CULTURAL DIVERSITY COMPETENCY (2 pages)

NAME AND TITLE:_____ DATE: _____

Article: Cultural and Ethical Issues in Working with Culturally Diverse Patients and Their Families: The Use of the Culturagram to Promote Cultural Competent Practice in the Health Care Settings

Of the 10 topics listed/discussed on the Culturagram, choose 3 that you believe play a role in a patient's health and understanding of therapy instructions. Explain why.

1.

2.

3.

What are the 6 guidelines that will help a clinician develop a culturally sensitive practice?

1.

2.

3.

4.

5.

6.

CULTURAL DIVERSITY COMPETENCY (2 pages)

NAME AND TITLE:_____ DATE: _____

Article: Cultural Health Attributions, Beliefs, and practices: Effects of Healthcare and Medical Education

The HEARTS model suggests methods to develop sensitivity, gain understanding and help people cope with the experience of trauma or violence. How can this model be adapted/utilized to make it relevant to the practice of therapy? Explain:

The conclusion of the article lists 10 bullet points that may be utilized to assist the clinician develop meaningful interactions with culturally different individuals . Choose 2 bullets and explain why they are relevant to the practice of therapy.

Cultural and Ethical Issues in Working with Culturally Diverse Patients and Their Families: The Use of the *Culturagram* to Promote Cultural Competent Practice in Health Care Settings

Elaine P. Congress, DSW

SUMMARY. In all aspects of health and mental health care–the emergency room, the outpatient clinic, inpatient facilities, rehab centers, nursing homes, and hospices–social workers interact with patients from many different cultures. This paper will introduce an assessment tool for health care professionals to advance understanding of culturally diverse patients and their families. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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KEYWORDS. *Culturagram*, cultural diversity, cultural competence, cultural and ethical issues, family assessment, culture and health care, ethical issues and health care

INTRODUCTION

The increasing cultural diversity of the United States has been the subject of news articles (Cohn, 2001; Purdum, 2000; Schmitt, 2001), as well as professional publications (Devore & Schlesinger, 1996; Gelfand & Yee, 1991; Homma-True, Greene, Lopez, & Temble, 1993; Lum, 2000; U.S. Census Bureau, 2000). While immigrants in the early 1900s originated primarily from Western European countries, current immigrants come from Asia, South and Central America, and the Caribbean. It is projected that in this century over half of Americans will be from backgrounds other than Western Europe (Congress, 1994).

CULTURAL DIVERSITY AND CULTURAL COMPETENT PRACTICE

From the beginning the social work profession has provided services to culturally diverse clients. In the early days of the 20th century, social workers worked with immigrant populations in settlement houses. Since the late 1960s the NASW Code of Ethics has had an anti-discrimination section, and in last ten years there has been much stress on cultural competent practice. In the most recent Code of Ethics social workers are advised to understand cultural differences among clients and to engage in cultural competent practice (NASW, 1999), while the Council on Social Work Education (1996) mandates that each accredited school of social work include content on diversity. Cultural sensitivity often begins with self-assessment, and Ho (1991) has developed an ethnic sensitive inventory to help social workers measure their cultural sensitivity. The need for social workers in health care institutions to be attentive to the cultural diversity of patients has been stressed (Congress & Lyons, 1994).

Health care professionals have recently given much attention to the impact of cultural diversity on health care (Beckmann & Dysart, 2000; Chin, 2000; Cook & Cullen, 2000; Davidhizar, 1999; Dootson, 2000; Erlen, 1998). There has been some concern, however, that the curriculum of medical schools does not include content on cultural issues

(Flores, 2000). A recent Diversity in Medicine project funded by the U.S. Dept of Education, however, developed a curriculum for medical students in training on cultural factors that affect diagnosis, treatment, and communication between patient and doctor (O'Connor, 1997). Although the need for health care professionals to be culturally sensitive has been repeatedly stressed, providing health care to diverse cultural groups has been seen as one of the most challenging for health care providers (Davidhizar, Bechtel, & Giger, 1998).

While developing cultural competent practice is an ongoing goal for social workers (Lum, 2000), the diversity of clients' backgrounds, especially in urban areas, makes this process most challenging. The presence of families from 125 nations in one zip code in Queens (National Geographic, 1998) attests to the challenges that face health care social workers. How can a social worker know and understand the culture of each patient? Some literature has focused on teaching social workers specific characteristics of different ethnic populations (McGoldrick, 1998; Ho, 1987; Goldenberg, 2000).

Considering a family only in terms of a generic cultural identity, however, may lead to over generalization and stereotyping (Congress, 1994, 1997). In working with culturally diverse patients, social workers soon learn that one patient and family is very different from another. For example, an undocumented Mexican family that recently immigrated to the United States may access and use health care very differently than a Puerto Rican family that has lived in the United States for thirty years. Yet both families are Hispanic.

Even two patients from the same ethnic background may be dissimilar. For example one Puerto Rican patient who is hospitalized for a heart condition may be very different from another Puerto Rican patient with a similar medical condition. Generalizations about people from similar ethnic backgrounds may be not always give the most accurate understanding. When attempting to understand culturally diverse patients and families, it is important to assess the family from a multi dimensional cultural perspective.

CULTURAGRAM

The culturagram grew out of the author's experience in working with families from different cultural backgrounds. Two social work assessment tools, the ecomap (Hartman & Laird, 1983) that looked at families in relationship to the external environment, and the genogram (McGoldrick &

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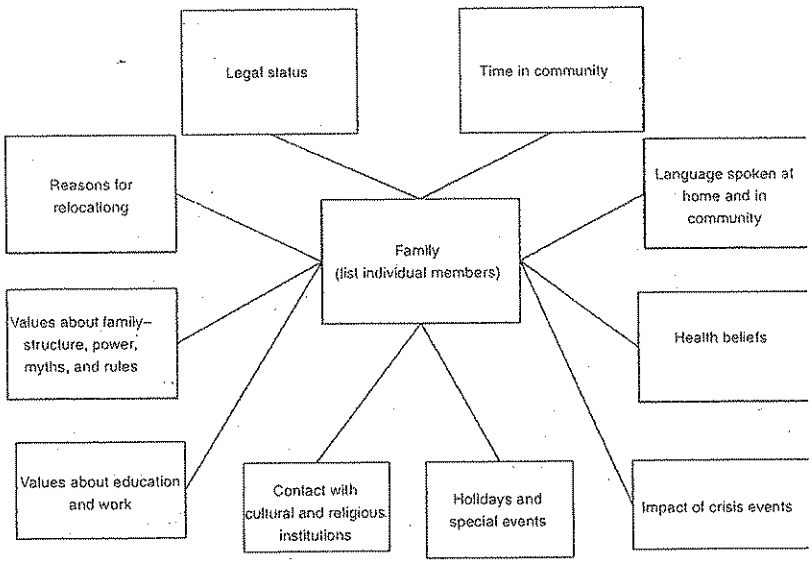
FIGURE 1. Culturagram–2000



Legal Status. The legal status of a family may have an effect on patients and their families. If a family is undocumented and fears deportation, members may become secretive and socially isolated. Patients may have difficulty accessing treatment because of their undocumented status. They may also avoid seeking treatment until their health condition is very severe, less they will have to disclose their undocumented status. An important first step for the health care professional is to establish trust and to reassure the undocumented patient and family about the confidentiality of contact with health care professionals. This may not be easy especially in the patient has come from a country in which confidentiality is unknown (Congress, 1994).

Length of Time in the Community. The length of time in the community may differ for patients and their families. Often family members who have arrived earlier are more acculturated than other members. Another key factor is that family members are different ages at the time they relocate. Because of attending American schools and developing peer relationships, children are often more quickly assimilated than their parents. Children often become interpreters for parents in contacts with schools, health care providers and social service agencies.

