

## CHAPTER 1

# Introduction to Multicultural Health

*We have become not a melting pot but a beautiful mosaic.*

—JIMMY CARTER

*One day our descendants will think it incredible that we paid so much attention to things like the amount of melanin in our skin or the shape of our eyes or our gender instead of the unique identities of each of us as complex human beings.*

—AUTHOR UNKNOWN

### KEY CONCEPTS

Acculturation	Dominant culture	Multicultural health
Assimilation	Ethics	Morality
Autonomy	Ethnicity	Nonmaleficence
Beneficence	Fidelity	Race
Cultural adaptation	Health disparity	Racism
Cultural competence	Healthy People 2030	Respect
Cultural ethnocentricity	Heritage consistency	Stereotype
Cultural relativism	Hill–Burton Act	Veracity
Culture	Justice	
Discrimination	Minority	

### LEARNING OBJECTIVES

After reading this chapter, you should be able to do the following:

1. Explain why cultural considerations are important in health care.
2. Describe the processes of acculturation and assimilation.
3. Define race, culture, ethnicity, ethnocentricity, cultural relativism, stereotype, and discrimination.
4. Explain what cultural adaptation is and why it is important in health care.
5. Explain what health disparities are and their related causes.
6. List the five elements of the determinants of health and describe how they relate to health disparities.
7. Explain key legislation related to health and minority rights.

Why do we need to study multicultural health? Why is culture important if we all have the same basic biological makeup? Isn't health all about science? Shouldn't people from different cultural backgrounds just adapt to the health care system and perspectives in the United States?

For decades, the role that culture plays in health was virtually ignored, but the links have now become more apparent. As a result, the focus on the need to educate health care professionals about the important role that culture plays in health has escalated. Health is influenced by factors such as genetics, the environment, and socioeconomic status, as well as by other cultural and social forces. Culture affects people's perception of health and illness, how they pursue and adhere to treatment, their health behaviors, beliefs about why people become ill, how symptoms and concerns about the problem are expressed, what is considered a health problem, and ways to maintain and restore health. Recognizing cultural similarities and differences is an essential component for delivering effective health care services. To provide quality care, health care professionals need to provide services within a cultural context, which is the focus of multicultural health.

**Multicultural health** is the phrase used to reflect the need to provide health care services in a sensitive, knowledgeable, and nonjudgmental manner with respect for people's health beliefs and practices when they are different from our own. It entails challenging our own assumptions, asking the right questions, and working with the patient and the community in a manner that respects the patient's lifestyle and approach to maintaining health and treating illness. Multicultural health integrates different approaches to care and incorporates the culture and belief system of the health care recipient while providing care within the legal, ethical, and medically sound practices of the practitioner's medical system.

Knowing the health practices and cultures of all groups is not possible, but becoming familiar with various groups' general health beliefs and preferences can be very beneficial and improve the effectiveness of health care services. In this text, generalizations

about cultural groups are provided, but it is important to realize that many subcultures exist within those cultures, and people vary in the degree to which they identify with the beliefs and practices of their culture of origin. Awareness of general differences can help health care professionals provide services within a cultural context, but it is important to distinguish between **stereotyping** (the mistaken assumption that everyone in a given culture is alike) and generalizations (Juckett, 2005). Generalizations can serve as a starting point but do not preclude factoring in individual characteristics such as education, nationality, faith, and level of cultural adaptation. Stereotypes and assumptions can be problematic and can lead to errors and ineffective care. Remember, every person is unique, but understanding the generalizations can be beneficial because it moves people in the direction of becoming culturally competent.

**Cultural competence** refers to an individual's or an agency's ability to work effectively with people from diverse backgrounds. *Culture* refers to a group's integrated patterns of behavior, and *competency* is the capacity to function effectively. Cultural competence occurs on a continuum, and this text is geared toward helping you progress along the cultural competence continuum.

Specific terms related to multicultural health, such as *race* and *acculturation*, need to be clarified, and this chapter begins by defining some of these terms. Following that is a discussion of the demographic landscape of the U.S. population and how it is changing, types and degrees of cultural adaptation, and health disparities and their causes. The chapter concludes with information about legislation related to health care that is designed to protect minorities.

## Key Concepts and Terms

Some of the terminology related to multicultural health can be confusing because the differences can be subtle. This section clarifies the meaning of terms such as *culture*, *discrimination*, *race*, *ethnicity*, *ethnocentricity*, and *cultural relativism*.

### Culture

There are countless definitions of culture. The short explanation is that **culture** is everything that makes us who we are. E. B. Tylor (1871/1924), who is considered the founder of cultural anthropology, provided the classical definition of culture: "Culture, or civilization, taken in its broad, ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (p. 1). Tylor's definition is still widely cited today. A modern definition of culture is "group membership, such as racial, ethnic, linguistic or geographical groups, or as a collection of beliefs, values, customs, ways of thinking, communicating, and behaving specific to a group" (Centers for Disease Control and Prevention [CDC], 2021).

Culture is learned, changes over time, and is passed on from generation to generation. It is a very complex system, and many subcultures exist within each culture. For example,

universities, businesses, neighborhoods, age groups, the gay and lesbian community, athletic teams, and musicians are subcultures of the dominant American culture. **Dominant culture** refers to the primary or predominant culture of a region and does not indicate superiority. People simultaneously belong to numerous subcultures, because we can be students, fathers or mothers, and bowling enthusiasts at the same time.


## Race and Ethnicity

**Race** refers to a person's physical characteristics, but race is not a scientific construct. Race is a social construct that was developed to categorize people, and it was based on the notion that some "races" are superior to others. Many professionals in the fields of biology, sociology, and anthropology have determined that race is a social construct and not a biological one because not one characteristic, trait, or gene distinguishes all the members of one so-called race from all the members of another so-called race. "There is more genetic variation within races than between them, and racial categories do not capture biological distinctiveness" (Williams et al., 1994).

Why is race important? Because society makes it important. Race shapes social, cultural, political, ideological, and legal functions in society. Race is an institutionalized concept that has had devastating consequences. Race has been the basis for deaths from wars and murders and suffering caused by **discrimination**, violence, torture, and hate crimes. The ideology of race has been the root of suffering and death for centuries, even though it has little scientific merit.

The 2020 U.S. Census questions related to ethnicity and race can be found in **Figures 1.1** and **1.2**. **Box 1.1** explains how these race terms were defined in the 2020 census. The U.S. government declared that Hispanics and Latinos are an ethnicity and not a race.

### Is this person of Hispanic, Latino, or Spanish origin?

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin – Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc. 

**Figure 1.1** U.S. Census origin question, 2020.

It is important to note that there is great variation within each of the racial and ethnic categories. For example, American Indians are grouped together even though there are variations between the tribes. It is essential to be aware of the differences that occur





**BOX 1.1 Definition of Race Categories Used in the U.S. Census (2020)****White**

The category "White" includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun, and Chaldean.

**Black or African American**

The category "Black or African American" includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.

**American Indian or Alaska Native**

The category "American Indian or Alaska Native" includes all individuals who identify with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, and Nome Eskimo Community.

**Asian**

The category "Asian" includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, and so on.

There are individual Asian checkboxes for people who identify as one or more of the following:

- Chinese
- Filipino
- Asian Indian
- Vietnamese
- Korean
- Japanese
- Other Asian (e.g., Pakistani, Cambodian, and Hmong)

**Native Hawaiian and Pacific Islander**

The category "Native Hawaiian or Other Pacific Islander" includes all individuals who identify with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited

(continued)

**BOX 1.1 Definition of Race Categories Used in the U.S. Census (2020) (Continued)**

to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, Yapese, and so on.

There are individual Pacific Islander checkboxes for people who identify as one or more of the following:

- Native Hawaiian
- Samoan
- Chamorro
- Other Pacific Islander (e.g., Tongan, Fijian, and Marshallese)

**Some other race:** Defined by Census respondent

person knows nothing about Korean history and culture, but in the United States that person would likely be treated racially as Asian. Let's consider another example. The physical characteristics of Caucasians (a race) are typically light skin and eyes, narrow noses, thin lips, and straight or wavy hair. A person whose appearance matches these characteristics is said to be a Caucasian. However, there are many ethnicities within the Caucasian race such as Dutch, Irish, Greek, German, French, and so on. What differentiates these Caucasian ethnic groups from one another is their country of origin, language, cultural heritage and traditions, beliefs, and rituals.

