

## On the Role of Culture in the Interaction Between Patient and Provider of Health Care

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**Abstract.** The process of the formation of illness representations is described, with special attention to the role of culture in this process. Illness representations have strong effects on the emotional and coping reactions of the patient. Also via other ways, culture has an influence on the interaction of the patient with the providers of care, for example in terms of the risk of non-compliance with medical advice. In this paper the implications of these relations for practice are explored.

Key words: illness, culture, patient, compliance, health care provider

**Abstrak.** Diuraikan proses pembentukan representasi penyakit, dengan perhatian khusus pada peran budaya dalam proses ini. Representasi penyakit memiliki pengaruh yang kuat terhadap reaksi emosional pasien dan cara mengatasinya. Juga lewat cara lain budaya memiliki pengaruh terhadap interaksi pasien dengan penyelenggara perawatan, misalnya dalam masalah risiko ketakpatuhan pada nasihat medis. Dalam artikel ini didalami implikasi hubungan tersebut dalam praktik.

Kata kunci: penyakit, budaya, pasien, kepatuhan, penyelenggara perawatan kesehatan

When a person experiences a physical problem, this experience acquires meaning for that person in a rather complex process. In this process cultural variables play a role at different stages. The fact that a health problem or a physical problem has a specific meaning for the suffering person, is important because this meaning will determine what the person will feel, also emotionally, and will do in relation to this problem and it will have an influence on how the sufferer perceives what is done by others in relation to this problem. So this meaning will determine how the patient perceives and interprets medical interventions and it will determine its behavior in the context of care.

In this paper the implications of the process of symptom formation, and thus of the role of culture, on the interaction between patient and provider of health care will be explored. A more comprehensive discussion of the role of culture in general and in relation to health is found in Matsumoto and Juang (2004).

Specifically, I will (1) describe the process

through which symptoms acquire meaning or how, as it is often called, illness representations are formed (Weinman & Petrie, 1997); (2) indicate the role of culture in this process; and (3) show the importance for medical practice to take these cultural variables into account, and how to do so.

Especially in Western medicine, its dualistic conceptual basis has had as one of its consequences that patients were seen as "lay people" that, because they had not had the required medical education, were unable to understand what happened in their bodies, and, consequently, were unable to decide what had to be done in order to cure illness. This position follows from the dualistic, "Cartesian", scission between body and mind. In this model, illness is, necessarily, situated in the body as a material system. It was, then, in this model further assumed that patients would simply accept medical diagnosis, and comply with medical prescriptions given by the medically competent caregiver. Patients were, in other words, thought of as having to passively undergo medical treatment. If this were the case, it would not matter what the patient thought, or how he/she perceived his/her problem. However, reality appears to be more complex. One of the phenomena that testify of this greater com-

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plexity, is the fact that in a large percentage of cases, patients do *not* comply with medical prescriptions (Greenberg 1984; Vermeire, Hearnshaw, van Royen, & Denekens, 2001). Ley (1982), e.g., found, over a large number of studies, an average of 56% compliance. Together with other variables, this phenomenon is explained by characteristics of the interaction between patient and provider of care, and as we will see, patients tend to behave in line with their own illness perception.

It is therefore, important to examine how physical symptoms acquire meaning and what role culture plays in this process.

## The Process of Symptom Formation

The classical, biomedical hypothesis to explain that a person experiences a physical symptom, is to assume that such symptom will reflect some physical event, that is perceived by the person. While, of course, what happens in our body is one of the variables that play a role in the formation of symptoms, this is far from being the sole variable. A number of non-physical variables are involved. While also a number of personality variables predict medically unexplained symptoms (De Gucht 2001), we will focus on variables that are related to culture (e.g. Matsumoto & Juang, 2004; Bean, Cundy, & Petrie, 2007).

*Attention* is one such variable: stimuli inside the body are perceived only if one is paying attention to them. A large number of studies show that, if attention is diverted to external stimuli, internal stimuli are less easily perceived (Pennebaker & Watson, 1991). In one study, for example, two groups of students performed the same physical activity; in one group attention was directed to external stimuli, in the other to internal stimuli. After the physical activity the first group felt significantly less tired – they had not given attention to the physical effects of the activity (Pennebaker, 1983). This explains also the well-known phenomenon that tissue damage is not (or less clearly) felt during an activity that requires intense attention. In such instances physical stimuli remain in the background of our field of consciousness. Of course, when stimuli are intense (as is the case with many injuries), it is more difficult to keep them away from the foreground of

consciousness and thus not to perceive them.