Language. Language is the mechanism by which families communicate with each other. Often families may use their own native language at home, but may begin to use English in contacts with the outside community. Sometimes children may prefer English, as they see knowledge of this language as most helpful for survival in their newly adopted country. This may lead to conflict in families. A most literal communication problem may develop when parents speak no English, and children speak only minimally their native tongue.

Often children are used as interpreters in health care settings. Exposure of the child to sensitive health care issues and role reversals may be the unwanted results. Another concern is how can the health care provider insure that the patient has given informed consent, if it is unclear that information has been accurately understood. This points to the need for bilingual staff to facilitate the care of culturally diverse patients.

Health Beliefs. This part of the culturagram must be thoroughly explored by social workers working in health care settings. Families from different cultures have varying beliefs about health, disease, and treatment (Congress & Lyons, 1992). There are significant differences in how culturally diverse populations seek health care (Zambrana, Dorrington, Wachsman, & Hodge, 1994), view chronic illness (Anderson, Blue, & Lau, 1991; Wallace, Levy-Storms, Kinston, & Andersen, 1998), and death and dying (Parry & Ryan, 1995). Differing life expectancies have also been identified (Devore & Schlesinger, 1998).

Often health issues impact adversely on culturally diverse families, as for example when the primary wage earner with a serious illness is no longer able to work, a family member has HIV/AIDS, or a child has a chronic health condition such as asthma or diabetes. Also, mental health problems can impact negatively on families. Coping with the aftermath of losses associated with immigration, a mother may be too depressed to care for her children or a child may be acting out in school as a result of feeling an outsider in a new country. Families from different cultures especially if they are undocumented may encounter barriers in accessing medical treatment, or may prefer alternative resources for diagnosing and treating physical and mental health conditions (Devore & Schlesinger, 1996).

Many immigrants may use health care methods other than traditional Western European medical care involving diagnosis, pharmacology, x-rays, and surgery (Congress & Lyons, 1992). Some immigrants may choose to use a combination of western medicine and traditional folk beliefs.

An important issue is that of preventive care. We continually hear from early childhood about the importance of regular checkups. Managed care has reinforced the concept of regular preventive care in order to avoid future expensive medical treatment. Many new arrivals may not share American health care values about the importance of preventive care, as the following example indicates.

A mother brought her 18-month-old son to the emergency room with a very high fever. The doctor questioned if the child had been seen previously in the Well Baby Clinic. The mother responded that she had never brought the child for care previously, as he had not been sick.

When a member of a cultural diverse family is hospitalized, there may be issues in adjusting to hospital policies and procedures. For example, a family may wish to have all family members including small children come to the patient's hospital room. There may be concerns about limited visiting hours or the number of concurrent visitors. Families may want to bring the patients foods that are contrary to medically prescribed diets. The health care professional has a responsibility to explore the health beliefs of the patient and family. An important ethical dilemma arises when the health beliefs of the patient may seem contrary to those of the employing health care institution.

Crisis Events. Families can encounter developmental crises as well as "bolts from the blue" crises (Congress, 1996). Developmental crises may occur when a family moves from one life cycle stage to another. A particular stressful time for culturally diverse families may be when children become adolescents. Parents with expectations for adolescents to work or care for younger siblings may not accept that American adolescents often want to socialize with peers. Different familial attitudes about sexuality are often quite apparent for health care professionals who work in adolescent health clinics.

Families also deal with "bolts from the blue" crises in different ways. A family's reactions to crisis events are often related to their cultural values. For example, a father's accident and subsequent inability to work may be especially traumatic for an immigrant family in which the father's providing for the family is an important family value. While rape is certainly traumatic for any family, the rape of a teenage girl may be especially traumatic for a family who values virginity before marriage. Also, the serious illness and death of an elderly member may have tremendous impact on the culturally diverse family who look to the elderly family member for major support and decision-making.

Holidays and Special Events. Each family has particular holidays and special events. Some events mark transitions from one developmental

stage to another; for example, a christening, a bar mitzah, a wedding, or a funeral. It is important for the social worker to learn the cultural significance of important holidays for the patient and family, as they are indicative of what families see as major transition points within their family. It may be particularly traumatic for culturally diverse patients who are too ill to participate in an important family celebration.

Contact with Cultural and Religious Institutions. Contact with cultural institutions is often very important for immigrant patients and their families. Family members may use cultural institutions differently. For example, a father may belong to a social club, the mother may attend a church where her native language is spoken, and adolescent children may refuse to participate in either because they wish to become more Americanized.

Religion may provide much support to patients and their families and the health care provider will want to explore the patient's contact with formal religious institutions, as well as informal spiritual beliefs. Knowledge of a patient and his/her family's religious beliefs are particularly important for health care professionals whose patients are struggling with serious illnesses.

Values About Education and Work. All families have differing values about work and education, and culture is an important influence on such values. Social workers in health care settings must explore what these values are in order to understand their patients and families. Economic and social differences between the country of origin and America can affect immigrant families. For example, employment in a low status position may be very denigrating to the male breadwinner. It may be especially traumatic for the immigrant family when the father can not find any work or only works on an irregular basis. Another very stressful event for immigrant families is when the breadwinner is not able to work because of serious illness, accident, or disability. For workers who are marginally employed there may not be worker's compensation or social security benefits to help the patient and families when the primary breadwinner is not able to work.

Immigrant families usually believe in the importance of education for their children. Yet children may be expected to work to maintain families in times of economic hardships. With a strong commitment to family, culturally diverse families with a parental member who is struggling with a serious illness may not want children to leave home to pursue further education.

Values About Family–Structure, Power, Myths, and Rules

Each family has its unique structure, beliefs about power relationships, myths, and rules. Some of these may be very unique to the cul-

tural background of the family. The clinician needs to explore these family characteristics individually, but also understand in the context of the family's cultural background. Culturally diverse families may have differing beliefs about male-female relationships especially within marriage. Families from cultural backgrounds with a male dominant hierarchical family structure may encounter conflict in American society with a more egalitarian gender relationships. This may result in an increase in domestic violence among culturally diverse families. The health care professional needs to be sensitive to recognizing family violence within culturally diverse families.

If there are more rigidly proscribed household roles for women, there may much stress on the family when the woman/wife/mother is hospitalized and/or unable to carry out usually household responsibilities. Other female relatives who previously would have helped out during a health crisis may have remained behind in the country of origin and thus not be available to the immigrant family.

Finally, child-rearing practices especially in regard to discipline may differ in culturally diverse families. The social work in health care settings is always very alert to signs of child abuse or neglect, as social workers are mandated reporters of child abuse. Since health care professionals want to be culturally sensitive, however, they may face a dilemma about whether to report a mother who is disciplining a child using mild physical punishment that is acceptable in her country of origin.

The following case vignette will be used to illustrate how the culturagram can be used to understand better a family with its unique cultural background:

Thirty-five-year-old Mrs. Carmen Perez was seen in an outpatient mental health agency in her community because she was having increasing conflicts with her 14-year-old son Juan who had begun to cut school and stay out late at night. She also reported that she had a 12-year-old daughter Maria who was "an angel." Maria was very quiet, never wanted to go out with friends, and instead preferred to stay at home helping her with household chores. Maria was often kept out of school to accompany and interpret for her mother at medical appointments. Mrs. Perez did express concern that Maria had recently begun to menstruate. Every month she became ill with severe cramps and vomiting. *Mrs. Perez commented that this was women's cross that that there was nothing to be done about this.*

Mrs. Perez indicated the source of much conflict was that Juan believed he did not have to respect Pablo, as he was not his real father.

Juan complained that his mother and stepfather were "dumb" because they did not speak English. The past Christmas holidays had been especially difficult, as Juan had disappeared for the whole New Years weekend.

