. Indeed research has found that there are certain erroneous psychological traits associated with tallness (e.g. the impression of intelligence), just as there may be with skin colour. Thus people from different parts of the world differ in certain physical features and they also differ in how they explain this variation in human features. The construction of ‘racial’ differences in one culture can be quite different to its construction in another culture. Indeed in some countries people may now choose their ‘race’.

Whether there is one human race or several does not seem to be a crucial issue for health. What is important is whether there are some groups of people whose genetic make-up disadvantages them in terms of health. Such disadvantage will always express itself alongside skin colour, eye colour, hair type, height, etc. What we should be interested in is whether there are links between disadvantageous genes and the location of any individuals or groups on the many continua of human genetic variation. Such links, through the provision of physical markers for disadvantageous genes, can be meaningful and useful if they lead to health-enhancing interventions. Sometimes such links may coincide with skin colour and at others they may coincide with other characteristics. However, this book is based on the premise that the great majority of variation in human health is not related to genetic variation as such, but to the different ways in which people exist in the world, i.e. to their culture.

**Social variations**

We have reviewed one aspect of our adaptation to different environments in the form of the different physical characteristics that humanity exhibits; another aspect of this variation is the plethora of social characteristics to be found among us. Social variations exist because hunter–gatherers in the Kalahari Desert and car production workers in Tokyo need to organise themselves in different ways in order to get the best out of their respective ecological niches. Given that human beings inhabit many different environments and that human characteristics vary along a multitude of continua, it is not surprising that our social features as well as our physical features should differ around the world. The way in which we organise ourselves socially also has a form of heredity – a means through which such organisation is passed on from one generation to the next.

Harris (1980, p. ix) suggests that cultural materialism is ‘based on the simple premise that human social life is a response to the practical problems of earthly existence’. Harris draws on Marx’s idea that the means of production found in a society will determine its functioning, or culture. Thus different geographical locations will require different social orders (cultures) for optimal functioning. Social orders are passed on from one
generation to the next through a variety of mechanisms including traditions. Over the years people have organised themselves in certain ways in order to get the most out of their environment.

Historically society has presented successive generations with similar problems. Social structures, from one generation to the next, have often adopted similar solutions to the ‘timeless’ problems of survival, e.g. food, shelter and reproduction. It is easy to forget this in our modern ever-changing world, where many of us cannot keep up with the rush of innovative technologies that sweeps us along unknown paths. In the past a social culture could provide solutions to the problems of living, over many generations. Today the demands to adapt to a rapidly changing society can themselves constitute an acculturation experience (see later and see Chapter 4).

**Culture as communication**

So what about the term ‘culture’? The term has been so widely used that its precise meaning will vary from one situation to another. In 1952 Kluckhohn and Kroeber reviewed 150 different definitions of ‘culture’ and the passage of time has not witnessed much consensus. Some academics have tried to put the plethora of definitions into conceptual categories. Allen (1992), for instance, distinguishes seven different ways in which the word ‘culture’ can be used:

1. Generic: referring to the whole range of learned as opposed to instinctive behaviour.
2. Expressive: essentially artistic expression.
3. Hierarchical: through which the superiority of one group over another is suggested in contrast to ‘cultural relativism’.
4. Superorganic: analytically abstracting meaning concerning the context of everyday behaviour rather than the minutiae of the behaviour.
5. Holistic: recognising the interconnectedness of different aspects of life such as economics, religion and gender.
6. Pluralistic: highlighting the coexistence of multiple cultures in the same setting.
7. Hegemonic: emphasising the relationship between cultural groups and power distribution.

Even this attempted simplification of ‘culture’ produces a rather complex matrix of overlapping concepts.

Here we emphasise a pragmatic role of culture, one that is especially pertinent to health. A culture presents us with a set of guidelines – a formula – for living in the world. Just as a biologist may need a particular ‘culture’ to allow the growth of a particular organism, social cultures nurture the growth of people with particular beliefs, values, habits, etc. But, above all, culture provides a means of communication with those around us. Different styles of
communication reflect the customary habits of people from different cultures. In each case, however, the culture is the medium through which communication takes place. A culture that prohibits communication has no way of passing on its ‘shared customs’.

At the most obvious level it may be the custom for a language to be spoken in one place but not in another. A gesture may mean one thing in Britain and quite another thing in Greece. An amusing example of this is the raised thumb used as a symbol of approval in Britain, but as an insult in Greece, where it is taken to mean ‘sit on this!’ Even in the same country gestures can be taken to have different meanings. In France, the ring sign created by bending and touching the tips of the thumb and index finger is interpreted to mean ‘OK’ in some regions and ‘zero’ in others (Collett, 1982). In a similar way a form of art may convey a particular message to one group of people and be apparently incomprehensible to others. Whether it is words, gestures, music, painting, work habits or whatever, a culture creates a certain way of communicating ideas between people. Culture then is the medium that people use for communication; it is the lubricant of social relationships.

Communication varies in many contexts. The form of communication may be quite different depending on whether you are at home or at work, with people of the same gender as yourself, whether they are elders or children, of the same class or caste, etc. We are each members of many cultures, or subcultures, as they are sometimes called. There are subcultures of region, religion, gender, generation, work, income and class, to name but a few of the obvious.

It is the amalgam of these ‘memberships’ that constitutes the (often differing) experiences of one’s self. This allows us to know ourselves in different ways. Different cultures require us to ‘show’ different aspects of our selves. Different cultures, because they allow different forms of communication, allow us to relate to others in different ways and to be related to in different ways. Thus, experiencing a new culture can often allow one to experience a new aspect of oneself. Generally we have most in common with people who share the same culture(s) and we find communication easiest (but not necessarily ‘best’) with them, i.e. we share a customary way of relating to each other.

Sometimes the language used to relate to each other has great symbolic significance, as well as being the means of communication, e.g. the language of South Africa’s Apartheid was Afrikaans, the language of the Boer oppressors. It was Afrikaans that sparked the 1976 Soweto riots which left 500 dead, when the then Nationalist Party government sought to make it the medium of black education throughout the townships. As Roup (2004) poignantly says ‘the language of the oppressor in the mouth of the oppressed is the language of the slave’ (p. 2). Of course many languages ‘have blood on their vowels’ (p. 1) and for most of them that blood has long since dried and stained their speaker’s constructions of their own identity. No doubt this is also true in South Africa, where today they aspire to every child having the right to be educated in his or her ‘mother’ tongue, including – quite correctly – Afrikaans.
Not only is culture a ‘voice’ through which we can communicate, it is also the eyes and ears through which we receive communications. As such, customary forms of communication often ‘frame’ what we expect to see and hear, e.g. in one cultural context we expect to see a woman in a short white dress and people applauding (at the Wimbledon tennis championships), whereas in another cultural context we expect to see a woman in a long black dress and people crying and wailing (at a Greek funeral procession). As smell and touch are also forms of sensing the world, they too are part of the machinery of culture.

Our senses are the instruments through which we receive and exhibit our own and other people’s cultures. What gets into us and what we give out (either knowingly or unknowingly) are the elements, or building blocks, of culture. When we ‘just don’t get it’, no wonder things seem senseless – they are! Once the involvement of our biological sense organs is recognised as part of the process of culture, the psychological and physiological implications of culture become not only more apparent but also more credible.

**Ways of thinking about culture**

There are a great number of different ways of thinking about culture and thus far I have primarily emphasised its identity function, achieved through the means of communication. However, it is also useful to consider different ways in which ‘culture’ can affect people, in terms of both their apparent health and their broader sense of empowerment. In the following I discuss taxonomy that is intended to be neither comprehensive nor mutually exclusive, but that can nevertheless heighten awareness of the influence of culture on health (for a fuller description, see MacLachlan, 2004).