How is ethnicity different from culture? One can belong to a culture without having ancestral roots to that culture. For example, people can belong to the hip-hop culture, but they were not born into the culture. With ethnicity, the culture is a part of the ethnic background, so culture is embedded within the ethnic group. Ethnic groups have shared beliefs, values, norms, and practices that are learned and shared. These patterned behaviors are passed down from one generation to another and are thus preserved.

**Cultural Ethnocentricity and Cultural Relativism**

Cultural **ethnocentricity** refers to people's belief that their culture is superior to another one. This can cause problems in the health care field. If professionals believe that their way is the better way to prevent or treat a health problem, health care workers may disrespect or ignore the patient's cultural beliefs and values. The health care professional may not take into consideration that the listener may have different views than the provider. This can lead to ineffective communication and treatment and leave listeners feeling unimportant, frustrated, disrespected, or confused about how to prevent or treat the health issue, and they might view the professional as uneducated, uncooperative, unapproachable, or closed-minded.

To be effective, one needs to see and appreciate the value of different cultures; this is referred to as **cultural relativism**. The phrase developed in the field of anthropology to

# Theories and Models Related to Multicultural Health

*Inadequate attention has been given to the range of variation in social, cultural, and health characteristics within and between racial or ethnic minority populations.*

—WILLIAMS ET AL. (1994, P. 26)

### KEY CONCEPTS AND TERMS

Ayurvedic system	Holistic medicine	Personalistic belief system
Biomedical (allopathic) medicine	Humoral system	Vitalistic system
Germ theory	Naturalistic theories of disease	

### LEARNING OBJECTIVES

After reading this chapter, you should be able to do the following:

1. Explain three overarching theories of the causes of illness and provide examples of each.
2. Explain the differences between the biomedical and holistic systems of care.
3. Explain two models of cultural competence.

“Being cold will give you a cold,” “cracking your knuckles will give you arthritis,” and “feed a fever, starve a cold” are three examples of beliefs in the United States about how illness can occur and be cured. People from different cultures hold their own beliefs about the causes and cures of illness, and these beliefs influence their behavior and where and when they decide to seek care. Many others factors also affect our health care experience, such as how we communicate about health, whether we believe we have control over our own health, and how health care decisions are made. These factors can be so deeply ingrained that they are almost invisible. Because of this invisibility, health care professionals can



overlook these key differences and forget that not all people who reside within the United States have the same beliefs about health and illness. Therefore, it is essential to bring these issues to light, which is the purpose of this chapter.

This chapter begins with a discussion of theories about how illness occurs and then presents models of care for when illness does occur. The chapter ends with a focus on cultural competence and ways to improve cultural competence.

## Theories of Health and Illness

Theories about health and illness address the beliefs people hold about how to maintain health and the causes of illness. These ideas, beliefs, and attitudes are socially constructed and are deeply ingrained in people's cultural experience, and they can have a profound effect on medical care. Where and when people seek care are rooted in their cultural belief system (Carteret, 2011). Their beliefs influence prevention efforts, delay or prevent medical care, and complicate the care given (Carteret, 2011). Cultural differences impact a patient's compliance, their ability to understand medical recommendations, and attitudes about medical care (EuroMed Info, 2020). Culture impacts how patients cope and manage an illness, the meaning of a diagnosis, and the outcomes of medical treatment (EuroMed Info, 2020).

Ideas about health maintenance vary among cultures and include ideologies such as consuming a well-balanced diet, wearing amulets, rewards for good behavior, and prayer. Illness causation ideologies include breach of taboo, soul loss, exposure to germs, upset in the hot-cold balance of the body, or a weakening of the body's immune system. Treatment methods range from medications and surgeries to witchcraft and returning the soul to the ill person. In the Western world, the human body is thought of as a machine; when the machine breaks, illness occurs. Eastern philosophies generally view health as a state of balance between the physical and social environments as well as the supernatural environment (Carteret, 2011).

Theories of health and illness serve to create a context of meaning within which patients can make sense of their bodily experience. They assist the patient in framing the illness in a meaningful and logical manner. A meaningful context for illness usually reflects core cultural values and helps the patient bring order to the chaotic world of serious illness and regain some sense of control in a frightening situation. Theories of illness shape how people receive and respond to prevention programs, treatment, and health education messages.

Theories of illness are often divided into three broad categories: personalistic, naturalistic, and biomedical (allopathic). In a personalistic system, illness is believed to be caused by the intentional intervention of an agent who may be a supernatural being (a deity or ancestral spirits) or a human being with special powers (a witch or sorcerer). The sick person's illness is considered a direct result of the harmful influence of these agents and is often linked to the ill person's behavior. In naturalistic causation, illness is explained in terms of a disturbed natural equilibrium. When the body is in balance with the natural environment, a state of health is achieved. When the balance no longer exists,

illness occurs. In the biomedical theory, illness is identified and cured using scientific evidence. The cause of illness is physiological in nature.

Many people's beliefs systems are a combination of these three theories. The theories are used by people to understand and respond to the illness. Through communication, patients and providers can work together and combine the theories to try to achieve a positive outcome for the patient.

### Personalistic Theories

In the **personalistic belief system**, illness is believed to be caused by the person's misbehavior. The behavior could be related to violations of social or religious norms. As a result of moral or spiritual failings, the person may have punishment invoked in the form of illness by a supernatural being or a human with special powers. The supernatural being may be a dead ancestor or a deity (Carteret, 2011). A dead ancestor may retaliate for not carrying out proper rituals of respect for the dead ancestor. The deity may retaliate for breaching a religious taboo. Bad luck or karma also may cause illness.

Illness also can be caused by people who have the power to make others ill, such as witches, practitioners of voodoo, and sorcerers. These malevolent human beings manipulate secret rituals and charms to cause illness in their enemies.

Recovery from the illness involves healers using supernatural means to understand what is wrong with their patients and return them to health. These supernatural means usually involve rituals or symbolisms used by healers, such as shamans, who are trained in the healing methods. American Indians and people from Latin America and Asia often hold the personalistic belief system (Carteret, 2011). Preventing personalistic illness includes avoiding situations that can provoke jealousy or envy, wearing certain amulets, adhering to social norms and moral behaviors, adhering to food taboos and restrictions, and performing certain rituals. Several personalistic beliefs and practices are reviewed in later chapters.

### DID YOU KNOW?

Osteopathic medicine is a form of medical care based on the philosophy that all body systems are interrelated and dependent on one another for good health. In 1874, Dr. Andrew Taylor Still, who recognized the importance of treating illness within the context of the whole body, developed the philosophy of osteopathic medicine. In 1892, Dr. Still opened the first school of osteopathic medicine in Kirksville, Missouri. Physicians licensed as doctors of osteopathic medicine (DOs) must pass a national or state medical board examination to obtain a license to practice medicine (American College of Osteopathic Medicine, 2020).

Osteopathic physicians utilize the same tools available through modern medicine, including prescription medicine and surgery. In addition, DOs use osteopathic manipulative medicine (OMM) in their regimen of patient care when appropriate. "OMM is a set of manual medicine techniques that may be used to diagnose illness and injury, relieve pain, restore range of motion, and enhance the body's capacity to heal" (American College of Osteopathic Medicine, 2020).

## Naturalistic Theories

**Naturalistic theories of disease** tend to view health as a state of harmony between the person and his or her environment; when this balance is upset, illness will result. The naturalistic explanation assumes that illness is due to impersonal, mechanistic causes in nature that potentially can be understood and cured by returning the patient to a balanced state. Humoral, Ayurvedic, and vitalistic are three of the widely practiced approaches to curing natural illness or to explain what causes illness. Preventing naturalistic illness includes methods such as proper hygiene, a balanced diet, and meditation. These types of illness are treated by practitioners such as physicians, nurses, acupuncturists, and chiropractors. Methods include dietary changes, massage, medication, exercise, and physical adjustments.

