

3.2: Culture, Beliefs, Attitudes, and Stigmatized Illnesses

Cultural Lens and How Culture Influences Your Perceptions

Cultural Awareness, Sensitivity, and Safety

Culture can be defined in terms of the shared knowledge, beliefs, and values that characterize a social group. Humans have a strong drive to maintain the sense of identity that comes from membership in an identifiable group. In primeval and nomadic times, a person's survival likely benefited from establishing strong bonds with an in-group of trusted relatives or clan-mates with whom one co-operated and shared, versus an out-group against which there was competition for scarce resources. Within the intermixing of modern society, many of us seek to retain a sense of cultural identity and may often refer to our cultural roots, or use double-barreled descriptions such as Asian-American. It is important that we are all aware of our own cultural influences and how these may affect our perceptions of others, especially in the doctor-patient encounter. In many subtle ways, the cultural identities of both doctor and patient affect their interaction, and in a diverse country this can form an exciting challenge.

Culture and individual

We all perceive others through the filter or perspective of our own cultural upbringing, often without being aware of it: communication can go wrong without our understanding why. The clinician must become culturally aware and sensitive, then culturally competent so that she or he can practice in a manner that is culturally safe.

Cultural awareness

Cultural competency in medical practice requires that the clinician respects and appreciates diversity in society. Culturally competent clinicians acknowledge differences but do not feel threatened by them. "Culturally competent communication leaves our patients feeling that their concerns were understood, a trusting relationship was formed and, above all, that they were treated with respect." While a clinician will often be unfamiliar with the culture of a particular patient, the direct approach is often the best: ask the patient what you need to understand about her culture and background in order to be able to help her. A direct approach helps establish mutual respect and tailor the best and most appropriate care for each patient.

Awareness of one's own culture is an important step towards awareness of, and sensitivity to, the culture and ethnicity of other people. Clinicians who are not aware of their own cultural biases may unconsciously impose their cultural values on other people. "As physicians, we must make multiple communication adjustments each day when interacting with our patients to provide care that is responsive to the diverse cultural backgrounds of patients in our highly multicultural nation."

Cultural safety refers to a doctor-patient encounter in which the patient feels respected and empowered, and that their culture and knowledge has been acknowledged. Cultural safety refers to the patient's feelings in the health care encounter, while cultural competence refers to the skills required by a practitioner to ensure that the patient feels safe.

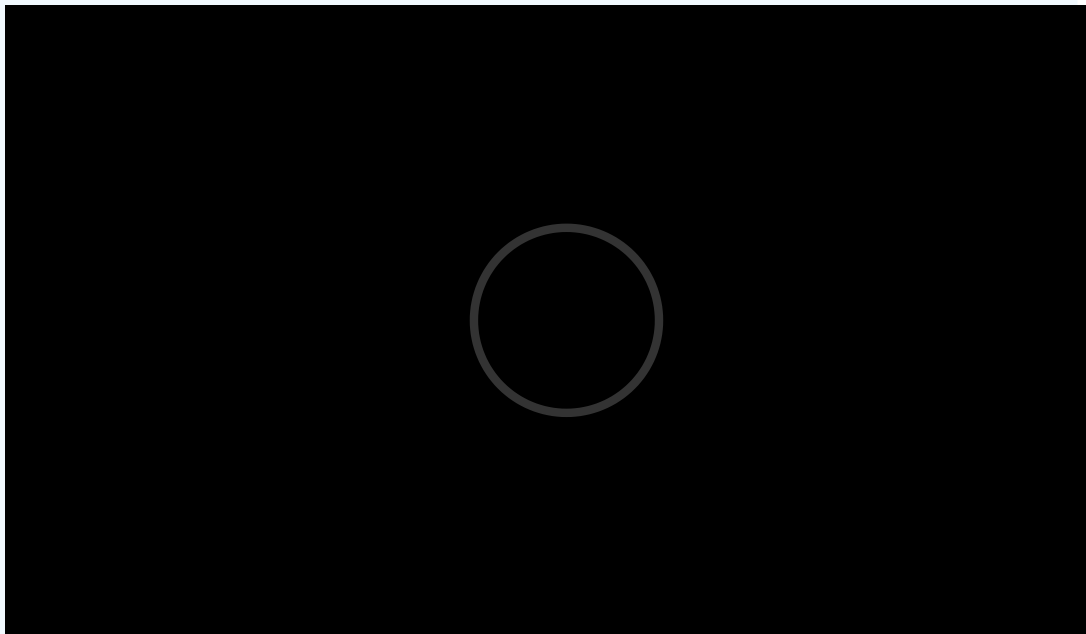
To practice in a manner that is culturally safe, practitioners should reflect on the power differentials inherent in health service delivery. Taking a culturally safe approach also implies acting as a health advocate: working to improve access to care; exposing the social, political, and historical context of health care; and interrupting unequal power relations. Given that the patient exists simultaneously within several caring systems, influenced by their family, community, and traditions, the culturally safe practitioner allows the patient to define what is culturally safe for them.