**Cultural colonialism**

In the nineteenth-century heyday of multiple European colonial powers (e.g. Britain, France, Belgium, Portugal, Holland, Italy), Europeans sought to ‘farm’ South America, Africa and Asia for the benefit of the European ruling classes. An important aspect of this venture was not only to understand ‘the mind of the savage’, but also to make sure that ‘he’ was healthy enough to be productive. Dubow (1995) suggests that, through the colonial research agenda, Africans became the ‘objects’ of three distinct ‘scientific’ projects: accumulating scientific knowledge of ‘primitive minds’; Africa as a laboratory for the discovery of psychological universals; and the design of psychometric devices for the selection and training of African workers. These endeavours were exploitive and their primary relevance was to the academic, government and industrial communities of the time, and not to Africans (Nsamenang & Dawes, 1998). The *dramatic exotica* (Simons,
1985) of so-called ‘culture bound syndromes’, so often ‘typical’ of the colonies (see Chapter 3), although seemingly bizarre, do in fact usually have a meaningful order and perform a valuable social function within their cultural context. The idea of anthropology being the ‘hand maiden’ of colonialism is controversial (Asad, 1973), but persists and highlights the continuing sensitive issue of what function our understanding of cultural differences might serve.

**Cultural sensitivity**

This approach to healthcare is typical of the situation where ethnic minorities have particular requirements within a health system. These minority groups may be migrants or indigenous peoples whose culture has existed only on the periphery of mainstream society. The emphasis in this approach is to provide minorities with the same sort of health service as mainstream society, but to take into account the cultural ‘peculiarities’ of the minority groups. The best of intentions may, however, become problematic if, in an attempt to help identify service needs, for example, an ethnic minority group is surveyed for mental health problems and they are shown to have a high need for services, not because of inherent mental health problems but because of the cultural insensitivity of the instrument. An example of how this might come about is in the consideration of the criteria of the *Diagnostic and Statistical Manual, 4th edition* (DSM-IV) for personality disorder. There are behaviours that are characteristic of certain ethnic groups that increase the likelihood of such a diagnosis, in the absence of mental health problems (Alarcon & Foulks, 1995; see Chapter 4). Ultimately cultural sensitivity has to be more about an approach to human problems that is accepting of alternative causal models, than it is about modifying a mainstream theory or ethos to take account of cultural peculiarities.

**Cultural migration**

The focus here is on people who have left their own country either as temporary sojourners or permanent migrants, or sometimes as forced (involuntary) migrants or refugees. A major concern is how the stresses and strains of the adjustment to individual culture are dealt with and to what extent they create acculturative stress and associated problems: loss of familiar social networks and roles, communication difficulties, different attitudes regarding the relative status of older and younger people, vocational changes and changes in religious practices. Although it is important to consider the migration experience in terms of cultural change, it is also important to ground this in terms of a possibly more significant change in political, economic and social context (see Chapters 5).
**Cultural alternativism**

Kleinman (1980) identifies three overlapping sectors in healthcare: the popular, professional and folk sectors. If one adds the ‘New Age’ therapies to the ‘traditional healers’ of the folk sector, there is a plethora of approaches to healing that are attracting ever-increasing numbers of followers (Furnham & Vincent, 2001). Although many of these approaches may be beneficial in their own right, it may also be that they are attractive to people because they offer a different ‘culture’ of healthcare – perhaps one that stresses less the curing of disease and the control of symptoms, and more a caring concern with life domains beyond the physical domain, and viewing disease as symptomatic of underlying systemic problems (Gray, 1998). Furnham and Vincent (2001) suggest that a centrally attractive – and probably therapeutic in itself – feature of complementary medicine is the consultation process (see Chapter 6). In short, conventional medicine seems increasingly to focus on the clinician finding technical outcomes that will create better health, whereas alternative practitioners are more aware of the process of healing and use this to facilitate better health. While recognising that not all alternative therapies are complementary (e.g. St John’s wort and some antidepressants are antagonistic), I use the term ‘cultural alternativism’ in the sense that those not choosing to stick solely with conventional healthcare are entering into an ethos of ‘pick and mix’, which offers many alternatives to orthodoxy, some of which may be complementary.

**Cultural empowerment**

In many historical and contemporary conflict situations ‘the conquered’ are often re-oriented to consider the world from the perspective of those who conquered them. This re-orientation effectively strips people of the value of their own culture. Even after the ‘independence’ of many former colonies, which had been culturally denuded of their traditional practices and customs, there remained a diminished sense of cultural worth. It was not, after all, so much that the colonials were giving up control, more that they were giving up residence, often maintaining strong economic and political influence. Recently indigenous psychologies have sought to give credence to more traditional and localised ways of understanding people, as an equally legitimate alternative to European and North American ‘mainstream’ psychology (Holdstock, 2000). Thus, reconnecting individuals with their cultural heritage may not only provide a medium for intervention, but also regenerate a collective sense of value and meaning in the world (see Chapter 6).

**Cultural globalisation**

Just when you thought we were finished with colonialism, it is back again! Giddens (1999, p. 4) describes how:
Globalisation is restructuring the way in which we live, and in a very profound manner. It is led from the West, bears the strong imprint of American political and economic power, and is highly uneven in its consequences.

Although there are many facets to globalisation (technological, cultural, political, economic), some of which can be quite positive, there are also many victims, especially of economic globalisation.

One of the most disturbing hallmarks of this globalisation is the huge inequities with which it is associated, e.g. the three wealthiest people in the world (Bill Gates, Warren Buffet and Sultan Hassanal Bolkiah, with a combined wealth of US$117 billion) are a few million ahead of the combined gross national product (GNP) of the world’s 45 poorest countries, the population of which is close to 300 million (Hopkin, 2002). In 1997 the UN Development Report stated that, in Africa alone, the money spent on annual debt repayments could be used to save the lives of about 21 million children by the year 2000 – that did not happen. Indeed it has been argued by many that debt is now the new colonialism (see, for example, George, 1988; Somers, 1996). ‘Third world’ debt and globalisation are different branches of the same tree. Many ‘third world’ countries that have had to cut back spending on health and social welfare to liberalise their markets and invest in cash crop production – all in order to compete on the global market and to meet the requirements for structural adjustment loans (SALs) from the World Bank – the living conditions of the poorest deteriorate, and so does their health, unsurprisingly (see Chapter 9 and Marks, 2004).

Cultural evolution

Cultural evolution refers to the situation where values, attitudes and customs change within the same social system, over time. Thus different historical epochs, although being characteristic of the same ‘national’ culture (e.g. Victorian England compared with contemporary England), actually constitute very different social environments – cultures. Peltzer (1995, 2002), working in the African context, has described people who live primarily traditional lives, those who live primarily modern lives, and those who are caught between the two – transitional people. However, these ‘transitional’ people can be found throughout the world, including in its most ‘advanced’ industrial societies.

Inglehart and Baker (2000) examined three waves of the World Values Survey (1981–82, 1990–91 and 1995–98), encompassing 65 societies on 6 continents. Their results provide strong support for both massive cultural change and the persistence of distinctive traditional values with different world views. Rather than converging, many cultures are moving on parallel trajectories shaped by their cultural heritages. We doubt that the forces of modernisation will produce a homogenised world culture in the foreseeable
future’ (Inglehart & Baker, 2000, p. 49). Use of the term ‘cultural evolution’
does not necessarily imply attributes of biological evolution in the sense that
the fittest for the changing environmental niche will prosper at the expense
of those who are less adaptive. Yet adapting to culture change within one’s
own culture may be every bit as demanding as adapting to cultural change
across geographical boundaries, even when the changes within a culture are
broadly welcomed (see for instance, Gibson & Swartz, 2001, who give an
account of the difficulties that some people in South Africa have faced in
making sense of their past experience under Apartheid in the context of their
current democratised experience) (see also Chapter 4).