### Humoral

Humoral pathology was developed and became the basis of both ancient Greek and Roman medicine. It is part of the mainstream medical system in Latin America and Asia.

The humoral system is an ancient belief system based on the idea that our bodies have four important fluids, or humors: blood, phlegm, black bile, and yellow bile. These four fluids are related to seasons, internal organs, physical qualities (hot-cold; wet-dry), and human temperaments (see **Table 2.1**). Each humor is thought to have its own “complexion.” For example, blood is hot and wet, and yellow bile is hot and dry. Different kinds of illnesses, medicines, foods, and most natural objects also have specific complexions.

**TABLE 2.1** Humor and Related Organ and Complexion

Humor (Fluid)	Associated Internal Organ	Associated Season	Associated Element	Normal Complexion	Temperament
Blood	Liver	Spring	Air	Hot and wet	Sanguine (cheerfully confident; optimistic)
Phlegm	Brain and lungs	Winter	Water	Cold and wet	Phlegmatic (calm, sluggish; apathetic)
Black bile	Spleen	Fall	Earth	Cold and dry	Melancholic (in low spirits; gloomy)
Yellow bile	Gallbladder	Summer	Fire	Hot and dry	Choleric (easily angered)

Curing an illness involves discovering the complexion imbalance and rectifying it. A hot injury or illness must be treated with a cold remedy and vice versa. In the 19th century there was a radical transition from the humoral theory to the germ theory of disease, which involved new concepts, rules, and classifications, as well as the abandonment of old ones.

### Ayurvedic

Ayurvedic is an ancient naturalistic approach to health that is used in India and other parts of the world. The term *ayurveda* is taken from the Sanskrit words *ayus*, meaning life or life span, and *veda*, meaning knowledge. In the **Ayurvedic system**, illness is caused by an energy imbalance. The belief system has a long history and embraces the ideology that disease is a result of an imbalance in vital energies, which distinguish living and nonliving matter. In ayurvedic medicine the vital force is called the *prana*.

Ayurveda suggests that three primary principles govern every human body. These principles, called *doshas*, are derived from the five elements: earth, air, water, fire, and space. Doshas regulate all actions of the body. Most people have a predominant dosha, and each dosha type has typical attributes or characteristics. The Ayurveda system of medicine uses a genetically determined concept, *prakriti*, to categorize the population into several subgroups based on phenotypic characters such as appearance, temperament, and habits. This system is useful in predicting an individual's susceptibility to a particular disease, prognosis for that illness and selection of therapy, and variations in platelet aggregation (Bhalerao et al., 2012).

When the doshas are balanced, we experience good health, vitality, ease, strength, flexibility, and emotional well-being. When the doshas fall out of balance, we experience energy loss, discomfort, pain, mental or emotional instability, and, ultimately, disease. Ayurvedic ways to restore balance include breathing exercises, rubbing the skin with herbal oil, meditation, yoga, mantras, massage, and herbs. These modalities are energetic ways to balance the chakras.

The system links the body's *chakras*, or energy centers associated with organs of the body, with primal forces, such as *prana* (breath of life), *agni* (spirit of light or fire), and *soma* (manifestation of harmony). Each and every cell has a chakra, but like the doshas, one or more can often be found to be more dominant than some of the others. When the life force withdraws, the physical body dies; if the life force becomes blocked or compromised, illness or disease is the likely result. Two ways in which the life force enters the body are through breath and through the chakra system.

Breath sustains all life, and when we breathe we take in life-force energy and move the energy to the entire body via the respiratory and circulatory system. The chakra system is another way in which that energy force enters the body. *Chakra* means "wheels of life," and these invisible "wheels" pull in this vital life force. Our physical bodies contain seven major chakras between the base of the spine and the top of the head as well as many minor chakras (see **Figure 2.1**). Each chakra is associated with a major gland or organ and plays an important role in our emotional well-being. As we become older or ill, these chakras may slow down or become blocked, reducing the amount of life force taken into the body, which compromises health and vitality. Our life force also may become depleted due to prolonged stress, poor health habits, or unexpressed emotions.

### Vitalistic

In China a system similar to Ayurveda was developed. The **vitalistic system** can be defined as the concept that bodily functions are due to a vital principle or "life force" that is



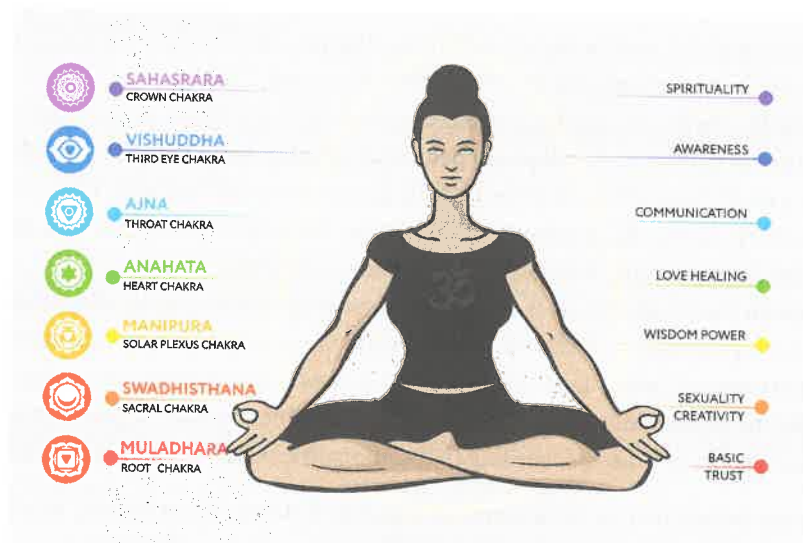


Figure 2.1 Chakra system.

distinct from physical forces explainable by the laws of chemistry and physics and is not detectable by scientific instrumentation. The system is built on the belief that an imbalance in vital energies causes disease.

The imbalance is related to the polar opposites, *yin* (female, dark, cold) and *yang* (male, light, hot), in which one combines the interaction of body fluids and energy channels, or meridians. This vitalistic belief system is widespread in China, South Asia, and Southeast Asia. In the Chinese system, the vital force is called the *chi*; in the ayurvedic system it is the prana. When vital forces within the body flow in a harmonious pattern, a positive state of health is maintained. Illness results when this smooth flow of energy is disrupted, and therapeutic measures are aimed at restoring a normal flow of energy in the body. In China the ancient art of acupuncture is based on this understanding of the body. Acupuncture needles help restore a proper flow of energy within the body.

### Biomedical Theory

**Biomedical medicine** (also known as **allopathic medicine**) is based on the mechanical view, or machine view, of the body: When the machine breaks illness occurs. Spirituality is generally kept separate from health and healing matters. Spirituality is usually viewed as a nonscientific approach to health and healing. Mental health problems are generally viewed as disorders of the mind, and physicians tend to treat these disorders by affecting brain physiology with pharmaceuticals or with counseling or behavior modification.

Allopathic medicine is the type of medicine most familiar to Westerners today. Allopathy is a biologically based approach to healing. For instance, if a patient has high blood pressure, an allopathic physician might give him or her a drug that lowers blood pressure. A core assumption of the value system of allopathic medicine is that diagnosis and treatment should be based on scientific data. The system is built on a molecular



understanding of the mechanisms underlying disease, and this lays the foundation for all medical application, diagnosis, and treatment (Carteret, 2011).

Allopathic medicine quickly rose to dominance in the West, in part due to successful scientific progress in developing specific drugs that treat disease. The discovery of antibiotics also triggered rapid growth of the pharmaceutical industry. Pharmacy evolved as an enabling discipline to allopathic medicine, helping it to achieve and maintain its dominance through many successful treatments and cures.

The germ theory of disease is a core component of contemporary allopathic medicine. **Germ theory** proposes that microorganisms are the cause of many diseases. Although highly controversial when first introduced, it is now a cornerstone of modern medicine and has led to innovations and concepts such as antibiotics and hygienic practices.