At 20 Mrs. Perez had moved to the United States from Puerto Rico with her first husband Juan Sr., as they were very poor in Puerto Rico and had heard there were better job opportunities here. Juan Sr. had died in an automobile accident on a visit back to Puerto Rico when Juan Jr. was 2. Shortly afterwards she met Pablo who had come to New York from Mexico to visit a terminally ill relative. After she became pregnant with Maria, they began to live together. Pablo indicated that he was very fearful of returning to Mexico as several people in his village had been killed in political conflicts.

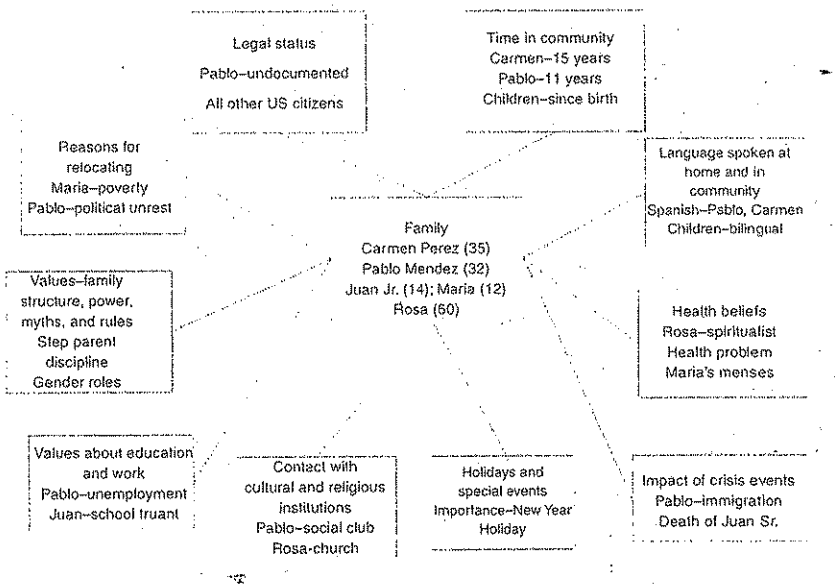
Because Pablo was undocumented, he had only been able to find occasional day work. He was embarrassed that Carmen had been forced to apply for food stamps. Pablo was beginning to spend more time drinking and hanging out on the corner with friends.

Carmen was paid only minimum wage as a health care worker. She was very close to her mother who lived with the family. Her mother had taken her to a spiritualist to help her with her family problems, before she had come to the neighborhood agency to ask for help. Pablo has no relatives in New York, but he has several friends at the social club in his neighborhood.

After completing the culturagram (see Figure 2), the social worker was better able to understand the Perez family, assess their needs and begin to plan for treatment. For example, she noted that Juan's undocumented status was a source of continual stress in this family. She referred Juan to a free legal service that provided help for undocumented people in securing legal status. The social worker also recognized that there had been much conflict within the family because of Juan's behavior. She has also concerned that Maria might have unrecognized medical problems and referred her for a health consultation. She also helped Maria and her mother talk to an adolescent health educator who was bilingual and bicultural. Finally she was keenly aware of family conflicts between Pablo and his stepson Juan. To help the family work out their conflicts the social worker referred the family to a family therapist who was culturally sensitive and had had experience in working out intergenerational conflicts.

The culturagram has been seen as an essential tool in helping social workers work more effectively with families from many different cultures. Initial evaluation of the culturagram has been positive, and there

FIGURE 2. Culturagram–2000



are plans to assess the effectiveness of the culturagram in promoting culturally competent practice.

Implications

Developing culturally sensitive practice, however, is only the first step. In addition, the health care social worker has an important responsibility to educate other health care providers about the beliefs of culturally diverse patients and their families. Fandetti and Goldner (1988) stress the important role of the social worker as cultural mediator. In a previous article Congress and Lyons (1994) outlined the following guidelines for social workers in health care settings:

1. increase sensitivity to culturally diverse beliefs;
2. learn more about clients' beliefs about health, disease, and treatment;
3. avoid stereotyping and emphasize individual differences in diagnostic assessments;
4. increase the ability of culturally diverse clients to make choices;
5. enlarge other health care professionals' understanding of cultural differences in the health beliefs of clients; and

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Cultural Health Attributions, Beliefs, and Practices: Effects on Healthcare and Medical Education

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Abstract: Health attributions influence health beliefs and subsequent health behaviors. Health attributions are partly shaped by culture. In turn, cultural health attributions affect beliefs about disease, treatment, and health practices. Likewise, culture influences health and healing practices. Certain cultures have culture-bound syndromes about which medical practitioners should be trained. Other sociocultural factors such as immigration, acculturation, and social support play significant roles in health attributions and medical adherence. Culturally diverse patient populations require that medical educators learn new methods of cultural assessment and treatment in order to be effective. Medical educators also need teaching and learning approaches and philosophies that consider health attributions, beliefs, and practices of patients.

Keywords: Cultural health attributions, health beliefs, cultural diversity, culture and medical education, culture and healthcare.

INTRODUCTION

Medical educators have wide ranging responsibilities in the education of physicians and other healthcare providers. Keeping current in the rapidly growing body of scientific knowledge in medicine is one of these responsibilities that requires extensive self-directed learning and continuing medical education activities. These activities provide the core medical knowledge that is required to accomplish the task of educating and training the next generation of healthcare providers. Of equal importance in this education is teaching the interpersonal interaction which must occur between physicians and patients and is critical to diagnosis and treatment of the diseases and conditions that initiated the encounter. This interaction requires communication and interpersonal skills which will build a trust between physicians and patients that will encourage them to accept and follow the medical advice (medical adherence) that will restore or maintain wellness.

This interaction in the medical setting is complex and requires shared knowledge about each other. This shared knowledge requires active give-and-take communication, empathy, and time to develop so that each party is comfortable with the other so the physician can provide the most appropriate advice and care. Shared knowledge is the key to establishing trust, which research shows to be an important factor in medical adherence. When there are significant differences between physician and patient, this process takes more work and more understanding. Differences in culture in its broadest sense (e.g. race, ethnicity, country of origin, socioeconomic status, gender) are present in virtually all interactions and these differences must be acknowledged and considered as healthcare decisions are made. This process is a learned process and a key role for the medical educator to teach.

In order to effectively address these issues, medical educators must have knowledge about cultural differences and how those differences affect treatment decisions and they must know how to obtain this information from patients. This article will address several aspects of how culture affects the health and well-being of patients, which will arm medical educators with the information needed to effectively teach this critical aspect of medicine. We will discuss several specific cultures, but it is not within the scope of this article to be inclusive. Healthcare providers who provide medical care to patients or groups of patients with cultural backgrounds unique to their practice need to learn from the patients the details of those cultures and how those cultures indigenous medical beliefs and practices might affect health outcomes and interactions with the services provided in the medical care setting.

Topics that will be covered in this article include 1) health attributions and the effects of different cultures on those health attributions; 2) models of common cultural health beliefs; 3) cultural practices of health and healing; 4) culture-bound syndromes (conditions found only in certain cultures; 5) effects of immigration and other sociocultural factors on health; 6) assessment of cultural background *via* treatment and therapy approaches; and 7) cultural considerations in medical education (relative to theories of adult learning).

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ATTRIBUTIONS AND HEALTH

Like any behavior, the heart of health behavior is attributions - the causal explanation process used to understand the world. Attributions have long been a focus for social psychologists, who have determined that attributions play an important role in both deciding to act and in decision-making among alternative courses of action [1, 2]. Individuals tend to have a consistent attributional style, but research shows that attributional styles differ cross-culturally (e.g., [3-6]). One example of cultural differences in attribution-making is found in one of the most well-documented facets of attributional theory, the self-serving bias, or the tendency to make dispositional attributions for successes and situational attributions for failures (in other words, we take responsibility for the good and deny the bad [7, 8]. Although the tendency to look into the mirror with rose-colored glasses exists across cultures, the self-serving bias is more pervasive in the West than in more collectivist cultures[1] [9]. Research from Western cultures has shown that having self-biases has been linked to improved health practices, better coping strategies, greater achievement, better health overall, and improved mental outlook [10, 11].