The seven cultural themes described in Table 1.2 represent different forms
that the interplay between culture and health can take. In a sense, just what
culture ‘is’ is becoming increasingly contested, as the notion of ‘culture’ is
being used to explain an increasingly diverse array of social phenomenon.

**Table 1.2** A typology of themes relating culture, empowerment and health.

**Cultural colonialism**
Rooted in the nineteenth century when Europeans sought to compare a God-given
superior ‘us’ with an inferior ‘them’ and to determine the most advantageous
way of managing ‘them’ in order to further European elites.

**Cultural sensitivity**
Being aware of the minorities among ‘us’ and seeking to make the benefits enjoyed
by mainstream society more accessible and modifiable for ‘them’.

**Cultural migration**
Taking account of how the difficulties of adapting to a new culture influence the
opportunities and well being of geographical migrants.

**Cultural alternativism**
Different approaches to healthcare offer people alternative ways of being
understood and of understanding their own experiences.

**Cultural empowerment**
As many problems are associated with the marginalisation and oppression of
minority groups, a process of cultural reawakening offers a form of increasing self
and community respect.

**Cultural globalisation**
Increasing (primarily) North American political, economic and corporate power
reduces local uniqueness, and reinforces and creates systems of exploitation and
dependency among the poor, throughout the world.

**Cultural evolution**
As social values change within cultures, adaptation and identity can become
problematic with familiar support systems diminishing and cherished goals being
replaced by alternatives.

Adapted from MacLachlan (2004).
Even if one accepts this ‘stretching’ of ‘culture’ as an explanatory term, we still need to ask a fundamental question: what is culture for?

**Culture as a defence**

Marin (1999) has described how the U’wa (meaning intelligent people who know how to speak) of Columbia, a traditional indigenous society, responded to plans for oil exploration in their traditional territory: that should the plans go ahead they would collectively commit suicide:

To be severed from their place, to be removed from the context of the stories which they have passed down from generation to generation, is to be killed as a people, and is, as they have made very clear, a fate worse than death.

Marin (1999, p. 43)

In their own words the U’wa explain this stance:

We must care for, not maltreat, because for us it is forbidden to kill with knives, machetes or bullets. Our weapons are thought, the word, our power is wisdom. We prefer death before seeing our sacred ancestors profaned.

Cited in Marin (1999, p. 43)

But surely this is too extreme and, if people will die for their culture, is this not an indication that cultural identity can go too far?

Over the last 15 years a trio of experimental social psychologists have developed and demonstrated the value of terror management theory (TMT), based largely on the writings of Becker (1962, 1968, 1973) (for a review, see Solomon, Greenberg & Pyszczynski, 1991, 1998; Pyszczynski et al., 2004). A review of either Becker’s work, or of the deft experimental evaluation of TMT, is beyond the scope of this book. The central premise of TMT is that our concerns about mortality – our death – play a pervasive and far-reaching role in our daily lives. One product of human intelligence is our capacity for self-reflection, along with an ability to anticipate the future, and the rather gloomy consequence of this is our unique capacity to contemplate the inevitability of our own death.

Along with Sigmund Freud and Otto Rank, Becker believed that humans would be rooted to inaction and abject terror if they were continually to contemplate their vulnerability and mortality. Thus cultural world views evolved and these were ‘humanly created beliefs about the nature of reality shared by groups of people that served (at least in part) to manage the terror engendered by the uniquely human awareness of death’ (Solomon et al., 1998, p. 12). The way in which reality is constructed through cultural world views helps to manage such ‘terror’ by answering universal cosmological questions: ‘Who
am I? . . . What should I do? What will happen to me when I die?' (Solomon et al., 1998, p. 13). In a sense, then, cultures give people a role to play: distracting them from the anxiety of worrying about what they fear most.

Cultures provide recipes for immortality, either symbolically (such as amassing great fortunes that out-survive their originator) or spiritually (such as going to heaven). While sticking to the ‘rules’ and interpretations of your culture can ensure immortality, it has an equally important ‘here-and-now’ function:

The resulting perception that one is a valuable member of a meaningful universe constitutes self-esteem; and self-esteem is the primary psychological mechanism by which culture serves its death-denying function.

Solomon et al. (1998, p. 13, italics in the original)

Whether self-esteem is seen as arising from the need to deny death or from needs for competence, autonomy and relatedness (Ryan & Deci, 2004), these different paths to self-esteem are clearly embedded within cultural norms and practices.

The U’wa may thus more fully appreciate the life-saving and death-denying function of culture than do many others. Too often and for too long psychologists have stripped hapless mortals of their shaky beliefs and sent them out to discover their ‘true self’ and their apparently obligatory, enormously creative inner potential (MacLachlan, 2004a). Sheldon Kopp’s (1972) best-selling book, If You See the Buddha on the Road, Kill Him! is typical of a genre of psychologists ‘individualising’ and ‘inverting’ their clients and warning against pursuing happiness through ‘following’ anything outside their ‘true’ self. What such a perspective fails to recognise is that sometimes people can ‘find’ themselves and ‘protect’ themselves through a collective identity shared by others. As Isaiah Berlin states in Two Concepts of Liberty:

When I am among my own people, they understand me, as I understand them; and this understanding creates within me a sense of being somebody in the world. (p. 43)

Singing other people’s songs

Bandawe (2005) has discussed a common theme that pervades many of Africa’s different cultures and also distinguishes them from many western cultures – the notion of uMunthu (although the actual term differs from place to place, for instance in South Africa it is uBunthu). In Chichewa (one of the Malawian languages), the philosophy is conveyed through the phrase ‘Umuntu ngumuntu ngabantu’ (a person is a person through other persons). As Bandawe points out, this is very different from the strident individualism enshrined in Descartes’ ‘cogito ergo sum’ (‘I think, therefore I am’), a perspective that pervades so much of western thinking about the self. The understanding of identity and the contents of what makes up that identity do of
course overlap and are political, in the sense that they reflect the influence of power relationships on people’s lives – in this case, their understanding of their own life.

A recent example of this is seen in a letter to the (South African) Sunday Times (20 March 2005) by Motsumi oa Mphirime, of Boksburg, who wrote in relation to accusations of racism in the Catholic Church:

Anglicans and Catholics have for many years enjoyed the exclusivity of being the representatives of England and Rome in South Africa. Their ‘organized’ church sessions are deeply rooted in perceptions and ideologies that hold no interest for African people. Most white Priests look down on our traditional ways of worshiping through our ancestors, yet expect us to listen to their stories about the Jewish ancestors. . . . We need to realize that we have been singing other people’s songs. (p. 20)

This idea of ‘of singing other people’s songs’ is powerful because it recognises that language is one of the ways through which we construct our experience of the world. Through language cultural myths seem to be ‘natural realities’, when they are in fact ‘cultured realities’ (Althusser, 1999). So the natural interjection – ‘ouch!’ in English, is ‘owa!’ in German (Saussure, 1999). When you learn a language you are not just learning an instrumental form of communication, you are also passively assimilating a way of constructing reality, which, with practice, seems to constitute the ‘natural order’ of things.