Our culture influences the way we perceive virtually everything around us, often unconsciously. Several useful concepts describe issues that can arise:

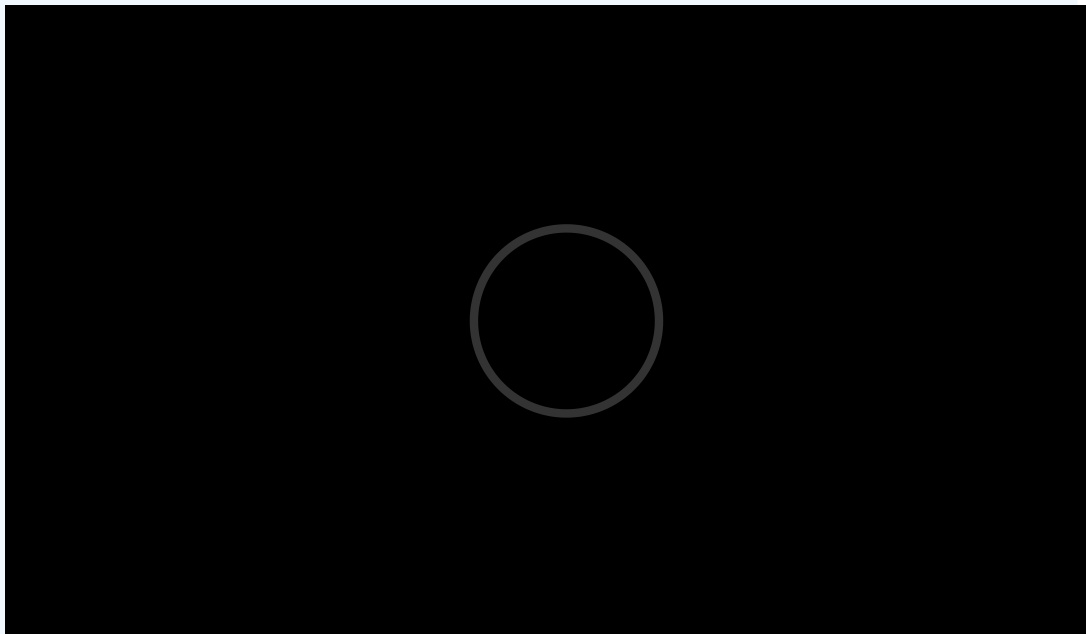
- *Ethnocentrism*. The sense that one's own beliefs, values, and ways of life are superior to, and more desirable than, those of others. For example, you may be trained in Western medicine, but your patient insists on taking a herbal remedy. You may be tempted to say "So, why are you consulting me, then?" Ethnocentrism is often unconscious and implicit in a person's behavior. Personal reflection is a valuable tool for physicians to critically examine their own ethnocentric views and behaviors.
- *Cultural blindness*. This refers to attempts (often well-intentioned) to be unbiased by ignoring the fact of a person's race. It is illustrated in phrases such as 'being color blind', or 'not seeing race'. However, ignoring cultural differences may make people from another culture feel discounted or ignored; what may be transmitted is the impression that race or culture are unimportant, and that values of the dominant culture are universally applicable. Meanwhile, the person who is culturally blind may feel they are being fair and unprejudiced, unaware of how they are making others feel. Cultural blindness becomes, in effect, the opposite of cultural sensitivity.
- *Culture shock*. Most physicians come from middle-class families and have not experienced poverty, homelessness or addictions. Exposure to such realities in their patients therefore requires great adaptations and can be distressing. This is a common experience in those who have visited a slum in a developing country, but may also arise at home in confronting abortion, infanticide, or female circumcision.
- *Cultural conflict*. Conflict generated when the rules of one's own culture are contradicted by the rules of another.
- *Cultural imposition (or cultural assimilation or colonialism)*. The imposition of the views and values of your own culture without consideration of the beliefs of others.
- *Stereotyping and generalization*. What may be true of a group need not apply to each individual. Hence, talking about cultures can lead to dangerously prejudicial generalizations. Prejudice is the tendency to use preconceived notions about a group in pre-judging one of the group's members, so applying cultural awareness to individuals can be hazardous. Yet, on the other hand, ignoring culture (cultural blindness) can be equally detrimental. The key is to acknowledge and be respectful of differences, and to ask patients to explain their perspective when in doubt.

