Culture and Health

A Critical Perspective Towards Global Health

SECOND EDITION

Malcolm MacLachlan

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Dedication

To my parents;
for the fun
of life

Contents

About the Author

Professor Malcolm MacLachlan is with the Centre for Global Health and School of Psychology, Trinity College Dublin. He originally trained and worked as a clinical psychologist, and then as a management consultant, in the UK, before taking up a lectureship at Chancellor College, University of Malawi. There he worked on a range of health promotion projects concerning HIV/AIDS and various tropical diseases, as well as with Mozambican refugees, and held a visiting position at Zomba Mental Hospital. Since moving to Trinity, he has held visiting positions at the Universities of Limpopo, Cape Town and Stellenbosch, all in South Africa, and at the College of Medicine, University of Malawi. Over the last 10 years he has also researched health-related aspects of rapid social change and increased multiculturalism in Europe, particularly Ireland. His major research interests concern cultural aspects of health, the psychosocial rehabilitation of people with physical disability and the human dynamics of international aid.

Professor MacLachlan is a Fellow of Trinity College Dublin and the Psychological Society of Ireland, and was elected to membership of the Royal Irish Academy in 2005. He has worked with a broad range of international and development organisations including UNICEF, OECD, WHO and UNESCO, the Academy for Educational Development, Finnish Refugee Council, American Refugee Committee, Banja La Mtsogolo, Concern and Development Co-operation Ireland. He was also a member of an EU-funded specialist group on Psychotrauma and Human Rights. He is Co-Director of the Masters Degree in Global Health at Trinity. He has the entirely unintentional distinction of a peculiar type of multicultural education – being a graduate from universities in Scotland, England, Ireland and Wales.

Critical acclaim for the First Edition

Psychology

. . . ideal for undergraduate students in psychology and the health sciences, while still having a great deal to offer to professionals.

> Christina Lee, *Australian Psychologist*, July 1998, p. 158

This book is a welcome addition to the literature, written by an author who is evidently an expert in this field.

> Rachel Tribe, *Behaviour Research & Therapy* **36**, 1998

. . . *Culture and Health*, is a welcome addition. It attempts to glean the relevant and most pertinent literature related to cultural influences on both mental and physical health into a single resource for the health practitioner. As one of the first, and perhaps to date only, book resource to do so, it attempts to fill an important gap in our knowledge, and provide an important service to those who work with cultural issues in their everyday professional practices, as well as to those who teach in these areas.

> David Matsumoto, *Journal of Health Psychology* **4**(1): 109–10

. . . health workers have a great deal to learn from this volume . . . of great value and interest are the many illustrations of health related cultural phenomena . . . which includes both illnesses and 'case studies'. The author uses these imaginatively to encourage the reader to challenge his or her assumptions of others and best practice . . . the concluding 'guidelines for professional practice' . . . are excellent tools for thinking critically about health care in a multicultural society . . .

> James Nazroo, *British Journal of Health Psychology* **4**(1), 1999

Psychiatry

I particularly liked MacLachlan's 'Problem Portrait Technique' as a helpful way of gaining an understanding of the individual patient's cul-

tural background from the patient himself/herself. . . . Perhaps it should be a requirement of every mental health professional that we demonstrate that we have mastered this technique . . .

George Ikkos, *Psychological Medicine*, 1998, pp. 1248–9

. . . an enlightening view of different facets of culture and human inter-action . . . [which will] fill an important gap in the field of cross-cultural psychiatry. MacLachlan provides a theoretical overview with guidelines for professionals . . .

Dinesh Bhugra, *International Review of Psychiatry* **11**, 1999

This work is important for two reasons. In the first place, the author emphasises correctly an aspect that is often forgotten: that an individual is mainly ill, both somatic and mental, *in his culture*. . . . Secondly, the author warns that Western based diagnostic systems should not be uni-versalised. . . I would like to recommend this book.

H. Van Hoorde (translated) *Tijdschrift voor Psychiatrie*, 1998

Medicine

MacLachlan provides an excellent overview of the relationship that culture plays in the health and wellness of both individuals and the com-munities in which they live. . . . I found this book to be well balanced and well documented and I would be comfortable recommending it for both undergraduates and graduate students alike. . . . *Culture and Health* should be considered a 'must read' for any health professional, especially those who will practice in a multi-cultural environment.