Health, illness and wellness

Many people think of health as a lack of illness. This notion of health is encouraged by a purely disease (or medical) conception of health and illness. By this way of thinking, if you have an infection, a broken leg, an inheritable disease or a latent virus you are in an undesirable state and therefore ill. However, a moment’s reflection on this rationale easily illustrates its shortcomings (Antonovsky, 1987). For instance, we may understand by the term ‘benign’ that somebody has a tumour but that it does not seem to be a problem at the moment. Is this being healthy or ill? Somebody may be HIV positive but not show any symptoms of AIDS. Is this being healthy or ill? A person who has experienced hallucinations and delusions, but who is presently free of them, may be diagnosed as ‘schizophrenic in remission’. Is this being healthy or ill? Someone who has suffered brain damage at birth may have reduced mental capabilities but above-average physical capabilities. Is this being healthy or ill? The inadequacy of a healthy versus ill dichotomy is demonstrated dramatically by the brilliant Irish author Christie Nolan. He is constrained physically by a ‘damaged’ body but his intellectual insight and creative expression graphically demonstrate an unconstrained and ‘undamaged’ mind.

In 1948, when the World Health Organization (WHO) was founded, it gave us the following definition of health: ‘a complete state of physical, mental and
social well-being and not merely the absence of disease or infirmity’. Although this definition of health got away from the idea that health is an absence of illness, and that it is one (physical) dimensional, it has been criticised for the inclusion of the word ‘complete’. As we have noted, health is a multidimensional state. It can be broken down not just into physical, mental and social domains, but also into further subdivisions within each of these. We can at once be relatively healthy in some aspects of life and relatively unhealthy in other aspects of it. There is no clear line that we cross to move from an unhealthy category into a healthy category. People, and their health, are more complicated than that.

In the Alma Ata declaration of 1978, the WHO put greater emphasis on the social dimensions of health by focusing on primary healthcare. This declaration stated that resources were too concentrated in centralised, professionally dominated, high-tech institutions – especially hospitals. Instead it emphasised the importance of community participation in healthcare and the importance of communities having some ownership over their health services. In focusing on the primacy of the community, this declaration allowed for the incorporation of community values. Different communities have different values. These differences often reflect different cultures or subcultures. Thus the movement towards community health also offered a mechanism for integrating cultural values into healthcare.

 Perhaps the clearest integration of culture into a community-focused definition of health is the following, adopted by Health and Welfare Canada (cited in Kazarian & Evans, 2001, p. 7):

... a resource which gives people the opportunity to manage and even change their surroundings ... a basic and dynamic force in our lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environment.

Community health and ecology

In his book *The Psychological Sense of Community* Sarson (1974) laments the downfall of the sense of community in contemporary North American society. A sense of community, or the experience of a feeling of belongingness, has real implications for health. A considerable amount of psychological research conducted over the past 30 years has illustrated how ‘people need people’, not just for the sake of their company, but also for the sake of their own health. A range of studies has illuminated how social support influences health, including physical health (Ornstein & Sobel, 1987; Uchino, Cacioppo & Kiecolt-Glaser, 1996), such that high levels of social support are associated with less stress, increased disease resistance, better adherence to treatment, easier labour and childbirth, less severe bereavement reactions and even reduced death rates.

As the importance of a sense of community, belongingness and social support has become increasingly recognised, health services have undergone
a community re-orientation. The ethos of community care has shifted our focus to the preventive, therapeutic and rehabilitative value of those people around us. The community is also the natural ally of the primary healthcare philosophy. Around the world, in both the most and the least industrialised countries, for economic, clinical and theoretical reasons, healthcare has come home to the community.

Once again, if we turn to definitions, we find that it is not easy to say exactly what a ‘community’ is. The ideal community, according to Heller and Monahan (1977, p. 382), is ‘one that maximizes citizen input by providing opportunities for individuals to participate and contribute to the welfare of that group’. This definition of the ideal community emphasises two important aspects. First, ‘citizen input’ and participation are key elements in what has been described as ‘community involvement in health’ (CIH – Oakley, 1989). Second, the recipients of good community health practices are the members of the community itself.

However, the community practitioner works in a context that incorporates much more than just community factors. This broader context can be described as the ‘ecological’ perspective (O’Conners & Lubin, 1984), suggesting that a person’s behaviour is strongly influenced by their surroundings. Thus, while an individual’s personality, attitudes, intelligence and other ‘internal’ attributes contribute to his or her behaviour, the context, or surroundings, also have an important influence. The ecological approach therefore focuses our attention less on the individual’s psychology and more on factors such as the community and the culture with which the person identifies.

This aspect of taking into account the person’s environment is perhaps one of the reasons why the ecological (or ecosystemic) approach is becoming increasingly popular and effective in the field of public health. The ecological perspective, in allowing us to move away from focusing on the individual, allows us to consider whether ‘the community’ is a healthy or unhealthy organisation in its own right. Winnett, King and Altman (1989, p. 130) state:

The ability to foster communities that promote health is dependent upon stimulating opportunities for group membership and influence, meeting group needs, and promoting the sharing of social support.

Our conception of community health now involves not just how the health of an individual can be influenced by the community, but also whether or not the community itself is healthy. These two notions are of course closely related, not only in contemporary thinking, but also among the ancients.

The origins of the word ‘community’ are concerned with the idea of sharing a wall (T. Knight, 1994, personal communication). A wall, of course, is a barrier; it can serve to keep others out, but it also defines the common ground to those within it. According to the ancients this sharing of space referred not just to physical space but also to the psychological space created by a sense of enclosure. It was not only the physical space therefore that was shared by those behind the walls, but also the psychological responsibility of living
within that space and of being with others. Once again, in ancient times, such communities, often protected by a circular wall, would congregate for meals and ceremonial occasions in the ‘forum’, which was built at the centre of the community. Such a community therefore literally shared the same forum or ‘focus’ (a word derived from forum). Another aspect of the meaning of ‘focus’ is the fire at the centre (around which people would crowd). Such a fire could literally keep the community alive and metaphorically keep alive the spirit of the community.

The ancients believed that places of great social value, such as a forum, were guarded by the gods. They would perform certain rituals in order to keep in good favour with the gods. In effect they would cultivate the favour of the gods. This was done by ensuring that only people who knew the correct etiquette were allowed to enter particular places such as the forum. Thus certain rituals would be performed on entering a forum, and their performance would signify the right of the individual to enter and take part in community activities. Such rituals and etiquette varied and distinguished one community from another. The word culture refers to the notion of cultivating – as in cultivating a crop – a relationship, not just with the gods, but also with other members of the community.

Evidently the ideas inherent in the words ‘culture’ and ‘community’ are intricately woven together in an ancient fabric of etymology. Of equal relatedness – and perhaps surprisingly to our ‘modern’ thinking – is the ancient understanding of health. Health was seen as an index of how useful or ‘appropriate’ a person was to their community. It was believed that if an individual’s behaviour was out of ‘balance’ with the requirements of the community, then ill-health and suffering would result. Interestingly, according to this belief system, the individual who caused the imbalance was not necessarily the one who suffered. Instead another person, or group of people, could suffer because of the inappropriate behaviour of an individual. In ancient societies health was a very public concern. How individuals relate to each other can therefore be seen to be a common element in ancient notions of culture, community and health. An understanding of how the self relates to others will be shown to be of crucial importance for contemporary mental and physical health.