Typical causes of illness, according to the allopathic belief, are as follows (O'Neil, 2005):

- Organic breakdown or deterioration (e.g., tooth decay, heart failure, senility)
- Obstruction (e.g., kidney stones, arterial blockage due to plaque buildup)
- Injury (e.g., broken bones, bullet wounds)
- Imbalance (e.g., too much or too little of specific hormones and salts in the blood)
- Malnutrition (e.g., too much or too little food, not enough proteins, vitamins, or minerals)
- Parasites (e.g., bacteria, viruses, amoebas, worms)

### WHAT DO YOU THINK?

What are your personal beliefs about how health is maintained and illness occurs? Do you hold any beliefs such as that a glass of milk will help you fall asleep? Where does that belief come from? Is it valid? How do your beliefs affect your behavior?

## Pathways to Care

The theory of illness with which a person identifies has an impact on where he, she, or they seeks care. Within the United States there are two general systems of care to choose from: the allopathic (biomedical) approach and the holistic approach. The allopathic approach is often viewed as being scientific and focuses more on the physical components of illness than on the social aspects. Holistic medicine is viewed by some as unscientific, and it is based on a psychosocial model of health care. A comparison of these two approaches is shown in **Table 2.2**. People select one health care delivery system over the other for a variety of reasons, and this decision-making process includes considerations such as culture, access to care, health beliefs, and affordability, but many people use both.

**TABLE 2.2 Two Health Paradigms**

Allopathic	Holistic
Focuses on measurements; symptoms	Focuses on experience; causes and patterns
Disease as entity; pain avoiding	Disease as process; pain reading
General classified diagnosis	Specific individual needs
Health as commodity	Health as process
Technical tools	Integrated therapies
Remedial, combative, reactive	Preventive, corrective, proactive
Crisis oriented; occasional intervention	Lifestyle oriented; sustained maintenance
Radical, defensive	Natural, ecological
Medicine as counteragent	Medicine as coagent
Side effects: chemicals, surgery, radiation, replacement	Low risk: conservative, organic, purification, manipulation, correction
Emphasis on cure	Emphasis on healing
Speed, comfort, convenience	Restoration, regeneration, transformation
Practitioner as authority; pacifying	Practitioner as educator; activating
Patient as passive recipient	Patient as source of healing
Mechanical, analytical, biophysical	Systemic, multidimensional, body–mind–spirit
Best for infectious diseases, trauma, structural damage, organ failure, acute conditions	Best for degeneration, chronic stress and lifestyle disorders, toxemia, glandular conditions, weakness, systemic imbalances, immunity

Source: Adapted from Lonny J. Brown, *Self-Actuated Healing (More Crystals and New Age)*. Copyright © 1989 by Naturegraph & Keven Brown Publications.

### Allopathic Medicine

In the Western world, the theoretical construct about the cause of illness is biomedicine. In biomedicine, the body is viewed as a machine, and a core assumption of biomedicine is that scientific data should be the basis of diagnosis and treatment. The approach is built on the ideology that illness occurs when the human biological system goes out of balance and that microorganisms are the cause of many diseases.

Care in the biomedical system is provided by a variety of types of professionals with diverse expertise and levels of training. Allopathic physicians include doctors of medicine (MDs) and doctors of osteopathic medicine (DOs). Numerous allied health professionals, such as nurses, respiratory therapists, physical therapists, physician assistants, health educators, and radiologists, also practice allopathic medicine.

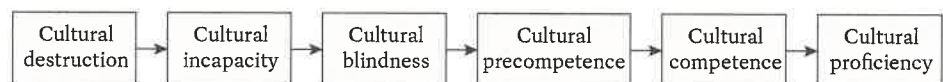
## Holistic Medicine

The holistic approach (also called alternative medicine or complementary medicine) has a long history and has been rapidly gaining popularity worldwide. **Holistic medicine** is an approach to maintaining and resuming health that takes the body, mind, and spiritual being into consideration. Holistic medicine uses a variety of therapies, such as massage, prayer, herbal remedies, and reiki. More detail about these therapies is provided in Chapter 4.

Holistic providers have vast differences in their levels of training. These differences include length of training, certification and licensing requirements, and required experience. For example, people who study ayurvedic medicine in India often have four or more years of training, and in the United States it is often much less. Because of this broad range of training and educational requirements, it is essential to inquire about education and experience when seeking a provider. Providers include professionals such as homeopaths, naturopaths, acupuncturists, and hypnotherapists.

## Cultural Competence

Cultural competence occurs when an individual or organization has the ability to function effectively within the cultural context of beliefs, behaviors, and needs of the patients or community it serves. The CDC (2020) defined cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.” Cultural competence requires a set of skills and knowledge that all health care professionals and organizations should strive to acquire. The ability to be culturally competent is on a continuum, with cultural destructiveness on one end of the continuum and cultural proficiency at the other end, as illustrated in **Figure 2.2**.



**Figure 2.2** Cultural competence continuum.

Being culturally competent does not mean that people need to know everything about every culture, because that is not possible. What it does mean is that people are respectful and sensitive to cultural differences and can work with clients' cultural beliefs and practices. To be culturally competent, one needs to understand his or her own worldviews and those of the person or community in which he, she, or they serves while avoiding stereotyping, judgment, and misapplication of scientific knowledge. Becoming culturally competent is a process that health care professionals should continue to strive to achieve. Models have been developed to assist individuals and organizations in achieving this goal.

## Cultural Competence Models

Models are tools that assist with understanding the causes of behaviors, predicting behaviors, and evaluating interventions. Cultural competence models help the learner understand the different components of cultural competence, guide their interactions with people of different cultural groups, and help them identify areas in which they may need to increase their education.

### The Process of Cultural Competence in the Delivery of Health Care Services

Joseph Campinha-Bacote (2009) developed a model of cultural competence that is based on five constructs:

1. *Cultural awareness.* The process of conducting a self-examination of one's own biases toward other cultures and an in-depth exploration of one's cultural and professional background.
2. *Cultural knowledge.* The process in which the health care professional seeks and obtains a sound information base regarding the worldviews of different cultural and ethnic groups as well as biological variations, diseases and health conditions, and variations in drug metabolism found among ethnic groups (biocultural ecology).
3. *Cultural skill.* The ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally based physical assessment.
4. *Cultural encounter.* The process that encourages the health care professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds to modify existing beliefs about a cultural group and to prevent possible stereotyping.
5. *Cultural desire.* The motivation of the health care professional to "want to" rather than to "have to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and to seek cultural encounters.

### The Purnell Model for Cultural Competence

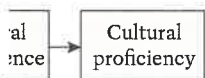
The Purnell model for cultural competence started as an organizing framework in 1991 when Dr. Larry Purnell discovered the need for both students and staff to have a framework for learning about their cultures and the cultures of their patients and families. The purposes of the model are to provide a framework for health care providers to learn concepts and characteristics of culture and to define circumstances that affect a person's cultural worldview in the context of historic perspectives (Purnell, 2005).

The model (illustrated in **Figure 2.3**) is a circle in which an outlying rim represents global society, a second rim represents community, a third rim represents family, and an inner rim represents the person. **Table 2.3** lists the four rings with their related definitions. The interior of the circle is divided into 12 pie-shaped wedges that depict cultural domains

plementary medicine) wide. **Holistic medicine** considers the body, mind, and spirituality of therapies, such as yoga and acupuncture. At these therapies is

ing. These differences and required experiences have four or more levels of this broad range of knowledge about education and training, such as homeopaths,

the ability to function as advocates for the needs of the patients or as "a set of congruent beliefs, attitudes, and agency, or among professionals and organizations on a continuum, with varying degrees of proficiency at the other



to know everything about a patient's culture. One assumption is that people are not aware of their own cultural beliefs and values and his or her own cultural beliefs and values or they serve while they serve. Becoming culturally competent should continue to be a goal for health care professionals and organizations

# Worldview and Health

*After all, when you come right down to it, how many people speak the same language even when they speak the same language?*

—RUSSELL HOBAN

*Nothing is so conducive to good health as the regularity of life without haste and without worry which the rational practice of religion brings in its train.*

—JAMES J. WALSH

*To prevent disease or to cure it, the power of truth, of divine Spirit, must break down the dream of the material senses.*

—MARY BAKER EDDY

### KEY CONCEPTS AND TERMS

Advance directive	Euthanasia	Religion
Ahimsa	Fate versus free will	Rituals
Animal sacrifice	Individualism	Shrines
Biomedical worldview	Karma	Spirituality
Collectivism	Living will	Temporal relationships
Durable power of attorney	Mind–body integration	Worldview
	Proxemics	

### LEARNING OBJECTIVES

After reading this chapter, you should be able to do the following:

1. Explain what worldview means and how it is related to culture.
2. Describe how worldview is related to health behaviors and decisions, how health is perceived, and how problems are expressed.
3. Explain the difference between spirituality and religion.
4. Describe ways religion can have positive and negative effects on physical and mental health.
5. Describe religious differences in birthing and death rituals.