Attention is related to *expectation*. When one expects something to happen, attention will be mobilized and the person will monitor the function or body site where it expects something to happen. Such enhanced attention increases the likelihood that one will indeed feel something. Imagine a man that knows that in his family males are quite vulnerable to cardiac problems as an adult; for such person feeling something in his chest will have a different meaning than for another person that has not the same familial background. Imagine, furthermore, that in a culture, risk for a fatal course of a specific disease is linked to, say, date of birth; then symptoms that are perceived as related to an illness that is perceived as "fatal" for a person because it is born at a moment that is associated to this disease being fatal, will be more intensively monitored and, hence, perceived more easily and intensely. The same is true for situations where culturally imposed rituals are not followed and punishment is expected in the form of some health problem (Matsumoto & Juang, 2004).

When one perceives "something" in the body, people will not simply register this stimulus as an emotionally neutral event, but will assign further meaning to it (see for example Pakenham, 2008). In the first place people will try to answer the question: "Is it normal or not; and if not: is it dangerous or not?" This is similar to the phase of "*primary appraisal*" in coping with stressful situations (Lazarus, 1993). So, in the first place, illness perception will determine our emotional reaction to the symptom (Donkin, Ellis, Powell, Broadbent, Gamble, & Petrie, 2006; Kaptein, et al. 2006). This emotional effect is not only important because it will determine the patient's further action in relation to the symptom, but also because of the relation between emotional well-being and health in general (Howell, Kern, & Lyubomirsky, 2007). In the example given above, it will be obvious that the cultural background can contribute to giving specific symptoms a very dangerous meaning: in the study by Philips and his associates, this conviction that one had a "fatal" illness (because one was born on the day that made this illness fatal) was even strongly related to life expectancy: those Chinese subjects that believed that the risk associated to an illness depended on the day of birth, died significantly earlier when

the disease that they got was, in this way, perceived as fatal (Phillips, Ruth, & Wagner, 1993).

In this process of "primary appraisal," the question of the *perceived cause* of the problem will be an important element. Here again, culture can play a significant role. In the classic study by Whiting and Child in 78 non-Western cultures, e.g., the presence of explanations of illness in a certain domain was found to be related to the severity of socialization in that specific domain (Whiting & Child, 1953). The most striking confirmation for their hypothesis was found in the domain of nutrition. In some cultures socialization of eating behavior is mild: children are allowed to breast-feed as long and as often as they wish, and the transition to normal eating patterns is gradual and not forced by punishment. In these cultures, people virtually never thought of eating things as a possible cause of illness. In most of the cultures with severe, frustrating socialization of eating, "oral" explanations of illness were found. Similar statistically significant associations were found between socialization for aggression and explaining illness as caused by aggressive acts of others and for the socialization of (in)dependence and attributing illness to influence exerted by higher forces, spirits or ancestors. Other examples of culturally determined causal attributions are also well-known: the attribution of ill-health to an imbalance between yin and yang (Matsumoto & Juang, 2004) and the conviction of Indonesian people that problems with pregnancy, may be caused by eating shrimps or drinking ice water (Utami, 2007). So cultures may induce strong convictions about what are potential causes of illness, and what are not.

Another element that will make a problem to be perceived as serious has to do with social comparison: if the problem is perceived as common ("Everybody has it") it will be perceived as less threatening than when it is perceived as rare or exceptional. This has been demonstrated in experimental research: Jemmott and his colleagues made students believe that they participated in the study of an instrument for testing a newly discovered disease; a number of students were told that they tested positive and were asked if they believed that this disease was serious. Whether the students judged the disease as serious or not could be manipulated by the information they received about the percentage of students that tested positive: when they were told

that a large percentage of students tested positive, they believed that the disease was not serious; when they were told that only a very small percentage tested positive, they believed it was a really serious problem (Jemmott, Croyle, & Ditto, 1988). Similarly in some cultures back problems are not considered to be serious while "everybody has back pain".

If it is perceived as abnormal and dangerous, attention will be enhanced and negative emotions will be elicited. And, in turn, negative emotions enhance the probability of feeling something and to perceive it as dangerous, abnormal. So pessimists report much more complaints than optimists (J.Vinck, Wels, Arickx, & S.Vinck, 1998). Several studies report differences between cultures in the amount of emotional distress and pain related to similar physical problems (Young & Zane, 1995).

## Coping With Symptoms

When people perceive a symptom, they will not remain passive, but will try to cope with the problem – the "secondary appraisal" – "what can be done about the problem?" (Lazarus, 1993).

When a symptom is not perceived as pathological, nothing special will be done. Sometimes simply going on as usual will be expected to solve the problem. When one feels hunger, one knows that in some time one will have the opportunity to eat and the hunger will disappear; if one is feeling tired, the expectation is that after a good night's sleep, the problem will be over. People will then monitor the evolution of the symptom and when evolution is as expected, nothing more will happen - no further attention will be spent on the issue.