People of diverse cultural backgrounds often make different attributions of illness, health, disease, symptoms and treatment. Cultural differences in health attributions have major implications for medical professionals because over time, attributions play an essential role in the formation of beliefs concerning health and illness (e.g., [12-14]). This relationship in turn becomes reciprocal and health beliefs form a cognitive schema that influences the way that people make attributions. For instance, with regard to health beliefs in the U.S., African Americans may be likely to attribute illness externally to destiny or the will of God (equity attributions) and believe in the healing power of prayer [15, 16]. As compared to ethnic minorities in the U.S., Anglo Americans are likely to hold more traditional Western health beliefs such as individual responsibility for health and illness [17, 18] and more "empirical" explanations of illness [12]. Because of the emphasis on micro-level and natural causes of illness, many White Americans believe that illness can be treated without reference to family, community or deities [17].

Although very diverse, Latino populations as a whole are likely to believe in attributional equity as the cause of illness (e.g., God is punishing me for bad behavior and making me ill) and utilize ethnomedical approaches to healthcare such as *santeros* (practitioners/priests of Santería who combine indigenous rituals with the saints of the Catholic church), *herbalista* (herbalists), and folk remedies [19]. Among the U.S. Latino populations, Murguía and colleagues found that U.S. acculturated Latino adults were less likely to make equity attributions about illness, and those Latinos who made equity attributions were more likely to delay seeking healthcare when sick [19]. Flores reported that Latino parents sometimes have false beliefs about the cause of certain illnesses and therefore are more likely to delay vaccinations in children and use home remedies [20].

[1]Collectivist cultures are those in which people tend to think of themselves as members of groups such as families, work teams, tribes, and nations. People in collectivist cultures are likely to put greater emphasis on the needs of the group rather than the needs of individuals. Most Asian cultures are collectivist.

In comparison to Western populations, African patients may be more likely to attribute illness to a spiritual or social cause rather than a physiological or scientific cause [21]. As such, medical practitioners in many African countries emphasize the whole person-body, mind and soul [21]. African patients are more likely to expect health practitioners to provide an experiential and a spiritual reason why they have been afflicted with illness. For example, one study found that Ethiopians were more likely to attribute mental illness to cosmic or supernatural causes, including curses or spirit possession [22]. In order to effectively treat these illnesses, remedies must be both material (e.g. herbal remedy) and spiritual (e.g., amulets) explanations and techniques. Chipfakacha [23] notes that most black Africans attribute illness to superstitious causes and therefore believe that disease is due to 1) magic and evil spirits; 2) conditions for which causes have been empirically determined; and 3) psychological phenomena. For many Africans, the cause of disease relates to conflict and tension between good/evil and harmony/disharmony [23].

MODELS OF CULTURAL HEALTH BELIEFS

Different cultural groups have diverse belief systems with regard to health and healing in comparison to the Western biomedical model of medicine. These belief systems may include different disease models, wellness/illness paradigms (e.g., Chinese medicine, magico-religious thinking), various culturally-specific diseases and disorders, feelings about healthcare providers and seeking Westernized healthcare, and the use of traditional and indigenous healthcare practices and approaches. Helman suggests that people attribute causes of illness to: 1) factors within individuals themselves (e.g., bad habits or negative emotional states); 2) factors within the natural environment (e.g., pollution and germs); 3) factors associated with others or the social world (e.g., interpersonal stress, medical facilities, and actions of others); and 4) supernatural factors including God, destiny, and indigenous beliefs such as witchcraft or voodoo [24]. Westerners tend to attribute the cause of illness to the individual or the natural world whereas individuals from non-industrialized nations are more likely to explain illness as a result of social and supernatural causes [12]. In a study comparing African Americans, Latinos and Pacific Islanders with White Americans on causal attributions of illness, the ethnic minority groups rated supernatural beliefs as significantly more important than White Americans [25]. There was no difference between the groups about illness causation due to interpersonal stress, lifestyle, environment and chance.

Stainton Rogers describes eight "theories" that people use as a basis in thinking about health and illness: body as machine, body under siege, inequality of access, cultural critique, health promotion, robust individualism, God's power, and willpower [26]. In a study of British lay perceptions on health and recovery from illness, Furnham found that strength of religious beliefs tend to predict fatalistic or supernatural health-related beliefs; older people and those with left wing political beliefs were more likely to emphasize external causes and cures for illness; and people who believed in alternative medicine were more likely to endorse controllable or internal causes of health, illness and recovery and less likely to believe in fatalistic or external causes [27]. Overall, the British participants emphasized psychological

and behavioral determinants of health and illness. Furnham also examined health beliefs across the three cultures of Britain, Uganda and South Africa and found that the African participants were more likely to attribute illness to "evil others" but all of the groups rated interpersonal stress as a potential source of illness [12]. The British participants rated fatalistic factors as extremely unimportant while both African groups rated them as a marginally important contributor to illness [12].

More recently, Jobanputra and Furnham [28] tested Helman's model of health beliefs [24] in British Caucasians and British Gujarati Indian immigrants and found general support for the four domains with the Gujarati Indian immigrants being more likely to endorse supernatural explanations of ill health as compared to the British Caucasians. There was no significant difference in the two groups in terms of attributions made to psychological factors, social factors, and the external environment.

CULTURAL PRACTICES OF HEALTH AND HEALING

All cultures have disease theory systems which include attributional concepts to explain illness causality. Three commonly held paradigms of disease across cultures are naturalistic, personalistic and emotionalistic [29-31]. Naturalistic disease theories explain disease in objective, scientific terms and have the core concept that illness occurs when the body is out of balance. For instance, the Western biomedical model views disease as originating inside the body due to a specific, identifiable "medical" cause or pathogen (viral, bacterial, etc.). In the traditional biomedical model, the pathogens need to be eradicated so that the person is without disease and only then are they considered healthy. The humoral system is another naturalistic disease theory originating from Greek and Roman philosophers and popularized by Hippocrates. According to Hippocrates, the body contains four elements (humors): blood, phlegm, yellow bile and black bile and health comes from an equal balance of the four humors. In this theory, healing occurs by restoring the proper balance of humors through removal (bleeding, starvation) or replacing (special diets, medicine) the deficiency [24].

Personalistic disease theory attributes illness to intervention by an agent such as another human, witch, sorcerer, non-human, or supernatural force. Emotionalistic disease theories explain illness as caused by strong emotional states (e.g., intense anger, jealousy, shame, grief or fright). The personalistic and emotionalistic disease theories are easily applied to patients of non-Western cultural backgrounds who are familiar with and have faith in the medical beliefs and practices from their own cultures [29, 30]. These health attributions and beliefs, however, are significantly different from those of Western medicine. Some Asian cultures believe in the yin and yang principle in which there is a balance between opposite forces (e.g. positive and negative, light and dark, hot and cold) that reflect the difference between health and illness. Others believe that illnesses are caused by spirits or ghosts [32].

In order to more effectively treat naturalistic, personalistic, and emotionalistic aspects of illness, there has been an increasing interest and training in osteopathic medicine and complementary and alternative medicine in North America and Europe (see for example, the article by Grossoehme *et al.* in this supplement). Two well known cultural systems of medicine and healing considered to be alternative by Western standards of medicine are Chinese Medicine and Ayurvedic Medicine. Traditional Chinese Medicine (TCM) is based on the concept that the human body has interconnected systems/channels (*meridians*) that need to stay balanced in order to maintain health. TCM healing practices include herbal medicine, acupuncture, dietary therapy, and Shiatsu massage. Qigong (breathing and meditation practice) is also closely associated with TCM [33]. Ayurvedic Medicine is native to India. The Ayurvedic system is based on the idea that every human contains a unique combination of *Doshas* (the three substances of wind/spirit/air, bile, and phlegm) that must be balanced for health. In addition, healthy metabolism, digestion, and excretion are thought to be vital functions of the body. Similar to TCM, Ayurvedic Medicine also uses herbs, massage, meditation and Yoga as healing practices [34].