A person's worldview is closely linked to his or her cultural and religious background, and it has profound implications for health care. Worldview influences lifestyle, and it is imperative that health care professionals understand its impact on health care decisions, involve patients in decisions and actions, and accommodate patients' beliefs to provide congruent care.

This chapter begins with a discussion of worldview and how it is related to health care. Then we move into more specific ways that worldview affects medical decisions and how people perceive and respond to illness. The chapter ends with a discussion on religion, spirituality, rituals, and health.

## Worldview

A **worldview** is a set of cultural assumptions and beliefs that express how people see, interpret, and explain their experience (Tilbert, 2010). It helps us make sense of our lives. Worldview includes our relationships with nature, our social relationships, our ethical reasoning, and cosmology (study of the universe and humanity's place) (Purnell, 2013). It even affects our view of aesthetics. For example, most of us know that sun exposure contributes to skin cancer, but some cultures view tans as looking healthy whereas others see very white skin as beautiful, which is why skin lightening is done.

Culture fits within the larger structure of worldviews. Worldviews are the beliefs and assumptions by which an individual can make sense of experiences, and these are what culture is built on. Cultural groups have varied views of the world, and when they clash, people may find the behavior of others offensive or confusing. Because worldviews contain and shape cultures, working effectively across cultures requires some understanding of the soil from which cultures grow—the seedbed called worldviews.

A person's worldview is closely linked with their cultural and religious background and has profound health care implications. For example, people with chronic diseases who believe in fatalism (predetermined fate) may not adhere to treatment, because they believe that medical intervention cannot affect their outcomes. Worldview is an equally important concept for educating health professionals about their own beliefs and assumptions that may influence the care they deliver. The medical profession consists of its own beliefs and assumptions just as do the cultures of the patients. Some of the major components of worldview that affect health care professionals are discussed in the following sections.

## Temporal Relationships

**Temporal relationships** refer to people's worldview in terms of time. These perceptions of time vary among cultures. In the West, time tends to be seen as quantitative elements of past, present, and future and is measured in units that reflect the march of progress. It is logical and sequential. In the East, time feels like it has unlimited continuity, and it does not have a defined boundary. Birth and death are not such absolute ends, because the universe continues, and humans, though changing form, continue as part of it.

Some cultures are present oriented, and others focus on the past or future. Time perspective affects our health behaviors and expectations of health care behavior. Present-focused people may not be willing to make sacrifices now for the future health benefits and engage in behaviors to satisfy their immediate desire regardless of the long-term consequences. Present-oriented cultures, including Native Americans and African Americans, may see living in the moment as the priority and are less willing to forgo immediate pleasures for future benefits. Future-oriented individuals may be willing to make sacrifices now knowing that their current health behaviors impact their future health status. Cultures that are past oriented tend to value elders and honor traditions. For example, the Asian culture is generally past oriented, and they value and perform traditional healing practices, such as acupuncture and herbal remedies.

Another component of time related to health care is expectations related to punctuality. Some cultures are very punctual, and people in these groups (e.g., people with a Polish culture) will arrive for appointments on time. Others are less rigid and will arrive around the time of the appointment. Some clinics who serve cultures who have less rigidity around time have stopped making appointments and changed to seeing patients on a first-come, first-served basis.

### Space (Proxemics)

Another variable across cultures is perception of space, or **proxemics**, which includes interpersonal distance and boundaries. Violating these boundaries can lead to conflict, stress, anxiety, miscommunication, or discomfort. If someone is accustomed to standing or sitting very close when they are talking with another, that person may see the other's attempt to create more space as evidence of coldness, condescension, or a lack of interest. Those who are accustomed to more personal space may view attempts to get closer as pushy, disrespectful, or aggressive. Research indicates that cultures that live in crowded areas, such as in a heavily populated city, are more tolerant of closeness and proximity to others when compared to members of other cultures who are not tolerant to closeness and instead prefer to be in and live in less crowded and congested areas. This distance and space tolerance may influence and impact on a person's tolerance of crowded areas and being in close proximity (Burke, 2020).

### Social Organization and Family Relationships

Social organization refers to patterns of social interactions. Examples include how people interact and communicate, the kinship system, marriage residency patterns, division of labor, who has access to specific goods and knowledge, social hierarchy, religion, and economic systems. Examples of social organization that have an impact in health care include individualism versus collectivism, fate versus free will, communication, and family relationships.

past or future. Time health care behavior. for the future health regardless of the long- Americans and African less willing to forgo als may be willing to impact their future and honor traditions. y value and perform dies.

ions related to punc- ps (e.g., people with a s rigid and will arrive ltures who have less ged to seeing patients

omics, which includes s can lead to conflict, customized to standing on may see the other's n, or a lack of interest. empts to get closer as s that live in crowded ness and proximity to erant to closeness and his distance and space wded areas and being

les include how people y patterns, division of lerarchy, religion, and impact in health care communication, and

### Individualism Versus Collectivism

Individualism and collectivism are contrasting perspectives and values (see **Table 3.1**). In **individualism** each person is seen as a social unit, and each person has primary responsibility for him- or herself. In the United States the overarching culture values of individualism, autonomy, and independence are rewarded and respected. Other individualistic cultures include Germany, Canada, and Sweden (Purnell, 2013). If someone is successful, it is primarily because of their personal qualities.

**TABLE 3.1 Individualism Versus Collectivism**

Individualism	Collectivism
Focus on self rather than group	Focus on group rather than self
Guilt	Shame
Self-respect	Saving face
Behavior primarily regulated by likes and dislikes	Behavior primarily regulated by group norms
Conflict more acceptable	Conflict avoidance; emphasis on harmony and hierarchy
Person is basic unit of analysis and reality	Group is basic unit of analysis and reality
Focus on being unique	Focus on fitting in
Direct	Indirect
Achievement is a product of personal qualities	Achievement is a product of society
Priority given to promotion of own goals	Priority given to promotion of goals of others

In **collectivism**, people are socialized to view themselves as part of a larger group, such as a family, a community, or a tribe. The group is the social unit, and dependence and connections within the group are valued. An individual's identity is determined by his or her relationship and position within the group. People make decisions based on what is good for the group rather than on what is good for themselves. Saving face is valued, as is showing respect for others. The needs and goals of the individual are subordinate to those of the larger group and should be sacrificed when the collective good so requires. Collectivists believe that achievement is a product of society. Examples of collectivist cultures include the Amish, Chinese, Mexicans, and Vietnamese (Purnell, 2013).

Why are these two opposing views important in health care? People from individualistic cultures make their health care decisions independently, whereas individuals in collectivist cultures involve their families in the decision-making process.

In collectivist cultures, illness is considered a family event rather than an individual occurrence. Knowledge transmission, personal responsibility, shame and guilt, help-seeking

behaviors, competitiveness, and communication are affected by this aspect of worldview (Purnell, 2013). In individualistic cultures, direct questioning, sharing personal issues, and asking personal questions are typical. In a collectivist culture, disagreeing or saying no to a health care professional is considered rude; therefore, when a health care professional asks if the patient understands, the patient may answer yes even though understanding has not really occurred. In addition, disabilities, mental health issues, and other health problems that are stigmatized may be kept hidden to save face, and treatment may be delayed and care provided in the home (Purnell, 2013).