However, things do not always follow expectation. Sometimes what one feels in his stomach is not disappearing after a good meal. Then less inoffensive hypotheses are formed and tested. In this process, the person will accumulate information about the symptom by experience. It will also ask for information in his immediate social environment (Suls, Martin, & Leventhal, 1997). In this process, other people will not only help interpret the problem, but also give advice about remedies, about possible help from other lay people or professionals. This can lead to additional attempts to solve the problem, but may, at the same time, also delay med-

ical treatment. Of course, these actions add to the information a person gets about the problem and it will be clear that also here—when it comes to the question of how to act—cultural influences may be predominant, e.g. when a health problem is attributed to “cold” it will follow that eating “hot” food is to be recommended (Matsumoto & Juang, 2004). Evidence from Central Java shows that also in this region people tend to follow rules that are imposed by culture (Utami, 2007) or religion (Winarno, 2007).

When, eventually, the person will seek professional advice, he will choose that professional in function of the perception of the symptom, with all its aspects, described above, and in function of the perception and of the availability of health care providers. It will be obvious that not only the perception of the problem, but also the perception of the different possible providers of care is laden with cultural connotations as well (e.g. Utami, 2007).

Of course, illness happens in a person that is a member of a social system, and the experience of illness impacts that social system as well. So it is not only the afflicted person's illness perception that counts, but it does so in interaction with the perceptions and reactions of the other members of the social system (Benyamini, Medalion, & Garfinkel, 2007; Utami 2007; Winarno, 2007).

## Implications for Practice

What has been discussed up to now, is that symptoms acquire meaning even before the patient turns to the health professional, that culture plays an important role in this process, and that the patient will enter this interaction with this (culturally colored) meaning attached to the presented symptom. The patient does not enter this interaction as a “tabula rasa” or as a passive “object” of care. On the other hand, this holds, of course, also for the providers of care: they also have their own perspective on the health problem. This means that it may well be that both interacting partners approach the problem at hand from a different perspective. The risk that this happens will be greater when both approach the problem from a different cultural perspective, or from a different tradition – e.g. the biomedical tradition based on a dualistic view of man,

and the common-sense lay perspective (Leventhal, Nerenz, & Steele, 1984).

With two discordant perspectives, several problems may arise: “Is there a problem?” e.g. the patient feels back pain, but the doctor does not find any physical defect; implying the risk that the doctor concludes that “there is no problem.” “Is the problem serious?” When peers say it is not serious, e.g. while “everybody has it” the patient will not be inclined to initiate treatment or follow advice to do so. Or remember the Chinese who were convinced that seriousness of a disease is linked to date of birth – will they act when they are convinced that they are condemned anyway?

“What is the cause of the problem?” Here very different attributions can be made, based on social and cultural information. Several examples have been given. “What should be done?” The answer to this question will often, quite logically be related to the answer about the cause of the problem. When patient and care-giver differ in their idea about the cause, they will most probably also have different ideas about what to do, and imagine that the medical advice addresses a cause that, for the patient is irrelevant. On the other hand, people often have more or less conscious ideas about good cures (e.g. “eating strong food,” or sweating).

It will be obvious that the probability that a patient will follow the advice of the caregiver will be much higher if the patient feels that the explanation given by the caregiver and the associated advice are in line with its own convictions. So it will be equally clear that providers of care can best try to match their diagnosis and advice with these ideas of the patient or try to address these ideas. But, how do you do that? In Western tradition, it is certainly not customary for patients to bring in their own ideas, or to argue with the physician about alleged causes of illness or about treatment. Therefore, a condition to make it possible for the care-giver to take into account the meaning that the symptom has for the patient is that a relationship is formed, where the provider of care makes the patient feel that he or she is interested in the patient *as a person* and not only in his or her physical problem. At that moment, when both look at the problem from the perspective that it is the patient's problem, it becomes acceptable for both parties to reveal subjective and culturally colored ideas and concerns; then it becomes ac-

ceptable for the patient to question the physician's advice and to bargain for a treatment plan that is acceptable for both. This may not be the solution that from a purely objective bio-medical standpoint is the ideal treatment, but it will be a common solution that is the "second buy," which is acceptable for the patient and, therefore, will most probably be followed. As a positive by-product, such a consultation will be experienced as emotionally positive by the patient (Williams, Weinman, & Dale, 1998).

Of course, at the level of one consultation, such interaction will require more time; but in the long run, patient's problems will be tackled in a more efficient manner, what will ultimately save time, because otherwise, the patient will not comply with treatment advice and keep on consulting, eventually with alternative care givers.

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