The Western world has become more interested in alternative healing practices such as acupuncture, homeopathy, herbal medicines, and spiritual healing [35]. Depending on the model of health and cultural health beliefs, there are a variety of possibilities for the treatment approach.

CULTURE-BOUND SYNDROMES

There are some physical and mental illnesses that are unique to particular cultures and are influenced directly by cultural belief systems and other cultural factors. In 1994, the DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) added culture-bound syndromes (i.e., troubling patterns of behavior/ experience that may not fall into one of the traditional Western DSM diagnostic categories). Culture-bound syndromes are considered within the specific culture to be illnesses or at a minimum afflictions and the majority have local names. For example, *dhat* is a disorder affecting Indian males that involves an intense fear that losing semen will result in the depletion of vital energy. *Dhat* is thought to occur through intoxicants, eating heated foods, having a fiery constitution, and sexual excesses which can cause fatigue, weakness, body aches, depression to the point of suicidal feelings, anxiety, and loss of appetite [36]. *Susto* (magical fright) and *mal de ojo* (evil eye) are common afflictions in Latin America. *Susto* is a disorder occurring when the soul leaves the body after a frightful episode. Symptoms include sleep disturbance, easy startling, palpitations, anxiety, involuntary muscle tics, and other depressive symptoms. *Mal de ojo* is an affliction caused by an admiring glance from a more powerful/stronger person and usually affects children. The symptoms of evil eye are fussiness, refusal to eat or sleep, fever, and seizures. Prevention includes wearing special amulets and shielding babies from direct eye contact. Treatment for evil eye can include physical contact from the perpetrator on head or prayer and ritual with egg [37].

Eating disorders span both physical and mental boundaries of cultural health. Eating disorders especially in highly industrialized societies continue to rise [36]. Although in some cultures, being stout and plump is associated with good health and prosperity, and certain historical time periods

have celebrated more voluptuous women (consider the Rubenesque woman) being thin and fit as a cultural ideal for women has increased in popularity [36, 38, 39]. In the Western world, especially with young women, the cultural notion of the thin ideal makes it is clear that culture has a definite influence on attitudes toward body size, body shape, and eating behaviors [38, 40].

Somatization, or physical ailments due to stress or emotional distress, is common especially in collectivistic societies perhaps because people avoid expressing psychological complaints to families and friends [36]. In other words, a person suffering from depression or anxiety might use somatization as a culturally sanctioned way to signal distress [41]. Recognizing that there are culture-bound syndromes and that the expression and formation differs culturally paves the way for practicing culturally sensitive medicine and psychotherapy. Otherwise, misdiagnosis can occur when ethnic and cultural differences are not taken into account.

OTHER SOCIO-CULTURAL FACTORS RELATED TO HEALTH ATTRIBUTIONS, BELIEFS, AND PRACTICES

Cultural influences on health attributions and beliefs and practices are well recognized. Shifts have occurred both in the goals and approach of health and the definition of health itself. Rather than curing being the end-goal of health, now there is more emphasis on prevention of disease and promotion of health internationally (e.g., appropriate diet and exercise). Also increasing in importance has been the inclusion of social and behavioral sciences to understand health problems and supplement the biological and medical technology emphases [42]. This has underscored the importance of context *via* community-based approaches [43] and the important role that sociocultural, behavioral and environmental factors play in health such as poverty, social support, medical adherence/compliance with treatment regimen, resilience, acculturation, immigration, and shared water sources. The definition of health has been extended to include other aspects of well-being—"state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity" [44]. This extension of the definition of health encompasses well-being including quality of life, positive mental health, and the consideration of culturally sensitive approaches to healthcare as well as indigenous and alternative forms of healing as legitimate forms of treatment.

Immigration can have a significant effect on cultural health beliefs and practices. Immigrants may have certain infectious diseases which are endemic to the patient's country of origin. Immigration itself can cause illness and disease due to disrupted family and social networks, financial hardship, and discrimination that prevent the maintenance of a healthy lifestyle. Immigrants leave their countries for a variety of reasons including violence, economic hardships, or natural disasters all of which cause extreme stress and even physical injury [32]. Immigrants frequently work in low-paying jobs, face poverty, lack health insurance, have limited access to healthcare and social services, and have communication difficulties due to language differences [32].

Immigrant families may have trouble accessing healthcare services for a variety of reasons. Language and cultural barriers (including lack of cultural competent healthcare providers), distance to care, cost of treatments, lack of transportation, perceptions of lack of respect, discrimination or racism, and a complex Western healthcare system can all contribute to reduced access to healthcare [45]. Immigrant families from collectivist countries in which kinship is a strong value may view the role of caregiver as an expected way of showing gratitude and love when a family member is ill [46]—this may cause families to delay seeking professional healthcare. Mir and Tovey note that some immigrant families may not seek healthcare because they lack awareness of the healthcare services offered or they may find the services culturally inappropriate or insensitive [47]. Compared to the U.S. born population, foreign born immigrants are twice as likely to lack health insurance [48]. Recent immigrants to the U.S. have less contact in general and less timely contact with the healthcare system [49] and are more likely to have infectious diseases, especially tuberculosis, Hepatitis B, and parasitic infections, as compared to U.S. natives [50-53].

Immigrant children can have infectious diseases that Western pediatricians are not used to diagnosing and treating, and immigrant children often lack adequate immunization. The psychosocial factors of immigration may impose additional stressors on immigrant children (e.g., disparities in social, economic, and professional status from family's country of origin). Immigrant children may experience ongoing mental health issues due to relocation and potential atrocities experienced in home country and because of adaptation issues with school and peer groups. Like their parents, immigrant children may lack of a larger social support network of family and friends which was present in their country of origin [54]. As compared to U.S. born children, immigrant children may experience more dental problems and be more at risk for nutrition problems which result in growth deficiencies [54].

Much of the health-related information about immigrants paints a bleak picture. However, immigrants in the U.S. are generally better off on measures of health risk factors, chronic conditions, and mortality as compared to U.S. natives [55]. Recent immigrants to Westernized countries such as the U.S. seem to have a health advantage in certain areas which is known as the "healthy migrant" phenomenon. Interestingly, this health advantage, however, disappears dramatically and moves to health disparity. Length of time in the U.S. is positively correlated with increases in low birth weight infants, adolescent risk behaviors, cancer, anxiety and depression, and general mortality [55]. Such a phenomenon may be due to the loss of healthy resources from the country of origin including social networks, cultural practices and appropriate level of employment commiserate with education [56]. Social support offers people a mechanism to cope with stressful life events. Social support networks act as a buffer mitigating the adverse health effects of physical and mental stress [57]. Few studies have considered cultural differences when it comes to the role of social support and patterns of social relationships. One article by Kim and colleagues examines social support of Asians and Asian Americans [58]. In this study, Asians and Asian Americans, as compared to European Americans, were more reluctant to ask for support from close others (extended family, friends, etc.). This finding along with other similar findings suggests that social support is culturally mediated and must be viewed

within the context of cultural beliefs about social relationships. Social support has been shown to reduce psychological distress during difficult times and has a variety of health benefits including resilience to life threatening diseases. Social support can act to prevent illness, speed recovery from illness, and reduce the risk of death from serious disease [58]. If social support is defined as the "explicit seeking and receiving of support," it appears that people from collectivistic cultures are less likely to utilize social support than people from individualistic cultures [58, p. 522].

