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## Methodology in Cross-Cultural Care

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### The Disease—Illness Dichotomy

"Sickness" is what is happening to the patient. Listen to him. Disease is what is happening to science and to populations. (Weed, 1978, p 205)<sup>1</sup>

The biomedical model has become a cultural imperative, its limitations easily overlooked. In brief, it has now acquired the status of a dogma . . . Biomedical dogma requires that all disease be conceptualized in terms of derangement of underlying physical mechanisms. (Engel, 1977, p 130)

Health care is a complex issue. Cultural and language barriers complicate the situation. Western medicine has developed into a subculture with its own history, language, codes of conduct, expectations, methods, technologies, and concerns about the science which supports it. Science teaches us that human populations are governed by biologic universals that transcend cultural boundaries. The methods and language of biologically based and somatically focused health care have created an extraordinary gulf between practitioners and the public they serve.

There is a disparity between the biomedical categorization of human disruptions as *disease* and the patient's personal and social experience of *illness*. The dichotomy between disease and the illness experience has provoked extensive commentary. It has been proposed that the inability to deal with illness is a major failing of biomedicine. Cross-cultural circumstances often magnify the discrepancy between the views held by patients and health care providers. The inability to recognize and deal with perspectives of illness that deviate from those of the biomedically trained practitioner can paralyze attempts at identifying problems and developing plans for solving them.

Biomedicine must use approaches that recognize and account for the views and values of the individual and of cultures, not only in determining the nature of a patient's problems but also in describing solutions. *To undertake this task, the practitioner must be prepared to accommodate to the dictates of biology as well as the experience of illness as it is perceived by the patient, his family, and his group.*

1. Weed's use of the term *sickness* encompasses issues raised by others discussing the "illness vs. disease" dichotomy as it applies to biomedical practice (see Engel, 1977; Fabrega, 1975; Mechanic, 1968; Kleinman, 1978). In addition, he uses the term to describe the sequelae of complex interactions between multiple, interactive physiologic, psychological, and social problems.

### Issues of Provider Dominance in Communicating with Patients

Provider-patient communication involves socialization, diagnostic inquiry, planning, negotiation, goal setting, therapy, and education. As a verbal interchange progresses, each communicant has an evolving sense of his or her contribution to the information being shared, its basic meaning and content. Cultural boundaries are a major source of discrepant views of reality. In patient care, factors that distort the development of commonly shared information will necessarily alter the perceptions of clinical reality.

Clinical realities are formulated in a setting heavily influenced by a provider-dominant relationship with recipients of health care. Consider that (1) the provider has been asked to help, diagnose, counsel, treat, and often to certify the patient as "sick" in a socially approved fashion; (2) the provider organizes the discussion, directing it in a fashion that will be optimally relevant to the patient's complaints and situation; (3) the provider molds patient responses and findings into recognizable, manageable patterns (this allows for problem description via paradigms about illness that have been developed and accepted within the context of biomedical practice); (4) the provider determines which portions of the material will be regarded as significant, and this decision is often made unilaterally, independent of the patient's views; and (5) the provider then describes both the diagnostic and therapeutic actions to be taken.

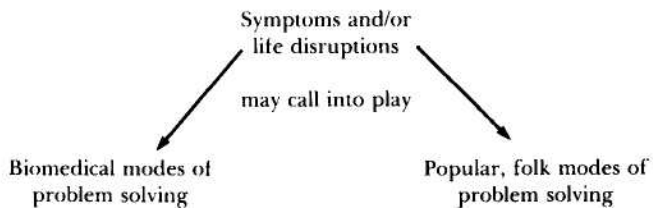
Provider dominance may introduce an extraordinary bias, which can lead to a unilateral and ethnocentric view of "what's wrong." Provider views may be further biased by his or her personal background, values, and social class. In addition, formal training, instruction and certification in medical methodology creates a sense of correctness, authority, and superiority in which "the doctor knows best." These circumstances can lead to a situation in which patient views are overlooked or excluded as invalid concerns.

Faced with the potential for discrepant views of what constitutes illness in cross-cultural interchanges, the provider must first recognize what it means for him or her to be in a dominant role. Provider dominance can serve to impede rather than improve communications. Failure to recognize this issue can block the practitioner's ability to consider the patient's views and role in the illness process.