Gender

Culture is patterned by many features, perhaps the most prominent and important of these being how men and women are treated differently. Men and woman are distinguishable by both their biological sex and their social gender roles. In terms of biological sex women, particularly in poorer countries, face significant hazards as a consequence of child bearing and pregnancy. There are also significant differences in the incidence of some diseases, e.g. on average, men develop heart disease 10 years earlier than women, women are around 2.7 times more likely than men to develop an autoimmune disease, and male-to-female infection with HIV is more than twice as
‘efficient’ as female-to-male infection (Global Forum for Health Research (GFHR), 2004).

These differing roles, expectations and rights for men and women across all cultures are also related to health. There are no societies in which women are treated as the equals of men (UNDP, 1998). Herein lies one of the major challenges in working with different cultural groups and in different socio-economic circumstances. The inequalities between men and women tend to be greatest in the world’s poorest countries, and so women in these contexts are disadvantaged the most. This disadvantage extends from the preference for male children (and reported infanticide of baby girls) to the greater burden on mothers to care and provide for the family, and these responsibilities and pressures perhaps account for the much higher incidence of mental health problems among women than among men. Challenging such inequalities often means challenging the traditions that underpin the culture. Often it will not be possible to be sensitive to both conservation of culture and liberation of women from oppression and subjugation. Sometimes cultures will need to ‘evolve’ and the rights and positions of different genders be re-negotiated.

This evolution of gender roles need not be at the expense of men, however, because many traditional male gender roles emphasise the role of breadwinner, so putting men at increased risk of occupational accidents. Men are also more likely to take part in dangerous or violent activities, such as smoking, excessive drinking, driving too fast, engaging in unsafe sex, and taking their own lives through suicide (Smyth, MacLachlan & Clare, 2003; GFHR, 2004; see Chapter 4). The relationship between sex and gender roles itself deserves much more research and more thinking through by clinicians. Gender relationships are almost always unequal across cultures and they show distinctive patterns of exposure to and experience of many of the major physical and mental health problems that people experience. This is an issue to which I shall return throughout this book and is salient to the case study described in the next section.

An integrative model

There have been numerous attempts to synthesise a comprehensive understanding of all things that affect health. Generally these models integrate physiological, psychological and sociological influences on health. However, to attempt this is no easy task and sometimes the complexity of ‘bringing it all together’ can confuse the reader. A model should, after all, be easier to understand than reality. Otherwise what is the advantage of having a model? Hancock and Perkins (1985) have described ‘the Mandala of health’ as a way of understanding and remembering an array of factors that can influence health. The model sees human ecology as an interaction of culture and environment, incorporating a holistic view of health and recognising the biological sediment of organs, cells, molecules and atoms, which form the substrata
of us all. Figure 1.2 shows this model, which, by its symmetrical design, implicitly reminds us of the importance of balance between different systems and subsystems. The community interfaces between the culture and family, and allows for differences in lifestyle along with biological, spiritual and psychological experiences of life. These three ‘divisions’ are enclosed within a circle suggesting that they are often interdependent. Spiritual experiences may have biological and psychological aspects or consequences.

The Mandala provides an aide memoire but not an explanation. One of its merits is that it leaves you space to think. It cannot prescribe an action, but it can guide towards a more comprehensive understanding than might otherwise have been the case. The following case study provides a fairly tough test of the value of any model seeking to relate culture to health.

Case study: torture or tradition?

Lydia Oluloro asked for ‘cultural asylum’ in the USA from her native Nigeria and Yoruba tradition of female circumcision. Lydia had been
married to a fellow Nigerian, Emmanuel, who held a US residency permit. After their divorce Emmanuel had failed to complete the necessary paperwork to allow Lydia and their two US-born children – Shade aged 6 and Lara aged 5 – to remain in the USA. One of the grounds for divorce was given as Emmanuel’s repeated beatings of the children. Lydia, who had been given custody of the children, saw herself as caught between leaving the children with an abusive father or bringing them to an ‘abusive culture’.

Female circumcision is described by some human rights activists as ‘female genital mutilation’. Although the procedure itself, and the age at which it is done, vary across cultures, generally young girls have some part (sometimes all) of their external genitalia cut off. The clitoris and labia may be completely excised and the vulva stitched together. The girls are awake during the entire procedure, the purpose of which is to ensure virginity, reduce sexual pleasure and thereby make the girls better marriage prospects.

A.M. Rosenthal, a New York Times columnist, has called for UN intervention on the issue and for economic sanctions against those countries where the practice is common. She claims that many girls are left ‘in lifelong pain and sexual deprivation’ as well as ‘more vulnerable to disease, infection and early death’. On the basis of Lydia Oluloro’s argument that her two daughters would be at risk of genital mutilation if they returned to Nigeria, the family was allowed to remain in the USA. In short, they received ‘cultural asylum’.

Many African women living in the USA are opposed to sanctions. Dr Asha Mohamud, a Somali-born paediatrician working in Washington, says that ‘The practice is not being done to intentionally harm anyone. Mothers do it in good faith for their children.’ Alice Walker, the author of the anti-genital mutilation book Warrior Marks, has been criticised by Dr Nahid Tobia, a Sudanese-born obstetrician who works in New York city: ‘It suggests that, “I, Alice Walker, save the beautiful children who are being tortured by their own people”. It’s like saying Harlem women give their children AIDS because they don’t love them. In reality it’s more complex.’ Indeed it is complex; some immigrants to the USA continue the practice of female circumcision, while others are disappointed that there is no formal provision made for it.

Although the above case was reported in Time Magazine in 1994, approximately 2 million cases of female circumcision/genital mutilation occur each year; it is practised in 28 African countries and almost universally in parts of North Africa (Rix, 2005). Interestingly, although it is not practised by most Muslims, it has acquired a religious dimension among those who do it, but Islamic leaders are divided on its practice (Rix, 2005).

Let us consider the utility of the Mandala for understanding culture, community and health in relation to each other in the context of this case study. The Mandala model of the human ecosystem depicts the interaction between culture – as the most abstract unit of social analysis – and the biosphere – as the
most abstract unit of physical analysis. As we have already seen culture and the biosphere are linked in that certain behaviours and social structures are appropriate to certain environments, but not to others. The model thus emphasises that lifestyles and community customs need to be understood in a broader context. Clearly American and Nigerian values may differ because they are an expression of cultures that have adapted to different environments. Instead of taking the context of an individual’s behaviour into account, we often attribute the cause of it solely and directly to the individual in question. This is one aspect of the ‘fundamental attribution error’. If we lack an understanding of the cultural context in which a behaviour occurs, the behaviour may appear quite bizarre and unwarranted. The US court judged that the Oluloro children should not have to experience the circumcision custom of the Yoruba. The court judged the practice to be unwarranted. It could be argued that the court’s decision can be understood only in the cultural context of the USA.

Apart from drawing our attention to the context provided by culture and biosphere, the Mandala model also suggests that the following sorts of questions (moving from the outside to the centre of the model) might be asked:

- Does the practice have other functions within the communities where it happens? (Does it act as a form of initiation right into womanhood? What are the consequences of not undergoing the ritual?)
- Does it have an economic value? (Is a dowry system part of the culture?)
- How does it affect how women see themselves?
- How does it affect future intercourse and/or ability to have children?
- Does it have any spiritual connotation?
- Are there health risks?

The Mandala model is an aid to the community practitioner to ‘think through cultures’ (see Shweder, 1991) and in doing so to be more able to evaluate and act in a culturally sensitive manner.

To argue that behaviour needs to be understood in its cultural context is not to argue for a liberal cultural relativism, where anything goes if it goes as part of ‘the culture’. Although evaluating cultures is a rather treacherous endeavour, I would venture that the value of cultural practices should be judged in terms of whether or not they serve their people well. Beneficiaries may be at various levels, including the individual, family and community levels. If the practice fails to deliver some advantage at any of these levels, it is likely to be of dubious value. If it is of value at some levels and not at others, whether or not change should be negotiated should be judged not only from within the cultural system, but also on the basis of a broader understanding of human rights.