? Learning Activity

Watch these brief videos from Think–Speak–Act Cultural Health to hear about specific cultural health examples.



[Think- Speak - Act Cultural Health: Part 1](#) from [jon merril](#) on [Vimeo](#).



[Think- Speak - Act Cultural Health: Part 2](#) from [jon merril](#) on [Vimeo](#).

The Relevance of Culture for Health

Culture influences health through many channels:

1. *Positive or negative lifestyle behaviors.* While we often focus on the negative influences of lifestyle behavior—such as drug cultures, or the poor diet of some teen cultures, for example—we should not neglect the positive cultural influences on behaviors and practices. For example, Mormons and Seventh Day Adventists have been found to live longer than the general population, in part because of their lifestyle including the avoidance of alcohol and smoking, but also because of enhanced social support.
2. *Health beliefs and attitudes.* These include what a person views as illness that requires treatment, and which treatments and preventive measures he or she will accept, as with the Jehovah's Witness prohibition on using whole blood products.

3. *Reactions to being sick.* A person's adoption of the [sick role](#) (and, hence, how he or she or he reacts to being sick) is often guided by his or her cultural roots. For instance, "machismo" may discourage a man from seeking prompt medical attention, and culture may also influence from whom a person will accept advice.
4. *Communication patterns*, including language and modes of thinking. Beyond these, however, culture may constrain some patients from expressing an opinion to the doctor, or may discourage a wife from speaking freely in front of her husband, for example. Such influences can complicate efforts to establish a therapeutic relationship and, thereby, to help the patient.
5. *Status.* The way in which one culture views another may affect the status of entire groups of people, placing them at a disadvantage. The resulting social inequality or even exclusion forms a health determinant. For example, women in some societies have little power to insist on condom use.

What elements of a patient's culture should a health care provider consider when deciding how best to manage a case?

Cultural influences may affect a patient's reaction to the disease, to suggested therapy, and to efforts to help them prevent recurrences by changing risk factors. Therefore, it may be important for health care providers to find out about such possibilities; they can explain that they need them to tell about their family's and community's feelings about health recommendations. Health care providers should explain that they are not familiar with their community and want them to tell if they may have beliefs or obligations that the health care provider should be aware of, such as any restrictions on diet, medications, etc., if these could be relevant.

Difference between cultural competence and cultural safety

Cultural competence is included within cultural safety, but safety goes beyond competence to advocate actively for the patient's perspective, to protect their right to hold the views they do. When a patient knows that you will honor and uphold their perspective and not try to change it, they will be more likely to accept your recommendations. A physician who practices culturally safe care has reflected on her own cultural biases recognizes them and ensures that her biases do not impact the care that the patient receives. This pattern of self-reflection, education and advocacy is also practiced at the organizational level.

✓ Example: Breast Cancer in Asian Women

Asian women, in general, and Vietnamese women, in particular, have been identified as ethnic groups that are not participating in breast cancer screening programs in the U.S. The reasons are complex and Vietnamese women may be especially vulnerable due to cultural variances in beliefs, health practices, language barriers, lack of access to care due to socio-economic factors, as well as the long term effects of the migration that occurred at the close of the Vietnam war.