### Accommodating to a Broader Universe of Patient Needs and Views

Symptoms and disruptive life events are often a stimulus for problem-solving activities. Patients often use more than

one system for problem solution. For example, it is not unusual to discover that a "modern" Westerner has called upon biomedicine, religion, and a popular therapy like chiropractic to solve a problem. This circumstance can be diagrammed as follows:



In patient care settings, biomedical and popular systems of care must be viewed as parallel, often simultaneous activities. It is often necessary to reach an accommodation between them. The patient's views must be taken into account and dealt with. It is clear that popular or folk therapies often work, although at other times they may have a negative effect. When patients have special knowledge or views (e.g., a cultural construct of cause and necessary therapy), a language or communication problem, or family-community problems, these issues may need to be elevated to a level of concern on a par with a problem such as congestive heart failure.

Cross-cultural accommodation in the care process allows biomedical, psychosocial, and popular definitions to coexist within the framework of both cultural systems. It requires that patient and provider consider plans and therapy directed at problems arising from both points of view. Failure to establish this accommodation may lead to failure in the health care process.

### Ethnocentricity in Differing Diagnostic and Therapeutic Traditions

Diagnostic and therapeutic processes in different cultures have evolved from both ancient and borrowed traditions. Each healing tradition, including biomedicine, is inherently ethnocentric. In cross-cultural settings, it is necessary for both patients and providers to accommodate to the circumstances of an illness described in the context of more than one system. In general, these systems involve the discovery and evolution of an illness, a description of what is wrong, the actions taken, and attempts at resolution.

Patients may connect life process and symptomatology in a way that does not fit with biologic definitions.<sup>2</sup> In addition, special knowledge and popular health beliefs may play a prominent role in patient concerns. Individual experience with traditional practices and beliefs as well as the

2. Patients often have explanations that connect diverse personal, family, community, religious or even economic issues to illness. These patient views have been described via narrative reconstructions (Williams, 1984) or explanatory models (Kleinman, 1978). In addition, biomedical activities have many of the qualities of folk systems. At times it appears that practitioners and patients, acting in the guise of science, use biomedicine to the exclusion of any other approach and in an almost magical context. Fabrega (1975, p. 969) has pointed out that "biomedicine . . . constitutes our own culturally specific perspective about what disease is, and how medical treatment should be pursued; like other medical systems, biomedicine is an interpretation which 'makes sense' in light of cultural traditions about reality."

ability to articulate them may vary. Many cultures discourage the revelation and exposure of personal and family issues. Unfortunately, biomedical focus often precludes these revelations, and they remain unrevealed and unspoken.

Each step of the problem-solving process is ethnocentric. In cross-cultural care, patient-provider interactions are complicated by the existence of parallel, usually discrepant, explanatory systems that may include disparate descriptions of natural phenomena. When an event occurs, entirely discrepant problem-solving methods and views may be called upon to describe and explain "What's wrong?" "Why?" "What should we do about it?" Hidden behind explanatory systems we find variations in communication and language use, different expectations regarding interpersonal interactions and interpersonal responsibilities, as well as different approaches to problem solving. The very complexity of cross-cultural circumstances magnifies the serious problem biomedicine currently has in dealing with nonbiomedical issues.

### The Application of Problem Orientation in Cross-Cultural Care

The problem-oriented method, described by Weed (1969), shifted medicine away from narrow biomedical focus and conclusions. It was his view that:

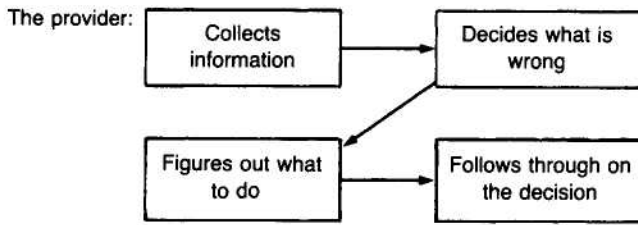
. . . doctors prefer to see only physical problems on a problem list; they're neater. A patient may resent a doctor's suggestion that problems can be blamed on his or her spirit, attitude, mind, home or job; and some doctors don't like patients who want to discuss their spirit, mind, home or job. . . . Most of medicine should be understanding and grappling with interactions between social and mental and physical problems. (Weed, 1978, p 19)

This approach facilitated a methodologic shift. Weed encouraged practitioners to state problems in language that best described the patient's circumstance. This prompted the use of a broader descriptive process. Biomedical and mental health diagnostic endpoints became part of an expanded universe of descriptions of patient's problems.