**Culture and human rights**

In the case study involving Shade and Lara Oluloro, a legitimate feminist argument is that ‘leaving it up to the culture’ is to deny these children their basic human rights. This is an appealing argument but it must also be recognised as a culturally based one, even though members of that culture may
believe their values to be ‘universal’ human rights. Let us not side step the issue here. There is nothing wrong with attempting to change certain aspects of a culture – that is how different cultures have evolved over many generations. Cultures will survive by adaptation but not by stagnation.

One of the most promising developments regarding health in recent years has been its recognition – or more precisely the recognition of the resources that can produce and sustain health – as a human right (see Chapter 9), e.g. the Dublin Declaration, arising from an international conference on HIV/AIDS in 2004, has as its first of 33 principles the idea of protecting people from the threat of AIDS, as a human right. The Universal Declaration of Human Rights, adopted by the UN in 1948, asserts that ‘all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood [and sisterhood].’

Mary Robinson (2004), the former President of Ireland and UN High Commissioner for Human Rights, stresses that the declaration ‘is not a Western human rights agenda, but a truly universal one’, in that it puts equal emphasis on civil and political rights (such as fair trial, freedom from torture, freedom of the press) and on economic, cultural and social rights (such as the right to food, safe water, health, education and shelter). Robinson points out that to ignore progress on some rights, e.g. progress on education and health in China, and focus only on a lack of progress on other rights, e.g. civil rights in China, is to be disingenuous. Although the interpretation of how health as a human right might differ in different cultures, it is hoped that its status as a human right can be agreed across all cultures.

If, in some traditional societies, female circumcision is seen to confer ‘eligibility’ as a marriage partner because the woman has adhered to the cultural rites of passage, then, in some highly industrialised western societies, cosmetic interventions may be seen as conferring ‘eligibility’ in other ways. Kalp (1999) catalogues the ‘improvements’ of Holly Laganante, a 35-year-old woman from Chicago, who has had an eyelid lift, liposuction on her thighs, varicose vein removal and a forehead peel. She said ‘It’s been tough on me financially, but it’s worth every penny . . . it’s life-changing’. According to the American Society of Plastic and Reconstructive Surgeons, there was a 153% increase between 1992 and 1999 in such operations, with more than one million in the last year. California leads America in ‘augs’ (augmentations) where it is apparently not uncommon for 16-year-old high school girls to get breast enlargements – long before they may have finished physically maturing. McGrath and Mukerji (2000) reported that the eight operations most commonly done on teenagers of 18 or less were (in descending order):

- rhinoplasty (‘nose jobs’)
- ear surgery
- reduction mammoplasty (breast reduction)
- surgery for asymmetrical breasts
- excision of gynaecomastia (male breast reduction)
- augmentation mammoplasty (breast enlargement)
• chin augmentation
• suction-assisted lipectomy (removal of fat under the skin).

Although these procedures may be necessary and appropriate in many cases, the difficulty is where to draw the line between cosmetic therapy and cosmetic recreation, and perhaps even a culturally sanctioned ‘cosmetic mutilation’. McGrath and Mukerji (2000, p. 105, italics added) state: ‘In the final analysis, the purpose of plastic surgery is to change the patient’s psyche in a positive way.’ It would seem that both genital mutilation and cosmetic surgery share the desire to change the way that people are seen psychologically, by physically altering them in some respect, causing them pain and changing physical aspects that work (in an anatomical sense) satisfactorily.

Airhihenbuwa (1995) has emphasised the importance of multiculturalism addressing all cultures, and not simply the majority culture using the concept of ‘multiculturalism’ to manage the health of other cultures. He has expressed justifiable concern that the agenda of health interventions is rooted in North American and European concerns to achieve what are seen within these cultures as positive outcomes, but which may not be seen as positive outcomes by other cultures. Whoever you are and wherever you are reading this book, a cultural analysis of health is every bit as applicable to your health and your culture as it may seem to be to the culture and health of far-off and exotic peoples. To understand ourselves we must stand outside ourselves and realise that our way is but one of many.

We have now reviewed the conceptions of culture and health to be used here. Culture is used broadly to refer to shared means of communication and social experience of living in the world, while also keeping in mind that culture influences health and people’s sense of empowerment in a plethora of different ways. Health is seen as multidimensional, with each dimension represented on a continuum, rather than in an all-or-none (healthy or ill) dichotomy. I place health within the community context, because this recognises both ancient thought and contemporary practice, and I also see access to health services as a right and not a privilege. With these working definitions in mind there follows a preview of forthcoming chapters.

Preview

Cultural differences (Chapter 2)

Acculturation describes the process whereby individuals encounter more than one culture and respond to the interplay between them in various ways. The way in which acculturation takes place, and the stress experienced, can seriously affect health. The reaction to acculturation is, however, not easily predictable and family members may have vastly different acculturative experiences.
One feature of encountering a different culture may be having to understand a different perspective on the factors responsible for health and illness. Within most western societies the biomedical model predominates, which attributes health and illness to changes in our biochemical and physiological substrate, changes that often occur at such a microscopic level that belief in them is, for most people, an act of faith. On a worldwide scale, faith in other causal mechanisms, such as the intervention of displeased spirits or the use of witchcraft, is probably more widespread. It would seem vital therefore to understand not only the nature of a person’s presenting complaint but also their explanation of it, because the two are almost certainly interwoven to some extent. Health professionals, often through ignorance and sometimes because of arrogance or insecurity, may try to impose their own model on their patients. Clinicians are often less tolerant of ambiguity and less accepting of more than one explanation for illness or suffering than are their patients. Within a multicultural society clinicians must recognise and show some tolerance towards a pluralistic approach to health.

In assessing any one individual there is always the difficulty of knowing to what extent they conform to cultural stereotypes. Stereotypes refer to conceptual and statistical averages, not to individuals. We must therefore find a way of mapping out how individuals’ beliefs about their state of health relate to their own personal situation, the community in which they live, their culture, etc. The problem portrait technique is proposed as a tool for unravelling such interlocking influences. Through a collaborative interview methodology, the clinician may assess the relative strengths of many factors that simultaneously influence a person’s health-related behaviour. The problem portrait technique is a way of integrating individual (foreground) and culture (background).

**Syndromes of culture (Chapter 3)**

The idea of ‘culture-bound syndromes’ has been popular for many years. One interpretation of these exotic conditions has been that they embody social myths, perform certain social functions and/or reflect particular social pressures within the cultures where they are expressed. However, this sort of analysis may be made of any syndrome of illness. All illness or disorder occurs in a cultural context of some kind, and it is argued that, to some extent, cultural contexts influence the way in which suffering is caused, experienced and expressed, and the consequences of such suffering. In describing some syndromes as ‘culture bound’ it has been implied that some syndromes are not influenced by culture. Such an assumption is not warranted and in most cases is probably ethnocentric, in that it suggests that ‘our’ syndromes are not culture bound but universal, i.e. they really do exist!