While trying to adjust to a new culture, most immigrants undergo a shared experience dealing with "unexpected obstacles of poverty, discrimination, language, ambiguous immigration or legal status" [59, p. 282]. In most situations, immigrants have been parted from family, friends, and are estranged from the inherent security one attains with being a member of a community [60]. Immigrants may also feel burdened by the necessity of learning and/or enhancing non-primary language skills and overcoming bias when seeking employment, living arrangements, and schools. This process is often hampered by an overwhelming sense of ineptness in a new and different social environment. These cultural hurdles add to the "confusion and conflict, anomie, personal disorganization, and a variety of other problems related to social marginality...." [61, p. 78].

Immigrants and other non-dominant individuals can be affected by acculturation. Smart and Smart define acculturative stress as "the psychological impact of adaptation to a new culture" with potential effects on physical health and self-esteem [62, p. 25]. Acculturative stress occurs as immigrants lose touch with self-identifying constants, values and social institutions of their former homeland. Theorists have suggested that this process of acculturation may lead to higher rates of mental disorders especially depression, adjustment, and general psychosocial dysfunction [42] all of which result from "the processes of adaptation, accommodation, and acculturation which involve dynamic and synergistic changes in the immigrants' intrapsychic character, their interpersonal relationships, and their social roles and statuses" [61, p. 78]. Uncertainty about the future along with heightened levels of anxiety may contribute to family dysfunction which can manifest as strict and authoritarian childrearing practices including harsh disciplinary methods (spanking) and possible severe, physical abuse [60]. Additionally, households in which both parents work means children may be left unsupervised or neglected, and in some cases, parents have left children behind in their native country. Both of these circumstances can increase conflicts surrounding relationships, gender roles, and respect issues [60].

According to Berry, individuals and/or groups develop one of four strategies toward acculturation [63, 64]. He delineates these strategies on two dimensions: 1) maintenance of heritage, culture and identity and 2) relationships sought among groups, including both dominant and non-dominant groups. Berry postulated that the four strategies of ethnocultural groups include integration (maintain one's original culture and have regular interactions with dominant culture), separation (maintain cultural identity and avoid interactions with dominant culture), assimilation (seek out interaction with dominant culture and do not maintain cultural identity), and marginalization (do not maintain cultural identity and exhibit little interest in interactions with dominant culture). The acculturation strategies chosen by individuals or groups depend on the socio-cultural context of the larger society. For instance, the integration strategy will only work in societies that value cultural diversity and have relatively low levels of prejudice [42]. The dominant group and larger society play an essential role in how acculturation occurs. Assimilation when desired by the dominant culture is termed "melting pot" indicating a blending into the dominant group. When separation is demanded by the dominant group, it is "segregation". Integration occurs when the dominant society endorses mutual accommodation now widely called "multiculturalism". In several studies, Berry's acculturation strategies have been examined in non-dominant acculturating groups. Across these studies, the strategy of integration is generally preferred over the three other strategies and marginalization is the least preferred. However, exceptions do occur such as some Turks in Germany and Canada [42] who prefer separation over integration.

Managing psychological acculturation is challenging given the complexity of situational and personal factors that contribute to the process [42]. First, there is the society of origin and the society of settlement both of which have unique cultural factors. The cultural characteristics of the individual (developed from the society of origin) and the cultural characteristics present in the society of settlement (including political, economic, and demographic conditions) must be understood in order to estimate cultural distance between the two societies. The "migration motivation" of the individual needs should be considered in order to understand the individual's degree of reactive (negative, constraining) versus proactive (positive, enabling) factors toward the migration experience [42]. The presence or absence of a multicultural ideology in the society of settlement gives important information about openness to cultural pluralism and thus acceptance of new members. Societies that support cultural pluralism generally provide a better context for immigrants due to the presence of multicultural institutions and corresponding resources (i.e., culturally sensitive healthcare and multicultural education curricula and services) and because of less pressure to assimilate or be excluded [42].

Although the process of acculturation is fraught with variability due to moderating factors that occur before or during the process, Berry has outlined five primary features that affect the process of psychological acculturation [63]. First, there is the stress or demand of dealing with and participating in two different cultures. Second, individuals evaluate the meaning of dealing with the two cultures and depending on the appraisal, the changes that follow will either be relatively easy or more challenging and problematic. Third are the coping skills and strategies used by individuals if the situation is deemed problematic. The fourth feature of acculturation is the physiological and emotional reactions to the situation. The fifth and last feature is the long term adaptation that may or may not be achieved depending on how the other aspects of acculturation have been addressed.

Other factors related to cultural health attributions, beliefs, and practices include poverty and medical adherence. Poverty remains pervasive and is a causal factor affecting health and health disparities of vulnerable populations across the globe. In 2005, The World Bank estimated that one

fourth of the population of the developing world lived below the international poverty line of $1.25/day considering 2005 prices [65]. Because of the generational aspects and relation to other cultural categories (i.e. race, ethnicity), some view socioeconomic status and poverty as the key disadvantages in society trumping other cultural categories such as gender and race/ethnicity alone [66]. According to the World Health Organization and other international groups, there is an extremely high rate of malnutrition of children under the age of five in developing countries, and this is intimately tied to socioeconomic status [67]. Socioeconomic status and poverty have profound effects on children's development. The effects of poverty contribute to deficiencies in cognitive outcomes, school achievement, emotional or behavioral outcomes, and other areas like teenage pregnancy, increased child abuse and neglect, increased violent crimes, and fear of neighborhoods [68]. Poverty can seriously play a significant role in health risks and barriers to care. One consequence of poverty is substandard housing which can be a factor causing stress and illness and may be even worse for immigrants because of language barriers, large family sizes, and lack of awareness about housing rights.

Patients' health attributions and beliefs are also considered to be a major factor in medical adherence [69]. Depression, social support, and disease severity all play a significant role in predicting adherence. This suggests that approaches to medical care need to effectively understand, assess, and manage "language, culture, ethnicity and social class to enhance patient adherence" [69]. Medical adherence is second only to gaining access to appropriate healthcare in directly affecting health outcomes of children and adults.

CULTURAL CONSIDERATIONS IN TREATMENT AND THERAPY

One aspect of healthcare is how a culture organizes the health system in terms of public or private access to care. In some countries, access to healthcare is mediated by socioeconomic factors, and only the wealthy receive quality care. In other countries, healthcare is widely accessible by all regardless of income level or insurance status. Many aspects of culture can affect successful and effective treatment approaches including religion and spirituality, social support networks, beliefs and attitudes about causes and treatments, socioeconomic status, and language barriers [40]. There is no one perfect program that is culturally relevant for all involved, however, approaching treatment and healing from a culturally competent perspective should be paramount.

There is an undeniable need for culturally competent healthcare services in order to address the health needs of an increasingly diverse pluralistic world, eliminate existing health disparities for minorities, mend a fragmented system of care where some receive better services than others, and meet the required cultural competency standards of accreditation bodies within medical training. Within medicine, the notion of cultural competency originated from medical anthropology with emphasis on the universality/relativity of distress and disease. Kleinman described medicine as a cultural system which requires careful cultural analysis to determine disease and illness (e.g., what is considered illness in one culture may be considered idiosyncratic or even divine in another) [70]. Historically, most Western healthcare initiatives in cultural sensitivity have emphasized immigrants and refugees with limited dominant language proficiency and "buy-in" to Western norms. This approach became somewhat problematic because stereotyping was common and therefore the unique experiences and perspectives of the various immigrant and refugee groups were not recognized.

Cultural issues have increasingly become incorporated into medical care as there has been greater recognition of the intimate tie between cultural beliefs and health beliefs. Perceptions of good and bad health and the causes of illness are formed in a cultural context—what is acceptable in one culture is not in another. For example being overweight is viewed as acceptable in some cultures—it may even be seen as a sign of health and wealth. Many healthcare institutions and community sites have incorporated linguistic competence into their services and have employed skilled interpreters to manage linguistic diversity in their patients. However, being linguistically competent is not the same as being culturally competent. For example, although a site may have interpreters available for patients, the site may still impose a Western values-based healthcare and environment (e.g., certain feeding practices and dietary mandates, lack of religious accommodation such as non-denominational spaces for prayer, particular grieving expectations, non-recognition of extended family members or "tribal" connections as immediate family, etc.).

