

CULTURE AND HEALTH

Culture is both a product of human behavior and a regulator of behavior. It refers to the particular beliefs, customs, norms, and values of a set of people, usually defined by a special history, geography, and dialect or language. Almost all countries have different cultural groups, often called ethnic groups, within their borders. The United States is multicultural or multiethnic, while Japan is relatively monocultural.

Health is not just the absence of disease or infirmity but is a state of physical, psychological, and social well-being. Health psychology is an applied discipline closely related to public health. It aims to improve human functioning, especially by better health care and prevention programs. Each culture has its own definition of health and health service. The Western industrialized countries tend to use a biomedical model for their services, emphasizing individual physical health. Developing countries, especially Asian ones, have a more collectivist, family-oriented, and holistic view of health and health service. Separation between mind and body is less distinct. Although Western ideas have penetrated deeply into many areas of the rest of the world, there remain strong influences from widespread folk beliefs about health. For instance, most Chinese believe that healthy nutrition requires a balance between hot and cold foods, and they accept and expect traditional Chinese medical practices such as herbal remedies, massage, and acupuncture. Within the United States the many ethnic subcultures vary in their willingness to accept Western medicine and in their faith in traditional helpers such as Latino curanderos.

How much do peoples around the world share regarding health? Obviously, in physical matters (as epidemics and organ transplants demonstrate) there is much in common, but what about psychological and sociocultural characteristics? One major debate in cross-cultural theorizing is between universalists and relativists (the etic-emic distinction). Psychologists tend to try to find categories and principles that apply to all cultures in varying amounts and intensity: anthropologists point out the unique patterns of each particular culture. Attempting to create a universal system, the World Health Organization (1992, 1993) has put forth an international classification system for diseases and indicators of health. The measurable indicators cover health status, policies, social and economic factors, and primary care services. Reports from over 150 WHO member states are useful, but questions remain about the consistency of diagnoses and practices across countries and cultures. Particularly problematic are misdiagnoses because of poor cross-cultural understanding.

Despite the difficulty in transferring Western health practices, Beardsey & Pedersen (1997) describe not only some of the remarkable successes of international public health projects, such as the near eradication of river blindness (in west Africa) and Guinea worm disease, but also the difficulties in controlling malaria and

HIV infection/AIDS because of cultural differences in compliance and education. They discuss how research by Cohen (1988) and others has shown that social support (which varies across cultures) is important for a healthy immune system. Some health-related practices are dramatically culture-bound, such as infanticide and malnutrition with girl children because of boy preference in several Asian countries. Certain mental illnesses, such as amok (sudden frenzy), koro (fear of penis constriction), and taijin-kyofusho (fear of being looked at) are thought to be culture-specific rather than universal. Anorexia nervosa (self-starvation and distorted body image) is mainly confined to Western countries, but more recently has been showing up in Asian locations (Tanaka-Matsumi & Draguns, 1997).

Beliefs about causation of mental illness differ among cultures. For instance, Bedouin-Arabs in Israel believe that symptoms occur because of supernatural powers, such as God's will or sorcery (Al-Krenawi, 1999). The degree of acculturation is another aspect of understanding meanings in cross-cultural work. One American study showed a difference between normative beliefs of adolescents with Middle Eastern backgrounds who were born in the United States versus those who immigrated. The American-born adolescents were more accepting of aggression (Souweidane & Huesmann, 1999). On the positive end of health, that is, life satisfaction, there are strong differences between poorer and wealthier nations, with poor people valuing financial success and people from wealthier countries valuing home life and self-esteem (Oishi, Diener, Lucas, & Suh, 1999). The research questions about health and ethnicity are numerous and intriguingly complex, especially when they overlap with economic and educational factors.

One example of health and cultural issues from Indonesia is the overuse of injections not related to diagnosis. Such injections, especially with reuse of needles, increase the risk of communicable diseases such as hepatitis B and HIV. It is important to understand that Indonesians like ceremonies. From birth to death, Indonesians are accustomed to rituals. The practice of injection by a medical worker is like a ritual. The provider has to go through a certain sequence in the injection preparation and process. The patients feel the pain as the soluble preparation is inserted in their bodies. This ritual seems to give both parties satisfaction. The providers have done something, and the patients have received something directly into their bodies. Such a ritual might seem strange to people from developed countries, who are accustomed to being informed and giving consent before medical intervention takes place yet; for laypeople in Indonesia who are not well educated, the health service provider is the authority for the treatment, and the patients do not have to know anything (Hadiyono, 1997). To overcome this problem, Hadiyono and colleagues (1996) used a behavioral intervention: both providers and consumers discussed the proper use of injections in a small group led by a clinical pharmacologist and a behavioral scientist. This approach, using culturally sensitive behavioral methods and involving the recognition of in-group norms and the development of consensus, has successfully reduced the unnecessary use of injections in public health centers.