? Learning Activity

Find out about how culture impacts health decisions and access by visiting each of the websites linked in the list below:

- [Hispanic-Latino Culture](#)
- [Chinese Culture](#)
- [Iraqi Culture](#)
- [Vietnamese Culture](#)
- [Lesbian, Gay, Bisexual, and Transgender Health Issues](#)

What are some of the positive and/or negative ways that culture impacts an individual's health care decisions and access?

Answer

Some Ethiopians living in the United States may avoid getting treatment if the medical facility is central and visible to their community. This could be due to the social stigma of TB (tuberculosis) in that culture combined with a cultural identity that highly values community participation. So, in order for Ethiopian-Americans to be more likely to get treatment for TB, the medical facility needs to be located in place where patients can come and go without being seen easily.

Stigmatized Illnesses and Health Care

Being disabled because of a disease or injury can lead to benefits – for example, a parking space that is close by. In some instances, the benefits are very attractive but, in most countries of the world, the disabled have no access to any governmental help, and insurance premiums are so high that only a minority of the population can participate in disability compensations schemes. In some situations, disability due to a war injury or to some other situation that confers hero status can also bring social respect and moral prestige to the disabled person.

For the vast majority of disabled people, however, the disadvantages of disability are much more important than its advantages. A restriction of the possibility of participation in normal social life and limitations in the pursuit of personal happiness are often grave and depressing for the person with an impairment that causes a disability.

When the disease or the situation that has produced impairment is stigmatized, the limitations of functions are aggravated and the possibility of compensating disability is significantly reduced. There are a number of diseases that are stigmatized—mental disorders, AIDS, venereal diseases, leprosy, and certain skin diseases. People who have such diseases are discriminated in the health care system, they usually receive much less social support than those who have non-stigmatizing illnesses and—what is possibly worst—they have grave difficulties in organizing their life if their disease has caused an impairment that can lead to disability and handicaps.

Mental disorders probably carry more stigma (and consequent discrimination) than any other illness. The stigma does not stop at the persons who are suffering from a stigmatized illness. Their immediate and even remote families often experience significant social disadvantages. The institutions that provide mental health care are stigmatized. Stigma reduces the value of the persons who have a mental disorder in the eyes of the community and the government.

Medications that are needed in the treatment of mental disorders, for example, are considered expensive even when their cost is much lower than the cost of drugs used in the treatment of other illnesses: they are not considered expensive because of their cost but because they are meant to be used in the treatment of people who are not considered to be of much value to the society.

The awareness of the fact that stigmatization is one of the major—if not the major—obstacles to the improvement of care for people with stigmatized illnesses is gradually growing. In a number of countries governments, non-governmental organizations, and health institutions have launched campaigns to reduce stigma related to illness. They display posters and distribute leaflets, as well as organize radio and television programs.

There is, however, an important sector employing many individuals that does not participate very actively in the reduction of stigma and in efforts to eliminate the discrimination that follows it. It is the health sector—which, by its definition, could gain from the reduction of stigma almost as much as the individuals who have the stigmatized illness. The managements of general hospitals, as well as heads of various medical departments often refuse to have a department of psychiatry and, if they accept it, they usually assign the worst accommodation for it—in a remote corner of the hospital grounds, for example, or in the lowest (sometimes partly underground) floor. In the order of priority for maintenance or renovation work departments of psychiatry come last although they are often in a pitiful state. Doctors who are not involved in mental health care participate and sometimes excel in making fun of the mentally ill, of psychiatrists, and of mental illness. They will often refuse to deal with physical illness in a person with a mental disorder and send such patients to their psychiatrist, although they are better placed to deal with the physical illness than the psychiatrist.

Nor are the psychiatrists and other mental health care staff doing as much as they should about the reduction of stigma. They seem unaware of the stigmatizing effects of their use of language—they speak of schizophrenics when they should say a person with schizophrenia and about misbehavior or lack of discipline when they should make it clear that behavioral abnormalities are part of the illness they are supposed to recognize and treat. In some countries they requested and received longer holidays or somewhat higher salaries saying that they deserve this because they deal with dangerous patients—although they have publicly proclaimed that mental illness is a disease like any other. They often disregard complaints about the physical health of people with mental disorders and do not do much about them, thus providing sub-optimal care and contributing to the tendency to dismiss whatever people with mental illness may be saying. In their teaching activities, stigmatization as well as the prevention of discrimination and its other consequences often receive only minimal attention.