If we accept the influence of social forces on our well-being, it follows that the problem with which a particular individual presents may reflect factors beyond the self. An individual may, for instance, become anxious because of unease within the community in which he or she lives. In such a case a
person’s suffering can be said to point beyond that person: he or she may be a social scapegoat. If an individual’s suffering sometimes reflects community or cultural concerns, how should this concern be demonstrated? What form should suffering take? A society that is anxious about the way in which child-like girls enter adult-like womanhood may express this anxiety through an individual adolescent female’s concern with her body shape, size or weight. In an extreme case an adolescent female may starve herself of food, perhaps unconsciously seeking to retain the body of a child-like girl. Here we may also talk of the body being used as a symbol, symbolising concerns within the culture. In this way cultural concerns may interfere with physical and mental functioning, either ‘exploiting’ existing ailments or shaping new ones into a form of cultural expression. The experiencing of a culture-bound syndrome by a person of a different culture may reflect their anxieties over self-identity and cultural identity. At times cultural-bound syndromes may also be seen as a means of cultural resistance to oppression or exploitation.

*Mental aspects of health (Chapter 4)*

The study of cross-cultural mental health takes place in different forms. Comparative mental health compares the nature of mental health and disorder in one culture with that in another, minority culture mental health considers what the consequences of being a member of a minority cultural group are for mental functioning, and transition mental health is concerned with how experiences of, say, refugeehood or migration affect mental health. Each of these perspectives is quite distinctive but in reality they also overlap. Thus immigrants are often members of minority cultural groups and may be reported as having a higher incidence of certain disorders than the majority cultural group. A multitude of factors influence consideration of mental health, and these factors should include social, economic and political forces that interact with cultural considerations as indicated in Table 1.2.

It is tempting for clinicians to try to classify the unknown through diagnostic systems that are familiar to them. A Chinese person presenting with stomachache after experiencing bereavement as a result of the death of a family member may be described as suffering from ‘masked depression’. This insinuates that he is not suffering from the real thing but from something else that replaces it, for whatever reason. Contrariwise, in theory, a Chinese clinician may say that a French man who is depressed after experiencing a similar bereavement is suffering from ‘masked stomachache’. Such an explanation would be unacceptable to most westerners because they assume the universal primacy of psychological processes. The only way out of such a riddle is to try to understand people’s experience of suffering within the terms in which they experience it, i.e. within their cultural ‘terms of reference’. Failure to do so is to strip suffering of its meaning and symbolism and in so doing affront the integrity of the sufferer. When cultural ‘terms of reference’ change within a society this may also dislodge individuals’ sense of identity and threaten their mental health.
The communities in which people live should be seen as resources for community health. A sense of belonging and the opportunity to receive social support from similar people can have a positive effect on mental health. Also, living in areas where the number of people who constitute a minority cultural group is large appears to be much better for mental health than living in an area where your cultural group is in a small minority. Such considerations may help to buffer the stressful experience of transition that many immigrants experience on arriving in a new country or culture.

Physical aspects of health (Chapter 5)

Recent research has demonstrated that psychosocial stressors can influence physical well-being in a variety of ways. The fact that many of the salient psychosocial stressors are likely to vary across cultural groups also implicates cultural variations in physical disease processes. As already noted with mental health, a strong sense of community, or cultural identity, may benefit physical health. Research on ‘cultural inwardness’ has found that mortality from serious diseases is lower where traditional cultural values are cherished. It also seems clear that some cultural groups live a healthier life than others, e.g. Seventh Day Adventists appear to live longer and have fewer physical problems than most people. We must therefore be prepared to learn healthier ways of living from other cultures.

Reactions to illness will reflect the way in which cultures socially construct the meaning of illness behaviour. Consideration of the cultural aspects of pain, cancer, deafness and obesity illustrate the range of effects that culture has on quite diverse illness behaviour; how it affects sensation, help seeking, stigmatisation and indeed the creation of health problems.

Treatments (Chapter 6)

One reason why cultures vary in how their individual members present illness is that different cultures require different paths to be followed in order to become ‘legitimately’ ill. To be a good patient in Brazil you must understand the Brazilian way of being ill. If the patient and the clinician know the rules to be followed each can have faith in the other. The faith of a patient, or client, in a treatment is often referred to as the placebo effect. This effect applies not just to treatments but to clinicians as well. When a patient and a clinician come from different cultural groups, this may influence the degree of faith that a patient has in the treatment offered and in the clinician who is offering it. A faith grid can chart the interaction between clinician and patient.

Another aspect of the process of treatment concerns what sort of information is shared between clinician and client. A cultural difference in diagnostic disclosure (whether clinicians tell their clients the true diagnosis that they have made) is an example of this. Patients and clinicians are cast in different roles by different cultures and this affects clinical decision-making. Clinicians
are a product of their culture and so too are their treatments. Sometimes inappropriate therapies can be oppressive. If a black person suffers from depression because of their experience of racism, a treatment that focuses only on his depression (e.g. antidepressants or cognitive therapy) problematises his legitimate distress. Such a treatment supports the view that the problem is with the individual rather than with the context in which that individual lives. The concept of transference can assist the clinician in understanding the personal history that individuals (both patients and clinicians) bring to clinical encounters of all kinds. Another technique that may be useful is the use of critical incidents as a therapeutic technique, whereby the clinician can help clients think through how the problems that they present reflect their own values in the context of their culture. Rather than focusing on the culture and then ‘zooming in’ on the individual, the critical incident technique offers the possibility of focusing on the individual and then ‘panning out’ to take in the cultural and social context.

A recent development in thinking about culture and treatment is the recognition of the possible role of culture as treatment. For minority groups who have been marginalised by majority society, and who may in the process have lost any strong sense of identity and experienced low self-esteem, rekindling of their culture as a medium to their own rehabilitation has been encouraged; an example of this is seen among the indigenous people of Canada and Australia. The current interest in the west in different ways of living life (e.g. Buddhism) suggests that cultures or subcultures that are used as ‘treatment’ do not have to be one’s own culture to be effective. The therapeutic effect of culture may simply be that it gives a sense of belonging, an anchor in the sea of life. The rise of ‘race-based’ therapeutics does however question any construction of the relationship between culture and health that denies the existence of specific biological mechanisms associated with different skin colours. This in turn may raise ethical concerns regarding research and practice.

Health services (Chapter 7)

Health services of the twenty-first century must adopt a multicultural perspective. These services need to reach beyond just concerns with the way in which different cultures experience and express illness, and how clinicians and their clients communicate, to include a community’s infrastructure of care (of all types) in planning for health. Multicultural care requires western-trained clinicians to ascertain where they ‘fit in’ to the overall system, and not to centre the healthcare system on themselves. The community must be the home of health. Even in a monocultural society clinicians of different professions will hold different (subcultural) beliefs about the mechanisms of, and remedies for, suffering. So too will the lay members of such a society, because their health beliefs are constituted from popular and folk beliefs, not just the beliefs of health professionals. As such the very notion of a monocultural society is a fallacy.
Greater tolerance of pluralistic approaches to suffering is now required. This tolerance must extend not only to making allowances for other explanations of and interventions for suffering, but also to acknowledging that different systems of cause and effect may be synthesised in ways that do not always make obvious sense to you or me (from whatever our cultural perspective may be). This is not to say that ‘anything goes’, but it does suggest that we should be open to empirically evaluating interventions that we may neither fully comprehend nor recommend. In this sense clinicians must be prepared to learn from their patients.

**Promoting health (Chapter 8)**

Intervention can occur not only as treatment but also as prevention. We can go beyond the idea of preventing things from going wrong to promoting things going right! For too long health services have reacted to illness and disorder rather than living up to what that phrase implies – servicing health. Unfortunately even the best of health promotion initiatives are inevitably developed within particular models and cultural contexts. Thus cultural minorities may be disadvantaged because such initiatives are less accessible to them. Culturally sensitive health promotion will require working through different media and in different ways in different cultures. Flexibility and adaptability will be central requirements for health promoters working with diverse cultures.