In the United States, legal documents, such as advance directives and durable powers of attorney, are strategies to prolong autonomy in situations in which patients can no longer represent themselves. Other cultures de-emphasize autonomy, perceiving it as isolating rather than empowering. Their belief is that communities and families, not individuals alone, are affected by life-threatening illnesses and that they should be involved in making medical decisions.

### *Fate Versus Free Will*

“Fate and free will” refer to the degree to which people believe they are the masters of their own lives (**free will**) or believe they are subject to events outside their control (**fate**). Basically, fate and free will refer to the beliefs people hold about their ability to change and maneuver the course of their lives and relationships. This concept also is called *locus of control*. People who believe that they have control over their health have an internal locus of control (free will belief), and people who believe that it is outside of their control (fate belief) have an external locus of control. In some ethnic groups, factors outside medical intervention, such as a divine plan and personal coping skills, may be more important for health and survival than medical intervention and health behaviors.

Health care professionals need to consider this aspect of social organization. For example, when health outreach workers in India attempted to provide children with free polio vaccinations, they found that many parents refused the immunization because they believed Allah would take care of their children’s health. Providing preventive care and treatment can be challenging when people believe that fate will determine their health and that their health behaviors will not change what the master plan is for them.

### **Communication**

Communication is an interactive process that involves sending and receiving information, emotions, thoughts, and ideas through verbal and nonverbal means. It is the basis of human interaction. Effective communication enables health care professionals to accurately exchange information, establish relationships, and understand the person’s needs and concerns. Effective communication is important in all facets of life, but in health care it can be the deciding factor between life and death.

Intercultural communication is sensitive to exchanging information across cultural boundaries in a way that preserves mutual respect and minimizes miscommunication



this aspect of worldview  
ing personal issues, and  
agreeing or saying no to  
health care professional  
though understanding  
issues, and other health  
, and treatment may be  
ives and durable powers  
which patients can no  
onomy, perceiving it as  
s and families, not indi-  
they should be involved

they are the masters of  
side their control (**fate**).  
t their ability to change  
cept also is called *locus of*  
h have an internal locus  
ide of their control (fate  
factors outside medical  
y be more important for  
iors.  
social organization. For  
ovide children with free  
unization because they  
ing preventive care and  
determine their health  
plan is for them.

d receiving information,  
means. It is the basis of  
e professionals to accu-  
tand the person's needs  
of life, but in health care  
rmation across cultural  
zes miscommunication

and conflict. If communication is hindered, patients who utilize traditional remedies may be reluctant to inform their biomedical providers about them, leading to potentially dangerous interactions between medications and the undisclosed traditional remedies.

In addition to better health outcomes, effective communication can lead to higher patient satisfaction, continued care, and better adherence to treatment recommendations while reducing conflict and errors, lost opportunities for encouraging health behavior changes, misinterpretations of treatment plans, damaged relationships (including a loss of trust) between provider and patient or community member, and legal actions. All these reasons illustrate why culturally competent communication is a vital component of health care.

### Verbal Communication

As indicated in the quotation of Hoban at the beginning of this chapter, even people who speak the same language do not necessarily communicate even when using the same words. For example, in some age groups the word *fox* means attractive, but someone from a different generation may think of the animal. People in the United States whose first language is English have a difficult time communicating, so imagine how difficult it must be to communicate with people when English is not their first language. The limitations of language to convey experience—even between people who speak the same language—are extremely obvious when we cannot explain something as important as the intensity of pain we feel or the unrelenting worry and frustration pain sometimes causes. To further complicate communications, not all cultures describe health problems in the same way, and words from their language may not be easily translated to English and vice versa. For example, words used to describe pain typically include *sharp, throbbing, stabbing, or aching*. But in many tribal cultures, stories or symbols are essential in relating one's worldview, so very different words are used to describe pain. Clinicians might be baffled by patients explaining their pain using natural symbols like lightning, trees with deep spreading roots, spider webs, or the tones of drums and flutes (Carteret, 2010a).

In addition to the risks of everyday language breeding possibilities for miscommunication, health care has a language of its own with specialized terminology that can increase the chances of communication mishaps. Health care providers should avoid jargon and select words that people will understand without making them feel like you are talking down to them. Ask the receiver to summarize what you said to check for understanding, and look for nonverbal cues that indicate when miscommunication has occurred. A few cultural communication differences are described in the following paragraphs.

In some cultures, asking questions of health care providers is not an acceptable behavior. Patients from these cultures may be less likely to ask even clarifying questions and, subsequently, may not understand their condition or be able to follow their treatment plan, potentially resulting in a lower quality of care or even medical error.

In some cultures patients do not want doctors to inform them about their health problem. This nondisclosure may be because of the belief that the discussion about illness may eliminate or reduce the patient's hope or induce depression or anxiety. An example



is that family members in the Asian culture may wish to avoid discussing (sometimes withholding) information from a patient with a terminal illness or impending death. The discussion of death in the Chinese culture is usually considered forbidden and offensive. The Chinese do not discuss death with health care providers. They feel discussing death can lead to hopelessness; instead, the silence regarding the patient's condition is designed to maintain hope and alleviate undue stress on the patient. African, Asian, Chinese, East Indian, Hispanic, Indonesian, Japanese, Native American, and Vietnamese families may request providers not to disclose a terminal diagnosis as they want to avoid emotional suffering and preserve hope (Givler et al., 2020). Reluctance to discuss the patient's condition, especially making life-sustaining treatment decisions, often leads to a lack of preparation for advance directives (Saccomano & Abbatiello, 2014). Discussing the illness may raise concerns about making the person worse or that it is disrespectful. This issue also is a concern with regard to consent forms. The patient may believe that discussing the possible death or side effects of a medical procedure or medication may make it self-fulfilling and actually happen. Not discussing possible or eminent death may be viewed as doctors protecting patients from the emotional and physical harm caused by directly addressing death and end-of-life care. For example, cultures that value beneficence (physicians' obligation to promote patient welfare) by encouraging the patient's hope, even in the face of terminal illness. Emotional reaction to news of serious illness may be considered directly harmful to health. It is thought that a patient who is already in pain should not have to struggle with depression or stress as well.

### *Nonverbal Communication*

Communication is more than just words, and much information is conveyed nonverbally. Our system of nonverbal communication includes gestures, touch, posture, body language, objects, silence, spatial relations, emotional expression, eye contact, and physical appearance. Our sense of what nonverbal behavior is appropriate is derived from our culture. Differences in nonverbal communication may lead to misunderstandings, misinterpretations about the person's character, damaged relationships, conflict, or escalate an existing conflict.

Nonverbal communication can be received in three general ways: (a) the nonverbal message may exist in both cultures but not have the same meaning, (b) the nonverbal message exists in the sender's culture but not in the receiver's culture, or (c) the nonverbal message exists in both cultures and has the same meaning. Here are some examples of nonverbal communications that have different meanings in various parts of the world:

- In Asian cultures smiling is used to show pleasure, and it also is used to cover emotional pain or embarrassment. When a patient is asked if he, she, or they understands the treatment plan, if the person does not understand he, she, or they may smile to cover embarrassment.
- The "ring" or "okay" gesture has different meanings in different countries. In the United States and other English-speaking countries, the ring or okay gesture means

discussing (sometimes impending death. The forbidden and offensive. They feel discussing death and a condition is designed for Asian, Chinese, East Asian, and Vietnamese families may want to avoid emotional discussion of the patient's condition, often leading to a lack of discussion (Purnell, 2014). Discussing the patient's condition is disrespectful. The patient may believe that the doctor or medication may cause an imminent death or physical harm caused by the doctor. Cultures that value benefiting the patient's health and news of serious illness from the patient who is already ill.

conveyed nonverbally. Posture, body language, facial expression, and physical appearance are influenced by our culture. Cultural differences, misinterpretations may lead to an existing conflict. Cultural ways: (a) the non-verbal meaning, (b) the receiver's culture, or the sender's meaning. Here are some meanings in various cultures.

is used to cover emotions, or they understand it, or they may smile to

different countries. In the United States, the "okay" gesture means

"everything is okay." In Japan it can mean money; in some Mediterranean countries it is used to infer that a man is gay; in Indonesia it means zero.