Richard Mroz, *Social Science and Medicine* **48**: 857, 1999

MacLachlan is at his most interesting when recounting tales of cultural diversity

Kamran Abbasi, *British Medical Journal* **316**, 1998

Health services management

This publication addresses a particularly important issue, especially given the multicultural society within Europe, and deserves to be read by a managerial audience.

Press Release: European Healthcare Management Association, 1998
(Culture and Health was the runner-up for
the Association's Baxter Award)

Social work

. . . what I found particularly interesting was that it was not overly biased towards an academic discourse and had a clear(er) focus towards practitioners' needs. It does offer the practitioners ways to examine, compare and contrast their practice in relation to each subject area. Each chapter concludes with guidelines for professional practice that social workers in health settings and associated professionals will find useful.

Alison Cornwall-Dwyer, *British Journal of Social Work* **28**, 1998

International development

Although this text is relevant and timely as a useful academic text for students, it also incorporates a number of design and layout features which make it an invaluable field reference guide for clinicians working in a multicultural environment. As such, this book is highly recommended for students and practitioners in the health and social sciences.

Paul Watters, *Development Bulletin* **46**: 71, 1998

General book review publications

MacLachlan introduces various approaches used with immigrant and refugee populations for assessing problems and helping patients achieve treatment objectives. [The book is] . . . broad in scope, addressing communication patterns and health care issues among a wide variety of racial, ethnic and religious groups

Multicultural Review, 1998

Covers the assessment and treatment of illness as well as the promotion of health, introducing new techniques such as the problem portrait technique for assessment, and critical incident analysis as a form of treatment

New York Review, 1998

Preface to the First Edition

This book offers a path through a forest. The many and varied relationships between culture and health are what populate this metaphorical forest. At different times of day the light will play tricks on you with shadows pointing you to travel in one direction or another. These can be likened to the truly multidisciplinary perspectives that are relevant to an understanding of culture and health. While I have tried to be aware of these, the path travelled in this book doubtless reflects my own training in clinical psychology and my subsequent experiences of working in different cultures. As with any path it cannot take in all that it passes by and so my description of culture and health is one which makes personal sense.

The terrain covered in this book is not comprehensive; it is highly selective. I do not want you, the reader, to travel this path and believe that you have seen through the forest, but to retrace some of my steps and follow different shadows and kinks of light.

This book is written at a time of explosive activity in research and writing about both culture and health, and an increasing realisation of the importance of their tantalising interplays. I have omitted to tackle some topics which are undoubtedly important – emotion, interpersonal relationships, attitudes toward ageing and psychometric assessment, to mention but a few. Some of these issues are dealt with by other books in this series, while others would not squeeze into the confines of space allotted me. Some of the ideas included are, however, 'new' and doubtless somewhat raw. These include the Problem Portrait Technique, the Faith Grid, the use of Critical Incidents as a form of therapy and the suggestion of health change progressing through Incremental Improvement. They are served up to be chewed over and, if need be, spat out! They are things which I picked up and put into my pocket as I picked out a pathway.

It has been difficult to know how to refer to cultural groupings. One of these is the idea of 'Western' cultures. Of course there is no such thing as 'the West'. What is west of you all depends on where you're standing. It can be the height of ethnocentricity to talk of the Middle East or indeed the Far East. If I say I live in the 'Far East', you may well ask where it is that I am far from and east of! Yet such misnomers can be widely understood summaries of an abstract concept. In this book I have opted to use the term 'West' to refer to a range of cultures which have some important characteristics in common. These

countries include the United States of America, much of Europe, Australia, New Zealand and to a lesser extent some countries which have been strongly influenced by the values held by people from these 'Western' cultures. To remind us that there is no such place as 'the West' I have used the term with inverted commas.