In medical education, the most commonly cited approaches to cultural competence are a combination of culture specific information with enhancements to communication and assessment skills. Some of the more popular models include the L-E-A-R-N model [71], Kleinman's questions [70], cultural assessments [72, 73] and the ETHNIC framework [74]. Green, Betancourt, and Carillo recommend a social context review of systems to examine the factors of social stressors, support networks, changes in environment, life control, and literacy to understand cultural differences from a deeper perspective [75]. Coming from international business and sojourner work, Brislin uses critical incidents in order to provoke thinking as participants reason through different responses [76]. Many of the techniques/strategies share similarities but concentrate on different aspects/dimensions of cultural competence. Given the array of models and approaches, four main categories of culturally competent approaches to health and healing are suggested: 1) Collaborative Approaches; 2) Personality Approaches; 3) Assessment Techniques; and 4) Partnership/ Empowerment Strategies. This classification is discussed in detail elsewhere [77].

The "life domains" approach is a nontraditional model for healthcare that incorporates cultural health attributions, beliefs and practices [78]. Life domains include language, social affiliation, daily living habits, media, education, work, intimate relations, childrearing, celebrations and events, identity, values, religion/ spirituality, and health practices. By examining life domains, healthcare providers can better understand a family's acculturation level and their worldview which will assist in future healthcare provision.

Because physicians often lack time to do a thorough cultural assessment or go to the depth that may be necessary with some families or patients, other intermediaries such as cultural brokers and lay health workersshould be considered. *Cultural brokers* in the healthcare context are patient

advocates who act as liaisons, bridging, linking, or mediating between the healthcare provider and the patient whose cultural backgrounds differ in order to negotiate and facilitate a successful health outcome [79]. "A cultural broker program has the potential to enhance the capacity of individuals and organizations to deliver healthcare services to culturally and linguistically diverse populations, specifically those that are underserved, living in poverty, and vulnerable" [79, p. 6].

Lay health workers (LHW) or promoters, sometimes referred to as *Promotores* when working with Latinos, and by many other names[2], provide public health services to those who have typically been denied equitable and adequate healthcare in many different cultures and countries. LHW typically come from the communities in which they work. They do health promotion, education and service delivery within a limited scope of practice. "Lay health workers are effective because they use their cultural knowledge and social networks to create change" [81, p. 516]. There is good evidence that these type of models work because they are culturally appropriate and integrated into communities [82].

As globalization continues to increase, other international approaches to therapy should be considered especially ones which consider trauma and violence at a cultural level. One developmental approach to therapy is the HEARTS Model [83]. The HEARTS model is not linear and should be adjusted according to client's needs. The steps include:

H (Listening to History) - providing the opportunity for client to safely communicate their story; compassionate connection necessary keeping in mind the honor of a survivor's willingness to relay their story to you

E (Focus on Emotions and Reactions) - focusing on the emotions experienced throughout their experience; allowing survivor to put words to his/her feelings about what took place; increasing "feeling vocabulary"

A (Asking Questions about Symptoms) - discussing behaviors and physical symptoms

R (Explaining the Reasons for Symptoms) - helping survivor make sense of symptoms; discussing physical and psychological symptoms as related to experience of trauma; normalizing; helping establish sense of control; symptoms as method employed by body for protection

T (Teaching Relaxation and Coping Strategies) - increasing sense of mastery and reducing symptoms; imagery and focused breathing; identifying coping skills used during times of trauma, stress

S (Helping with Self-Change) - identify ways in which survivor is the same and different after trauma; positive changes; river example

[2]"Lay Health Promoters have gone by many names including: Village Health Workers, Primary Healthcare Workers, Indigenous Healthcare Workers, Community Health Workers, Community Health Assistants, Community Health Representatives, Medical Auxiliaries, Rural Health Assistants, Community Health Aides, Brigadistas, Promotores y Promotoras de Salud, Indigenous Health Aides, Lay Health Advisors, Auxiliary Health Workers, Front Line Health Workers, Barefoot Doctors, Feldsher, Community Health Promoters, Kaders, Prokesa. These terms are not necessarily interchangeable, since each has its own practical, historical and political significance" [80] Nuestra Comunidad Sana. Lay health promoters. [cited 2008 November 21]; Available from: http://community.gorge.net/ncs/background/promoters.htm.

Folklore therapy or the use of Spanish *dichos/refranes* (sayings or folklore) may be helpful to mental health practitioners working with Spanish-speaking clients. Dichos/refranes are proverbs and sayings that use folk wisdom to convey helpful information [84]. Dichos therapy groups and individual therapies have been used successfully by some psychotherapists [85]. Dichos often draw clients in whereas other efforts fail because the sayings are relevant to cultures and families, are associated with positive imagery, and offer flexibility in the approach [85].

Ubuntu therapy [86] comes from the South African Zulu Ubuntu philosophy which contains three dimensions: 1) psychotheological; 2) intrapsychic; and 3) interpersonal and "humanness"—(e.g., Zulu saying "umuntu ngu muntu nga bantu" which means I am because we are). The psychotheological dimension views god as creator who breathed life into all people. The intrapsychic dimension signifies the human essence enabling a person to become abantu (humanized being). The interpersonal dimension emphasizes relationships with others (kindness, good character, generosity, hard work, discipline, honor, respect, ability to live in harmony with others). The overall goal of Ubuntu therapy is to address conflicts within these three dimensions as related to ubuntu values. The therapeutic process consists of hearing the client's story and determining at what level their conflict exists and at what level to address the problem. Therapeutic techniques and approaches include "burning platform," eclectic approaches and art.

Such alternative models to health and healing bring a fresh perspective to cultural awareness and challenges. They do not rely on traditional methods which tend to focus either on improving the cultural competence of the provider, such as through training, or improving the patient, such as through culturally relevant informational materials. Making either party to the healthcare transaction more competent is laudable but addresses only the individual competency of persons and does not address the interaction between family and provider or the systemic competency of the organization. More creative and comprehensive approaches are required that do not rely on the traditional approaches of changing the persons involved but instead focusing on the system as a whole.

CULTURAL CONSIDERATIONS IN MEDICAL EDUCATION

A culturally diverse patient population requires that medical educators modify their teaching and learning approaches and philosophies in order to take into account cultural health attributions, beliefs, and practices of patients who medical learners will encounter. This diversity mandates medical educators to teach medical learners how to approach and manage illness in patients with different backgrounds from their own. In order to emphasize the importance of the role that cultural attributions, values, beliefs and practices play in health and healing, medical education programs need a teaching philosophy and curriculum in order to incorporate approaches, interventions and models which take such factors into account. Training in medical education must incorporate the changing demographics, globalization, and technology as sociocultural conditions that shape the learning needs in today's world [87]. Although changes and

diversity bring new possibilities for global interaction and expanding learning modalities, they also may have a "splintering" and "fragmenting" effect on society in which minorities and marginalized people may have less access to educational resources and may experience oppression from the dominant groups [87]. Critical theory and social change education offer important insights for medical education and learning concerning the political realm including sociocultural issues, globalization, oppression, and power within society.

Critical theory originated from the Frankfurt School, an informal name given to members of the Institute for Social Research (*Institut für Sozialforschung*) at the University of Frankfurt in Germany. The designees of the Frankfurt School were considered neo-Marxist and therefore ardently anti-capitalist. The School emphasized social theory, sociocultural research, and philosophy and became known for critical theory, which focused on radical social change, and was the antithesis of "traditional theory" in the positivistic and scientific ideologies . The emphasis of critical theory in general is the analysis and critique of power and oppression in society. At its root, critical theory aims for human emancipation from any circumstances that cause enslavement. Critical theory emerged as a critique of capitalism and the social inequalities (that result from capitalism), the dominance of a single ideology, and the potential impact of critical thought in the world [88].