- In the United States, getting someone to come toward you by motioning with your index finger is common or acceptable; however, in the Philippines, Korea, and parts of Latin America, as well as other countries, the same gesture is considered rude.
- In some cultures, direct eye contact is an indication of honesty, listening, and respect. People from some other cultures consider direct eye contact rude and feel as though they are being disrespected or challenged; therefore, they may avoid direct eye contact.
- Touch has variations of meanings among cultures as well. For some, casual touching is seen as a sexual overture and should be avoided. People of the same sex (especially men) or opposite sex do not generally touch one another. In other cultures, especially among collectivist ones, same genders can touch without having a sexual connotation. Health care providers should ask permission before touching someone (Purnell, 2013).

### WHAT DO YOU THINK?

Reflect on your own worldview and how it differs from others. What are the philosophical reasons for how your worldview differs from others? How do these beliefs affect relationships and possibly lead to conflict? Consider the following questions:

- How comfortable are you with being touched?
- What is your perspective of time?
- What does it mean to you when people are late?
- How do you make health care decisions?
- How do you view illness?

## Worldview and Health Decisions

Medical decisions such as abortion, the use of birth control, permission to allow blood transfusion, utilization of chemotherapy, advance directives, and euthanasia are difficult and life altering. In this section the focus is on two areas of medical decisions: beginning-of-life and end-of-life decisions.

### Beginning-of-Life Decisions

The beginning-of-life decisions include choices related to pregnancy, abortion, birth control use, fertility practices, birthing, and the postpartum period. Some of these decisions have deep ties to religious beliefs.

### DID YOU KNOW?

The ability to take medical histories and diagnose current symptoms may be adversely affected by the patient's comfort with modesty. Cultural values surrounding modesty are more than one's comfort level with covering the intimate body parts. By definition, modesty is about respect. A provider who takes cultural modesty into consideration shows respect and caring in the highest degree. Modesty in many cultures often means showing good manners via verbal communication, dress, or behavior.

In societies that place a high value on modesty, it is important for both sexes, but particularly emphasized for women. A woman's sexual purity and chastity honors her entire family. American women may view this as more discriminatory than protective. It is important not to assume that women in high-modesty cultures are forced to accept the restrictions placed on them by men. In fact, for many women in these cultures modesty is an attribute to be admired and attained. Women often impose modesty on themselves and other women as a way of keeping boundaries of privacy and respect. (Carteret, 2010b)

## Worldview and Response to Illness

Worldview has an impact on how people perceive and respond to illness. The dominant values and standards regarding pain and illness affect the behaviors of the individual. When people with a **biomedical worldview** of the mind and body being separate was shared by providers and most patients, this shared belief often contributed to substantial patient stress and alienation. In contrast, in a study conducted in Puerto Rico, providers and patients often shared a view of **mind-body integration** in illness and valued treatments that addressed chronic pain as a biopsychosocial experience. Culture also impacts on the ways which some cultures cope with stress. Some cultures cope with stress by openly expressing their feelings; other cultures avoid thinking about and expressing their feelings when confronted with stress. These cultures suppress their feelings. For example, members of the Asian culture tend to suppress their feelings and discussions about their true feelings rather than expressing their feelings; and, on the other hand, African Americans actively confront their stress and, more often than other cultural groups, tend to resolve their stress and distress on their own, often drawing on spiritual influences to assist them during stressful times (Burke, 2020).

The level of stigma plays a role in how people respond to illness as well. Mental health issues, tuberculosis, HIV, and other illnesses create a sense of embarrassment and shame in some cultures. As a result, people may not seek care or delay seeking care. If the person is diagnosed with a stigmatized illness, it can affect how the family responds. For example, the person may be "hidden" from the public, the family may be embarrassed by the ill family member and distance themselves from the patient, or the patient may be shunned.

In some cultures chronic illness and disability are viewed as forms of punishment, and the patient is viewed as being evil.

How people express and communicate about the illness has cultural roots. Most people experience pain sensations similarly, yet studies show there are important differences in the way people express their pain and expect others to respond to their discomfort. Stoic and emotive are two categories in which patients' culturally based responses to pain are often divided. Stoic patients are less expressive of their pain, tend to "grin and bear it," and socially withdraw. Native American, Asian, Black, and Hispanic are very stoic regarding pain and may maintain a neutral facial expression despite being in severe pain (Givler et al., 2020). Emotive patients are more likely to verbalize their expressions of pain, prefer to have people around, and expect others to react to their pain to validate their discomfort. There are also culturally based attitudes about using pain medication. Some patients might not take pain medications due to being fearful of harmful effects, including addiction (Givler et al., 2020). A summary of pain and end-of-life issues as they related to culture is in **Box 3.1**.

### BOX 3.1 A Summary of Pain and End-of-Life Issues

#### African American Culture

Death: Tend to display grief openly. Family and relatives usually present.

Pain: May avoid the use of pain medicine due to fear of addiction. Pain scales are often helpful.

Palliative care: Generally accepting of end-of-life care if educated on appropriate forms of pain management.

#### Amish Culture

Death: Death carries a lot of spiritual meaning.

Pain: Very high pain tolerance.

Palliative care: May accept palliative care.

#### Arab Culture

Death: May avoid discussions of impending death.

Pain: Very expressive.

Palliative Care: Usually not willing to accept do-not-resuscitate (DNR) orders.

#### ★ Cuban Culture

Death: Everything possible should be done.

Pain: May be stoic regarding pain, and thus reluctant to accept pain medication.

Palliative care: May be reluctant to accept palliative care.

#### East Asian Culture

Death: Reluctant to talk about death.

(continued)



not to the same extent; and still more culturally bound dynamics can include who makes the decisions and decision-making overall. For example, some families elicit and seek the help and support of those outside of the family unit to aid their decision-making, and others restrict discussions and decision-making to one person/persons, only the nuclear family members, or only the members of the extended family in collaboration with the nuclear family (Burke, 2020).

Patients from Asian cultures are often stoic in the face of pain because self-restraint is a strong cultural value. Complaining is viewed as having poor social skills. In traditional Asian cultures, preserving harmony in interactions with others is very important, so an individual should never draw personal attention, especially in negative ways. Though an individual may feel sadness or pain, it is not customary to make this obvious. This translates to communications with doctors and nurses, who have high status in Asian cultures. People of high status should not be bothered with complaints and should not be questioned (Carteret, 2010a).

### Worldview, Religion, and Rituals

Spirituality, religion, and health have been related in all population groups since the beginning of recorded history (Koenig, 2012). In earlier times, physicians were often clergy, and for hundreds of years religious organizations were responsible for licensing physicians (Koenig, 2012). Belief in the ability of the supernatural to heal surfaced in shamanism thousands of years ago. Recorded history describing spiritual healing includes Egyptian belief in the healing power of a particular holy site and Greek and Roman temples built to the healing gods. These types of practices are still known today. Shamanic traditions continue today in Africa, Central and South America, and among some Native American tribes, and Christians continue to make pilgrimages to holy sites that are believed to heal, such as the Sanctuary of Our Lady of Lourdes in France.

Spirituality is often described as a belief in a higher power, something beyond the human experience. For many people, spirituality is a means of living with, confronting, or otherwise addressing universally mysterious events and occurrences. These events include birth, death, health, personal challenges, and tragedies. Scientific research has determined that spiritual practices positively influence health and increase longevity. However, there is disagreement as to the mechanism of these benefits.

Closely related but distinctive is religion, which is the acceptance of the specific beliefs and practices of an organized religion. Religion is generally an organized approach to practicing a form of spiritual belief in and respect for a supernatural power or powers, which is regarded as a creator or a governing framework of the universe and is supported by personal or institutionalized systems grounded in belief and worship.

Although many people find spirituality in the form of religious practice, religion and spirituality are conceptually different. A person may be spiritual without being religious, or may be both. Research has shown that both spirituality and religious beliefs have positive effects on health.