Perhaps it is impossible for the health care workers themselves to launch large anti-stigma programs: what, however, they should and can do is to examine their own behavior and activity to ensure that they do not contribute to stigmatization and consequent discrimination. They should also participate in the efforts of others to reduce stigma or initiate such efforts whenever possible. Doing nothing about stigma and discrimination that follows it is no longer an acceptable option.

The Cultural Meaning of Illness

Our culture, not our biology, dictates which illnesses are stigmatized and which are not, which are considered disabilities and which are not, and which are deemed contestable (meaning some medical professionals may find the existence of this ailment questionable) as opposed to definitive (illnesses that are unquestionably recognized in the medical profession) (Conrad and Barker 2010). For instance, sociologist Erving Goffman (1963) described how social stigmas hinder individuals from fully integrating into society. The stigmatization of illness often has the greatest effect on the patient and the kind of care he or she receives. Many contend that our society and even our health care institutions discriminate against certain diseases—like mental disorders, AIDS, venereal diseases, and skin disorders (Sartorius 2007). Facilities for these diseases may be sub-par; they may be segregated from other health care areas or relegated to a poorer environment. The stigma may keep people from seeking help for their illness, making it worse than it needs to be. Contested illnesses are those that are questioned or questionable by some medical professionals. Disorders like fibromyalgia or chronic fatigue syndrome may be either true illnesses or only in the patients' heads, depending on the opinion of the medical professional. This dynamic can affect how a patient seeks treatment and what kind of treatment he or she receives.

In terms of constructing the illness experience, culture and individual personality both play a significant role. For some people, a long-term illness can have the effect of making their world smaller, more defined by the illness than anything else. For others, illness can be a chance for discovery, for re-imagining a new self (Conrad and Barker 2007). Culture plays a huge role in how an individual experiences illness. Widespread diseases like AIDS or breast cancer have specific cultural markers that have changed over the years and that govern how individuals—and society—view them.

Today, many institutions of wellness acknowledge the degree to which individual perceptions shape the nature of health and illness. Regarding physical activity, for instance, the Centers for Disease Control (CDC) recommends that individuals use a standard level of exertion to assess their physical activity. This Rating of Perceived Exertion (RPE) gives a more complete view of an individual's actual exertion level, since heart-rate or pulse measurements may be affected by medication or other issues (Centers for Disease Control 2011a). Similarly, many medical professionals use a comparable scale for perceived pain to help determine pain management strategies.

✓ ✓ Example 3.2.1

Consider these questions:

- What diseases are the most stigmatized?
- Which are the least?

- Is this different in different cultures or social classes?

Solution

Look at these sources to find some answers

Cultural Lens and How Culture Influences Your Perceptions: “The cultural lens and how culture influences your perceptions of others” AFMC Primer on Population Health, The Association of Faculties of Medicine of Canada Public Health Educators’ Network, phprimer.afmc.ca/Part1-TheoryThinkingAboutHealth/Chapter3CulturalCompetenceAndCommunication/Culturalawarenesssensitivityandsafety (Accessed March 11, 2012). License: Creative Commons BY-NC-SA

Example: Breast Cancer in Asian Women: Breast Cancer in Asian Women by Denise Little, Ethnomed, CC-BY-NC-ND, <http://ethnomed.org/clinical/cancer/breast-cancer-in-asian-women>

Stigmatized Illnesses and Health Care: Stigmatized Illnesses and Health Care, Norman Sartorius, Croatian Medical Journal, 2007 June; 48(3): 396–397, CC-BY-NC, www.ncbi.nlm.nih.gov/pmc/articles/PMC2080544/

The Cultural Meaning of Illness: OpenStax College, CC-BY, [The Social Construction of Health](http://cnx.org/content/m42927/1.2/), Connexions, May 18, 2012, <http://cnx.org/content/m42927/1.2/>

Sources

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