There are many "critical theories" that have been developed as a result of various social movements all of which attempt to eradicate domination and oppression. All critical theories share the emphasis on decreasing hegemony and increasing human freedom with "utopian hopes for new social responses in an alienated world" [89, p. 135]. As such, approaches like feminism, critical race theory, post-colonial theory, and queer theory can all be considered critical theories. Social change education, an educational application of critical theory, concerns itself with challenging injustices across social, economic, and political realms [90]. Much of the theoretical basis of critical theory and social change education comes from Jürgen Habermas and Paulo Freire.

German philosopher and sociologist, Jürgen Habermas was a later student of the Frankfurt school and is said to be one of the more activist members from that school. Drawing heavily on the ideas of Marx and yet rejecting some of Marx's work, Habermas's approach is described as a creative blend of systems theory, pragmatism, and analytic philosophy all with the intent of application to society [89]. Habermas was interested in a more equitable society and he believed that this could be achieved by empowering the members of society to action through self-reflection and dialogue. His writings promoted the idea that that we lack freedom in society and that powerful "systems" (government, corporations, media, etc.) are manipulating individuals and therefore not meeting our needs. He believed that communication has become a controlling tool primarily used to satisfy the selfish interests of the communicator regardless of the recipient's needs or interests [91]. Habermas advocated that we should engage in "communicative action" (a coming together to engage in dialogue for the purpose of common action) in order to become empowered against the hegemonic system. This theory of communicative action includes everyday communication practices and proposes that reason comes out of mutual understanding within ordinary human communication.

Welton and others have brought Habermas's version of critical theory to adult education and have pointed to the applicability of his ideas like reflective discourse and learning communities [87]. The ideal conditions that Habermas proposes for authentic reflective discourse (dialogue, discussions) to occur are comprehensibility, sincerity, truth, and legitimacy. A key element of his notion of discourse is that it should involve an honest attempt to put aside bias and be open to all sides of an argument in order to come to consensus [87]. In terms of learning communities, Habermas advocates determining whether institutions and adult educators are enabling us to reach our full potential by not being too concerned with planning classes or arranging classrooms and failing to consider more "political" issues like accessibility of education [87].

Paulo Freire was a Brazilian educator and activist who proposed a social emancipatory view of learning. This is sometimes called popular education, liberating education, social change education, or critical pedagogy. He follows in the footsteps of Habermas because the basis of his approach is "critical" in nature and critiques the oppressive systems of society. Freire rose in distinction during the 1960s and 70s when anti-colonialism was strong in the Third World. He examined education in terms of its emancipatory potential which appealed to the oppressed masses in Third World countries. His theory emphasized that "knowledge" came from those in power, so people need to deconstruct that knowledge and create new knowledge that is liberatory in nature. Freire found traditional educational practices constraining and non-liberating because he believed the oppressed have been conditioned to identify with the oppressor and view them idealistically [92]. He reasoned that if the oppressed wanted freedom they had to use critical consciousness to examine things as they truly exist in society.

Freire is well known for his participatory model of literacy described in his well-known book, *Pedagogy of the Oppressed,* first published in 1970. Overall, Freire critiques the dominant "banking model" of education and says that education in general is suffering from "narration sickness" [93, p. 71]. He says that traditional education is one-way with the teacher narrating the content to the students who are passive recipients of content who are required to memorize and repeat it back to the teachers. The "banking" metaphor derives from the teachers who "deposit" ideas into the students who become "depositories" and "automatons" waiting to be filled with the knowledge and wisdom of the all-powerful teachers. Freire views this as an inherently oppressive model and insists that such a banking model goes directly against the idea of dialogue and gets in the way of a critical orientation to the world [93]. Students are controlled, knowledge is static, the teacher is the authority, and the realities of life are trivialized which results in a dehumanized and paternalistic model that reinforces the inequalities and injustices of society.

Instead Freire calls for a "problem-posing" (authentic or liberating) education where "men and women develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality but as a reality in the

process of transformation" [93, p. 83]. Problem-posing education starts with a transformation of the teacher-student relationship whereby teachers become both teachers and learners and vice versa. Dialogue is an essential process within this model and the relationship between teachers and students is "horizontal" rather than hierarchical. In this model, the educational situation is marked by posing problems that relate to the real world which encourages critical reflection about these problems resulting in a continual creating and recreating of knowledge by both teachers and students. According to Freire, problematizing is a three-phased process that involves asking questions with no predetermined answers. Phase one is a naming phase where the problem is identified. Phase two is the reflection phase to discover why or how the situation can be explained. The third phase is an action phase marked by questions about changing the situation or considering options.

Prabhu summarizes the primary differences of the banking model and the problem-posing model in terms of world, teacher, student, teacher/student relation, style of communication, social function of education, and application to extra classroom situations [92]. He indicates that problem-posing education is dynamic and malleable. The teacher is a co-learner; the student is actively engaged in the process of learning; the teacher/student relationship is equalized; communication is dialogical and democratic; the social function of education is questioning for the purpose of transforming social reality; and learning is seen as lifelong and complex.

Ultimately such a model, according to Freire, is a "revolutionary futurity" because teachers and students learn that dominant ideas can be challenged and oppressive systems transformed which helps them move forward and transcend the past [93, p. 84]. Although some scholars have mistakenly labeled Freire's educational ideas as too laissez-faire, he asserts that problem-posing education is purposeful and rigorous. The teacher still gives structure and helps to facilitate the direction of learning through constructive feedback and goal setting.

Although critical theory and social change education certainly have their critics, the approaches bring more to the table compared to other theories that address diversity and the socio-cultural-political issues within education and learning. The intent of critical theory and social change education is "to extend democratic socialist values and processes, to create a world in which a commitment to the common good is the foundation of individual well-being and adult development" [94, p. 21]. The strength of such approaches is that they challenge the existing hegemony in hopes of transforming society for the better for all people even the disenfranchised or marginalized. The main weaknesses seem to be that such approaches are not always pragmatic. Although they call for change, they do not always offer specific strategies to effect change [87].

CONCLUSION

Given the increasing diversity of cultural health attributions, beliefs and practices, it is crucial that the field of medicine prioritizes such factors in healthcare and medical education. The following aspects of culture suggest ways to contribute to successful and meaningful interactions with culturally different individuals and groups at both the patient/provider and the medical education levels:

- *Culture is multi-faceted, complex and pervasive.* Culture encompasses more than nationality, race or ethnicity and is intimately related to beliefs and practices.
- *Many external factors impact culture.* These include immigration, acculturation, discrimination, economic status, and social support/networks.
- *Many cultural factors impact health.* These include health attributes, culture-specific health and healing practices, and access to culturally competent healthcare.
- *Bi-lingual does not mean bi-cultural and multilingual does not mean multicultural.* Language is one aspect of culture, but for many people it is not the most important. Do not make assumptions about an individual's cultural experience based on the language they speak on initial presentation.
- *Be humble, humanistic and hopeful.* We are all more similar than we are different especially when it comes to basic human needs and rights. Admit to what you do not know and be open to learning from those of different backgrounds than your own. (e.g., patients, students, parents, local leaders).
- *Collaborate WITH people rather than ON them!* Programs, interventions and healthcare are more successful if members of the target population are involved from the beginning and contribute to program development.
- *Cultural competency is a lifelong endeavor.* Because culture is fluid and constantly developing, it is impossible for even the most dedicated medical professional to know everything about every culture for every person.
- *Seek information to help your understanding of traditional health beliefs* and practices including religious practices that impact health and well being.
- *Relationships, relationships, relationships.* Building relationships based on mutual trust will enable cultural information sharing.
- *If you have questions about someone's cultural background and beliefs, ASK.* Most people welcome the opportunity to talk about themselves and their background and appreciate your interest.

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