Those who practice Eastern religions seek to refine the life force within themselves, and they attempt to find meaning and purpose in life through these efforts. Practitioners of Western Christianity may focus more on faith and belief in external guidance and salvation from a supreme being, a god, or gods.

Although much human conduct is related to spiritualism that goes beyond practicing formal religious teachings, these two concepts flow universally throughout all cultures. However, most of the research has focused on health and religion, as opposed to health and spirituality, primarily because religion is associated with behaviors that can be quantified (e.g., how often one prays or attends a place of worship), it can be categorized by type of religion, and there is more agreement about its meaning. Religion has a significant role in the United States and in the health. It has an impact on social lives and health behaviors and, hence, on physical and mental well-being.

Religion and rituals overlap, but not all rituals are related to religion. Rituals such as baptism and the burning of ghost money when a person dies (a tradition in China) are related to religious practices, but other rituals are not tied to religion, such as drinking tea at 3 o'clock in the afternoon every day.

### Religion in the United States

Spiritualism was part of the Indigenous populations when the Europeans first arrived in what would become the United States. The conquering Spanish brought their Catholic priests not only for their own guidance but also to impose Christian beliefs on the natives. To a large extent the United States was established by people of strong religious beliefs, including Protestants from Europe seeking a place to practice their beliefs free from religious conflict with other European religions, including Catholicism.

Religion and race/ethnicity are linked, but it is important not to assume a person's religion is based on his or her ethnicity. It also is not safe to assume that a person strictly adheres to the practices of a religion. Adherence to religious practices exists on a continuum, with some strictly adhering to all the guidelines and others having looser ties.

### Religion and Health Behaviors

Lifestyle represents the single most prominent influence on our health today. As a result, the United States is seeing the need for more emphasis on prevention and behavior modification. People with religious ties of any kind have been shown to engage in healthier behavioral patterns, and these positive lifestyle choices lead to improved health and longer lives. Why do people with stronger religious ties have better health? The answer includes several possible factors, such as proscribed behaviors, closer social relationships, and improved coping mechanisms.

Health behaviors encouraged or proscribed by particular religions are one possible explanation for how religion can positively affect health. Some religions prohibit tobacco, alcohol, caffeine, certain sexual practices, and premarital sex, and some encourage vegetarianism. Social relationships are another potential explanatory factor for the connection

between religion and improved health indicators. Social ties can provide both support and a sense of connectedness. Many churches and temples offer workshops, health fairs, and craft fairs, which provide social interactions. Social relationships are also tied to coping mechanisms because they provide support in multiple forms during times of stress. For example, financial support may be provided to people who have incurred a tragedy, such as a disability, loss of job, or a house fire. Religious organizations also conduct fundraisers for families who have experienced a death or personal tragedy in the family. Churches and temples assist elders by providing transportation or taking food to the homebound. Friendships and a sense of purpose are also methods of support.

### Dietary Practices

Dietary practices have a long history of being incorporated into religions around the world. Some religions prohibit followers from consuming certain foods and drinks all of the time or on certain holy days; require or encourage specific dietary and food preparation practices and/or fasting (going without food and/or drink for a specified time); or prohibit eating certain foods at the same meal, such as dairy and meat products. Other religions require certain methods of food preparation and have special rules about the use of pans, plates, utensils, and how the food is to be cooked. Foods and drinks also may be a part of religious celebrations or rituals.

The restriction of certain foods and beverages may have a positive impact on the health of those engaged in such practices. For example, restricting consumption of animal products, such as beef and pork or all animal products, may reduce the risk of health problems. Many religions, such as Hinduism and Buddhism, practice or promote vegetarianism, and these diets have been shown to have several health effects, such as the reduction of heart disease, cancer, obesity, and stroke. Some religions help prevent obesity through beliefs that gluttony is a sin, you should only take what you need, and self-discipline is necessary.

Religions may incorporate some element of fasting in their practices. In many religions, the general purpose for fasting is to become closer to God, show respect for the body (temple) that is a gift from God, understand and appreciate the suffering that the poor experience, acquire the discipline required to resist temptation, atone for sinful acts, and/or cleanse evil from within the body. Fasting may be recommended for specific times of the day; for a specified number of hours; on designated days of the week, month, or year; or on holy days.

During times of fasting, most but not all religions permit the consumption of water. Water restriction can lead to a risk of dehydration. Some fasters may not take their medication during the fast, which may put their health at risk. Prolonged fasting and/or restrictions from water and/or medications may pose health risks for some followers. Because of these health risks, certain groups are often excused from fasting. These groups include people with chronic diseases, frail elderly, pregnant and lactating women, people who engage in strenuous labor, young children, and people suffering from malnutrition.



## References

- American College of Osteopathic Medicine. (2020). *The history of osteopathic medicine*.  
<http://www.aacom.org/about/osteomed/Pages/History.aspx>
- Bhalerao, S., Deshpande, T., & Thatte, U. (2012). Prakriti (Ayurvedic concept of constitution) and variations in platelet aggregation. *BMC Complementary & Alternative Medicine*, 12-248.
- Burke, A. (2020, August 8). *Cultural awareness and influences on health: NCLEX-RN*.  
<https://www.registerednursing.org/nclex/cultural-awareness-influences-health/>
- Campinha-Bacote, J. (2009). *The process of cultural competence in the delivery of healthcare services*.
- Carteret, M. (2010a, November 2). *Cultural aspects of pain management*.  
<http://www.dimensionsofculture.com/2010/11/cultural-aspects-pain-management/>
- Carteret, M. (2010b, November 3). *Modesty in health care: A cross-cultural perspective*.  
<http://www.dimensionsofculture.com/2010/11/modesty-in-health-care-a-cross-cultural-perspective/>
- Carteret, M. (2011, February 21). *Culturally-based beliefs about illness causation*.  
<http://www.dimensionsofculture.com/2011/02/culturally-based-beliefs-about-illness-causation/>
- Centers for Disease Control and Prevention. (2021, August 31). *Culture and language*.  
<https://www.cdc.gov/healthliteracy/culture.html>
- EuroMed Info. (2020). *How culture influences health beliefs*. <https://www.euromedinfo.eu/how-culture-influences-health-beliefs.html/>
- Givler, A., Bhatt, H., & Maani-Fogelman, P.A. (2020, December 1). *The importance of cultural competence in pain and palliative care*. StatPearls. <https://www.ncbi.nlm.nih.gov/books/NBK493154/>
- Juckett, G. (2005). Cross-cultural medicine. *American Family Physician*, 72, 2267-2274.
- Koenig, H.G. (2012). Religion, spirituality, and health: The research and clinical implications. *Psychiatry*.  
<http://www.hindawi.com/journals/irsn/2012/278730/>
- O'Neil, D. (2005). *Explanation of illness*.
- Purnell, L.D. (2013). *Transcultural health care*. F.A. Davis Company.
- Saccomano, S.J., & Abbatiello, G. (2014, February 15). Cultural considerations at the end of life. *The Nurse Practitioner*, 39(2), 24-31. <https://doi.org/10.1111/jgs.14800>
- Tilbert, J.C. (2010). The role of worldviews in health disparities education. *Journal of General Internal Medicine*, 25(2), 178-181. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847101/>
- Tylor, E.B. (1924). *Primitive culture: Researches into the development of mythology, philosophy, religion, language, art, and custom* (7<sup>th</sup> ed.). Brentano. (Original work published 1871)
- Williams, D.R., Lavizzo-Mourey, R., & Warren, R.C. (1994). *The concept of race and health status in America*. <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1402239&blobtype=pdf>



## CREDITS

Fig 1.1: Source: <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/questionnaires-and-instructions/questionnaires/2020-informational-questionnaire.pdf>

Fig 1.2: Source: <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/questionnaires-and-instructions/questionnaires/2020-informational-questionnaire.pdf>

Fig. 2.1: Copyright © 2017 Depositphotos/olania

Fig 2.2: Source: Adapted from <https://files.eric.ed.gov/fulltext/ED330171.pdf>