Specific risk factors have been identified for particular disorders. In the case of depression, for example, experiencing severe stressors, having low self-esteem and living in poverty have been identified (among others) as risk factors. The distribution of such stressors across different cultural groups may be uneven, particularly for minority immigrant groups. Once again we need to appreciate that cultural variation does not present itself in isolation from other factors that influence health. Cultural expectations may also constitute risk factors. It can be argued that the emphasis on individualism and achievement, which is found in many western cultures, predisposes westerners to individual failure and self-deprecation; this may constitute a loss of faith in the self, a key feature in the western experience of depression.

Cultures offer different solutions to living and therefore different pathways to healthy living. They need to be understood at a systems level and not simply by extracting a few cultural practices on which to focus. Health promotion efforts that do not acknowledge established cultural pathways risk derailing these important conduits of health. Clinicians once again need to see themselves as facilitators of health and not directors of it. Promoting public health must be seen as a long-term strategic goal, which will not be achieved in a biotechnological flash! Instead, such a goal is more likely to be achieved through slower *incremental improvements* in existing services where the pace of change reflects what communities are able to absorb while retaining their distinctive character and culture. Health promotion must also consider the opportunities and challenges presented by specific sub-cultural groups and
what might be the most effective means of influencing behaviour in such groups, with research of the gay community in Sichaun province, China, being a particularly interesting example.

Global health (Chapter 9)

McAuliffe (2003) defines global health as an attempt to address health problems that transcend national boundaries, may be influenced by circumstances and experiences in other countries, and are best addressed by cooperative actions and solutions. The underlying assumption is that the world’s health problems are shared problems and are therefore best tackled by shared solutions. An implicit aspiration within this perspective is to work towards removing inequalities and privileges in accessing health, i.e. to establish health as a human right. More recently the need for health as a prerequisite to economic development has been recognised, as has its importance in maintaining international security.

Many of the world’s health problems are problems that thrive on poverty. This is not just a poverty of resources but also a poverty of research and, perhaps, interest too, e.g. ‘the 10/90 gap’ refers to the fact that only 10% of the world’s health research funding is given over to addressing 90% of the world’s disease burden, mostly found in the world’s poorer countries. We consider the millennium development goals (MDGs) and the UN’s targets for improved health by 2015 from a cultural perspective. Given such a diversity of goals and targets, the case of HIV/AIDS is considered as a result of its pervasiveness and devastation, and the richer world’s continual ability to turn away from it.

The challenge of global health is to recognise that the factors that affect health in one country or context are much the same as those in another. Although the extent of health and social problems may differ, the background determinates are similar. In a world of increasing interconnectedness we need to develop shared solutions to these shared problems. We also need to keep the economic engine of globalisation from ‘running away’ with our world, and to ensure that its’ proceeds are used to address, and not augment, existing inequities.

Conclusion

The indisputable process of internationalisation – the increasing contact between peoples of different countries – is often seen as making the world a smaller place, or reducing the differences between cultures. This is the ‘melting-pot’ perspective on our future. It asserts that the world’s cultures will be thrown together with little to distinguish the behaviour of an Indian from that of a Spaniard, or an Irish from a Japanese person. An alternative is the ‘kaleidoscopic’ perspective, which is that we are not getting more similar, but instead more different. Internationalisation is producing more subcultures within our traditionally recognised cultures. The Indian, Spanish, Irish and Japanese ways of life – the cultures – will still remain fundamentally differ-
ent, because these peoples operate in ecologically different contexts. For some people this ‘selection box’ of humanity presents threats and problems, yet for others it allows a world of variety, stimulation and opportunities.

Many modern industrialised cities are thronged with different cultures and communities. A community is not a geographical location; it is a state of mind, shared by a group of people. You and I may be next-door neighbours, but inhabit quite different communities. Whether you live in Berlin, Blantyre or Brisbane, your mere physical location does not give you a right of entrance into a ‘local’ community. Your membership of a community will depend on your methods of communication, practice of rituals, and adherence to certain ‘rules’. ‘Mainstream’ health services, and the clinicians who work in them, often fail to cultivate meaningful relationships with people who are not part of a mainstream culture. This book aims to outline ways in which good health can be understood and cultivated both within and across cultures.

Guidelines for professional practice

1. The social health sciences of medical sociology, medical anthropology and health psychology each has a legitimate claim to a useful perspective on the relationship between culture and health. Each of these perspectives offers interesting insights at the structural, systems and individual level of analysis. Although individuals are entitled to their own health psychology, how they construct such beliefs will be influenced by the cultural systems in which they live and how they enact such beliefs will be influenced by the constraints of the society in which they live.

2. The terms ‘culture’, ‘race’ and ‘ethnicity’ are often used interchangeably, although they refer to quite different ideas. Race is, strictly speaking, a biological term and refers to heritable physical characteristics. Ethnicity is often used to refer to common physical features that are in turn associated with a psychological sense of similarity. Culture refers to shared customs of communication and common experiences of living in the world.

3. Variations in human physique are often taken as evidence for the existence of several distinct human races. However, it is also the case that human physique varies within the traditional anthropological categories of race. Furthermore, significant genetic differences may also occur within traditional race categories, and these differences appear to be related to health. Consequently, although physical and genetic differences certainly do occur between peoples of different geographical origin, the concept of race provides an inadequate framework for assessing these differences in relation to health.

4. Whatever concepts we use to describe human variation – ‘race’, ‘ethnicity’, ‘culture’ – they are themselves a product of how this variation is understood to occur. Different groups of people have different explanations for this variation. As such, these ‘local’ ways of understanding
human variation (folk taxonomies) are subjective interpretations. Different cultures understand human variation differently. What most of them do share, however, is the belief that their own interpretation is the correct one!

5. Human variation is also found in the ways in which groups of people organise themselves. Whatever form this organisation takes, its functioning is facilitated by communication. In this book culture is seen as the medium of communication shared by a group of people.

6. Our senses are the biological conduits of our cultural communications. There is no barrier between the psychosocial processes of relating to fellow human beings and the biological substrate of processing this information. Culture’s influence on health is not restricted to mental functioning; it also affects physical functioning.

7. Traditional ideas about cultural differences associate them strongly with different geographical locales. This association no longer holds true and new types of culture–health relationships have emerged including ‘alternative’ healthcare, rapid social change, globalisation and empowerment.

8. Health is multidimensional and includes physical, psychological and social well-being. People can be healthy in some aspects of their life while being ill in others. On any one dimension, health and illness are not experienced in the absence of the other. Health is on a continuum; it is not a dichotomy. Thus patients are often healthy in many more ways than they are ill.

9. The community health philosophy invites consideration of how communities differ from each other. This is entirely consistent with examining cultural differences in health and recognising that cultures operate through local communities. However, when considering cultural differences, the clinician should also consider the social, economic and political contexts in which culturally different communities operate. Sometimes these latter differences can affect health more profoundly than can cultural differences themselves.

10. The belief that culture, community and health are related is not simply a reflection of modern practice; it was also a belief in ancient times. Our modern use of these terms often obscures their related etymologies. The way in which an individual relates to others is a common factor in culture, community and health.

11. The Mandala of health is a schematic for thinking through and attempting to integrate the many factors that can influence health. It is presented as a clinically useful aide memoir rather than a comprehensive academic model.

12. The status of health as a human right is becoming increasingly accepted both in international agreements and among practitioners. This perspective challenges the idea that health is a privilege that can be bought and recasts it as an obligation that must be met. Although this conception of health presents challenges across cultures, it also presents challenges within cultures and societies that take its ‘purchase’ for granted.