Since health is multidimensional world-wide, using only the biomedical model for explaining health issues is limiting and inadequate. Many different disciplines need to take part. Specifically,

social sciences, such as anthropology, demography, economics, education, ethics, political science, psychology, and sociology, have been involved in health-related studies and policy making for decades. To accomplish communication and cooperation among so many disciplines covering many cultures and countries is not an easy task. What names to use? How to bring these different disciplines and traditions together? The involvement of social sciences in health is reflected in names, with specialties such as medical anthropology, medical ethics, medical geography, and medical psychology. The approach is still mostly within the given discipline. Medical psychology, for example, has applied different psychological theories, research, assessment instruments, and therapies to physical diseases. The needed approach for many projects, nonetheless, is more interdisciplinary so that social scientists and health scientists are contributing together to research teams.

When a group has worked together for some time its approach becomes transdisciplinary by nature. The name Health Social Science (HSS) has been used within the International Clinical Epidemiology Network (INCLEN) since June 1987 (Higginbotham, 1994). In his paper, Higginbotham concluded that the INCLEN model aims to inspire a transdisciplinary approach into international health by promoting a common language among social scientists working with clinical epidemiologists, and by sensitizing clinicians to the contribution of social sciences in health research and policy health.

One of the greatest challenges for social scientists is learning how to collaborate successfully as equal partners with health scientists, especially medical doctors. To collaborate on an equal footing demands self-confidence, secure knowledge, and a willingness to learn and communicate across disciplinary boundaries on the part of all team members. This collaboration leads to a multidisciplinary approach in the beginning, an interdisciplinary approach in the process, and ideally, a transdisciplinary approach in the long run as suggested by Rosenfield (1992) and Albrecht, Freeman, and Higginbotham (1997). The area of culture and health requires a broad perspective for working together to meet the challenges of globalization and the rapid growth of medical and social science information.

REFERENCES

- Albrecht, G., Freeman, S., & Higginbotham, N. (1997). Complexity and human health: The case for a transdisciplinary paradigm. *Culture, Medicine, and Psychiatry*, 00: 1-38.
- Al-Krenawi, A. (1999). Explanations of mental health symptoms by the Bedouin-Arabs. *International Journal of Social Psychiatry*, 45, 56-64.
- Beardsley, L. M., & Pedersen, P. (1997). Health and culture-centered intervention. In J. W. Berry, M. H. Segall, & C. Kagitcibasi (Eds.) *Handbook of cross-cultural psychology: Vol. 3. Social behavior and applications* (2nd ed., pp. 413-448). Boston: Allyn & Bacon.
- Cohen, S. I. (1988). Voodoo death, the stress response and AIDS. In T. P. Bridge & A. F. Mirsky (Eds.) *Psychological, neuropsychiatric, and substance abuse aspects of AIDS: Advances in bio-*

- chemical psychopharmacology* (Vol. 44, pp. 95–110). New York: Raven.
- Hadiyono, J. E. P. (1997). Overgebruik injecties in Indonesie (in the Dutch Language), *WemosScoop*, 3, 7–8
- Hadiyono, J. E. P., Suryawati, S., Danu, S., Sunartono, & Santoso, B. (1996). Interactional Group Discussion: Results of a controlled trial using a behavioral intervention to reduce the use of injections in public health facilities. *Social Science & Medicine: An international journal*, 42(8), 1177–1184.
- Higginbotham, N. (1994). Capacity building for health social science: The International Clinical Epidemiology Network (INCLEN) social science program and the International Forum for Social Science in Health (IFSSH). *Acta Tropica*, 57, 123–137.
- Oishi, S., Diener, E. F., Lucas, R. E., & Suh, E. M. (1999). Cross-cultural variations in predictors of life satisfaction: Perspectives from needs and values. *Personality and Social Psychology Bulletin*, 25, 980–990.
- Rosenfield, P. (1992). The potential of transdisciplinary research for sustaining and extending linkages between the health and social sciences. *Social Science & Medicine*, 35(11), 1342–1357.
- Souweidane, V., & Huesmann, L. R. (1999). The influence of American Urban culture on the development of normative beliefs about aggression in Middle-Eastern immigrants. *American Journal of Community Psychology*, 27, 239–254.
- Tanaka-Matsumi, J., & Draguns, J. (1997). Culture and psychopathology. In J. W. Berry, M. H. Segall, & C. Kagitcibasi (Eds.) *Handbook of cross-cultural psychology: Vol. 3. Social behavior and applications* (2nd ed., pp. 449–491). Boston: Allyn & Bacon.
- World Health Organization (1992). *The international classification of disease and related health problems* (10th revision). Geneva: WHO.
- World Health Organization (1993). *World health statistics annual, 1993*. Geneva: WHO.

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