During the writing of this book I have had the great good fortune to travel five continents, work in three different universities and live in four 'homes'. The influences on me have literally been too numerous to mention. The thoughts of many people have beat out my path and pulled back the under-growth, so infusing me with the excitement and bewilderment which is born of true exploration. However, to move forward you must have some way of knowing where you have been. My editor, Daphne Keats, and publishers Comfort Jegede and Michael Combs at Wiley, have awoken me from slumber when I have dosed off in some cosy corner of a Malawian mountain or Irish hay field. Without the support and thoughtful commentaries of my wife, Eilish McAuliffe, and mother, Pat MacLachlan, the writing of this book would have been a very solitary pursuit. I am also very grateful to Lisa Cullen for her skill and patience in producing the tables and figures in this book. Finally, a thank you to all those colleagues and friends from different cultures, who over the years have tolerated many strange questions. Some of your answers are in this book.

Malcolm MacLachlan

Preface to the Second Edition

Since the first edition of *Culture and Health*, globalisation has increased apace. The ethos of diversity, whether in terms of multiculturalism, sexuality, gender roles or access for the disabled, is now much more pervasive then before. Confronted with the choice between a cultural mosaic and a cultural 'melting pot', the mosaic seems more resilient and more preferable. However, the term 'multiculturalism' stresses the need for an increasing array of distinct identities rather than being subsumed under a singular idea of 'diversity'. As is illustrated in this volume, cultural identity serves not just a group's need for cohesiveness, but also an individual's need for a coherent, and particular, world view.

In this second edition there are significant new additions and ideas. At a conceptual level, I have tried to think through the interrelationships of medical anthropology, medical sociology and health psychology, and acknowledge something that was implicit in the first edition – that, whatever the cultural or contextual parameters, *people have the right to their own health psychology* – to make what sense they can of the relationship between what they think, how they act and their well-being. I have also, however, tried to acknowledge my sympathy with a *critical* perspective, one that is concerned with broader social issues, less individualistic and less oriented towards biological and reductionist understandings of people's personal experiences. As such, I believe in a social constructionist perspective that is *critical for* rather than simply being *critical of* other perspectives on health.

In this second edition I also seek to emphasise the need for a *global health* perspective and that such a perspective must inherently recognise that this broad panoramic view is made up of different 'takes' from varying cultural positions. Although the idea of *health as a human right* is compelling, identifying just exactly what that means in different cultures is crucial if it is not to become yet another United Nations' 'feel-good' abstraction with few specifics to guide practitioners.

In the first edition of this book I paid insufficient attention to gender and poverty as 'cross-cutting' issues and I have sought to address this in the second edition. I have also tried to indicate how culture can often present ethical issues for which there may be no clear 'right answer'. All of the chapters have been updated and added to, and I have also added a completely new chapter on global health, because this movement is highly relevant

and sympathetic to cultural perspectives on health. While in the first edition I used inverted commas and a capital first letter to describe the idea of, for example, the 'West', I have dropped these and now simply refer to the west, as is now the trend. Perhaps it is an alternative way of acknowledging that while such an *idea* exists, the *place* does not. My publishers have been extraordinarily patient in their waiting for this second edition and I am most grateful for the time that they have allowed me. Finally, my children, Anna, Tess and Lara (all new additions since the first edition), and my wife, Eilish, have been my travel companions across each continent and furnished me with perspectives that I was quite foreign to. And this is the essence and value of understanding how cultures influence our lives, our health and our experience of illness.

Malcolm MacLachlan

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 mono-cultural '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 inter-pret 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 & Evan, 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
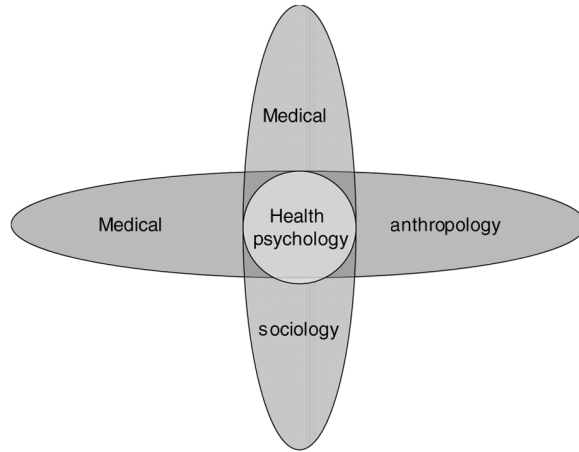
Figure 1.1 A schematic representation of the relationship between health psychology, medical anthropology and medical sociology.

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 difference 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 collect 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: