Cultural perspectives on health communication

Health and Society

Prof. Fanny Duckert, Department of Psychology, UiO

What is modern racism?

Prof. Fanny Duckert, Department
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Methodological sources of cultural insensitivity in mental health research

- Content validity neglecting cultural understandings (panel of ’experts’, ’judgement’ ’rational analysis of criteria’)
- Standarization procedures suppress culture (translation errors, unconscious assumptions)
- Uncritical transferring of concepts across cultures (intelligence, concept of ’self’, decision making etc)
- Irrelevant or wrong research tools

Levels of cultural understanding (Cook, 1994)

- Contact stage (disregarding the existence of cultures)
- Pseudo-independence stage (overgeneralising/stereotying)
- Autonomy stage (real understanding of culture/integrating culture sensitivity in all activities)

Cross-cultural communication problems

- Effects on clients:
  - Anxiety for negative feedback prevents handing in information for evaluation
  - Increased guardedness and lack of disclosure
  - Difficulties in raising issues with the health worker
  - ”Freezing” when experiencing difficulties
  - Defensiveness when receiving feedback from health worker

Problems (cont.)

- Effects on health worker
  - Misinterpretation of client's behaviour
  - Conscious/unconscious prejudice towards client resulting in creation of different standards

Role of context in communication

- Low context cultures put their thoughts directly into words. The messages are explicit, direct and completely encoded in words. Meaning is trusted almost entirely to words(Norway)
- High context cutures rely on the context to convey a large part of the message. The message itself can be elliptical, indirect or allusive. (Asia, Africa) (Yes = I hear you)

- Getting to know another culture

Knowledge and thinking

- Does knowledge come from concepts or experience?
- Does knowing coming from asking questions or mastering received wisdom?
- Does knowledge have limits?
- In what patterns do people think?

Doing and achieving

- Is doing important or is being important?
- Are tasks done sequentially or simultaneously?
- Do results or relationships take priority?
- Is uncertainty avoided or tolerated?
- Is luck and essential factor or irrelvant?
- Are rules to be followed or bent?

Our place in the universe

- Do humans dominate nature or does nature dominate humans?
- Are divine powers or humans at the center of events?
- How is time understood, measured, and kept?
- Is change positive or negative?
- Is death end of life or part of life?

The role of language

- Language as reflection of the environment
- Language as a reflection on values (time)
- The meaning of words (Dr., Director)
- Changes in language (Fireman/Firefighter)

Cultural competence

- Scientific mindedness
  - Forming and testing hypotheses, rather than making prematurely and faulty assumptions/conclusions
- Skills in dynamic sizing
  - Knowing when generalizations based on group membership are appropriate and when not
  - Knowing when to generalize own experiences to those of the clients
  - Empathy
- Culture-specific expertise

Open inquiry

- Do ask about tribal, ethnic, or background differences that are obvious
- Don’t insist on a more thorough explanation of these differences than is offered
- Do realize that acculturation and cultural identity are fluid and developmental.
- Don’t assume that all members of a given family group or couple have the same levels of cultural identity or the same expereiences interfacing with the dominant culture

Family

- Do realize that for many ethnical groups the concept of family is broader, more inclusive and more definitive in a given individual's sense of identity.
- Don't impose your own definition of family or what you have learned about the other person's culture. Simply be open to his/her sense of family.
- Don't define family strictly along biological lines.
- Do graciously include family members in parts of the interaction if they so request.

Communication styles

- Do remember that patterns of eye contact, body contact, direct verbalization of problem areas, storytelling and note taking all have culturally determined norms that vary widely.
- Don’t assume a chatty or overly familiar style, even if this is your normal style. Strive to demonstrate respect.
- Do ask for clarification if something is not clear.
- Don’t ask for clarification in a manner that suggests your lack of clarity is the other person’s problem

Religious and spiritual matters

- Do accept the other person's beliefs regarding the sources of distress: ancestral disapproval, the evil eye, God's wrath or trouble because of misbehaviour in another life, etc. A strong relationship of trust must be established before one can determine the adaptive/maladptive aspects of such beliefs.
- Don't assume that you are being told the whole story regarding faith or belief systems early on. Most are powerful and quite private and will not easily or fully be shared
- Use possible links to meaningful spiritual beliefs or connections that may help address the current distress
- Allow input into the problem from religious/spiritual persons respected by the other person

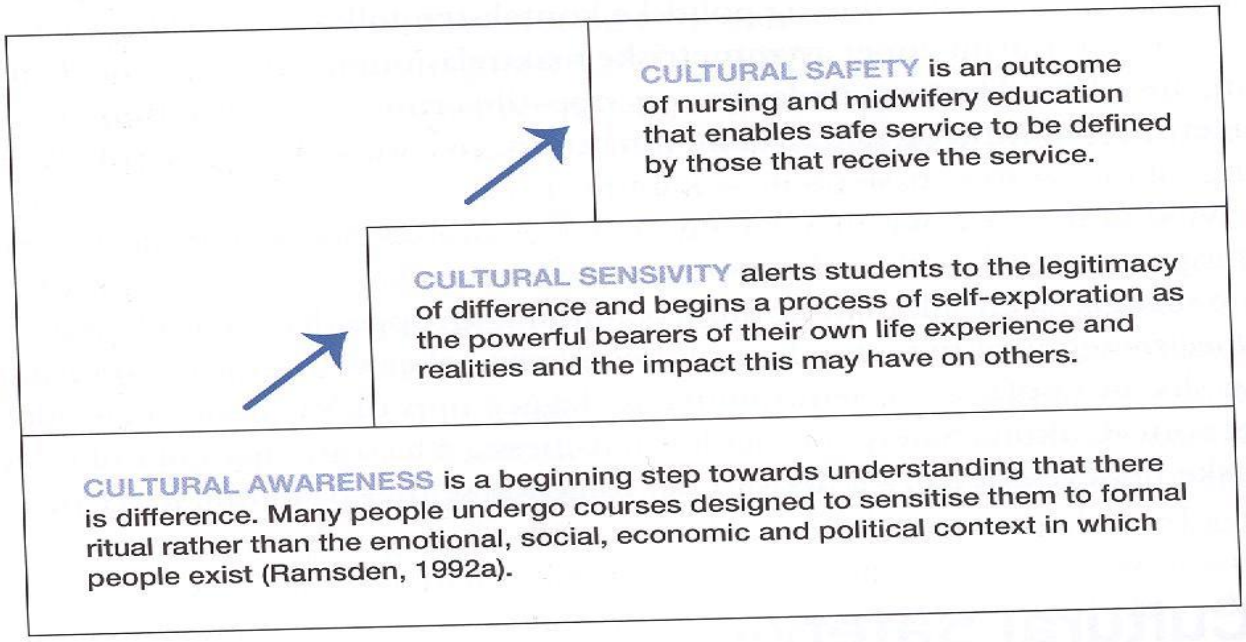
Understanding of human distress is culture bound

- Symptoms may be similar across cultures, but causes may be viewed very differently
- Causes of human distress (brain disease, trauma, exposure, etc.) may be identified similarly across cultures, but the disturbance or distress may show itself in vastly different symptoms

Forging relationships between researchers and community

- Communities must be allowed to define their own needs, their targets and their own outcome measures
- Health services need to link into the appropriate extant networks of authority and communication in a given culture
- Collaboration has to actual and active rather than passive aspiration
- The health practitioner must accept sharing power, authority and knowledge with appropriate community members

Achieving Cultural Safety



Figur 3.2 The process toward achieving Cultural Safety in nursing and midwifery practise. (Kilde: Nursing Council of New Zealand (2005))