If the problem-oriented methodology is used appropriately, one has to account for the patient's view and devise a care plan that accounts for the complex interactions between medical, social, psychiatric, and demographic<sup>3</sup> issues. Weed developed a basic description of problem solving around illness episodes (Fig. 229.1). This four-step model can be applied to problem solving in general, and may be used to compare the work of health care providers and healers universally. A formal outline of problem-oriented problem solving is described in Figure 229.2.

We will examine each aspect of medical interactions—data gathering, problem description, plans for care, and followup activities—from the perspective of cross-cultural

3. Statistical methods and demography are examples of recent changes in health care theory and practice. Their evolution and application have helped define a new mode of problem description and planning in health care. Weed's methods allow for the incorporation of "demography" as an illness-wellness issue. He suggested that demographic problems be added to problem lists and added to health maintenance flow sheets and plans. These plans for problem description and health care interventions account for known risk factors based on age, sex, and ethnicity (Weed, 1969).



Weed's generalized description of problem solving was prepared in a book written for patients (Weed, 1978). These four steps can be applied to problem solving in general, and used to compare the work of health care providers and healers universally. There are numerous intracultural and intercultural variables at each step, e.g., the means used to gather diagnostic information varies from culture to culture, system to system. In addition, families and individual patients undertake all or part of similar steps in solving illness problems.

**Figure 229.1.**  
Problem solving around illness episodes.

circumstances. The purpose of this process is (1) to point out the differences in expectations regarding varying modes of health care and "healing"<sup>4</sup> interventions; (2) to suggest steps that allow for and encourage cross-cultural exchange that incorporates and accounts for both the provider's and the patient's view of "what's wrong"; and (3) to describe an adaptation of biomedical methodology that allows for a broader study of illness process from both intracultural and intercultural perspectives.

**Data Gathering**

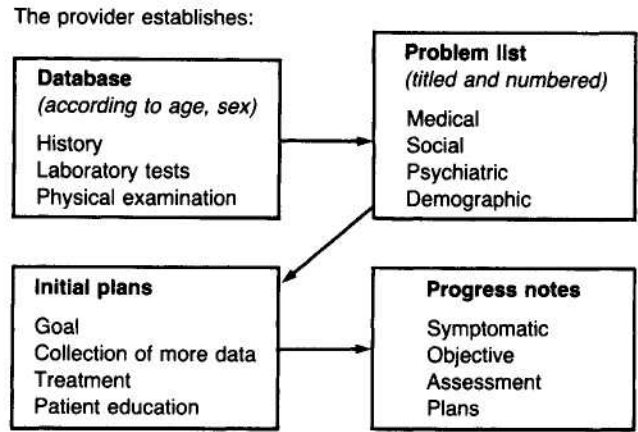
*The patient's sense of what's wrong is based on prior life experience, the course of recent events, and the lessons taught by cultural process. Fears, as well as hopes and expectations, are based on this prior experience.*

There may be a basic disparity in expectations regarding how a problem is uncovered or solved. Consider the dichotomy between biomedical and traditional Native American diagnostic techniques:

Biomedicine	Native American Medicine
<b>Assumes</b>	
People learn things by detailed inquiry and examination.	People learn things by means of prayer, visions, dreams or divination.
<b>Thorough inquiry depends upon</b>	
Extensive or brief questioning, physical or lab examination.	Extensive or brief divination, prayers or supplication, entering into a trance state.

Diagnostic practices worldwide are based on a broad spectrum of folk beliefs and historical traditions, and often on magical or religious practices. Whether the parallel diagnostic technique is pulse reading by a traditional Chinese doctor, the Nooksak *sg<sup>w</sup>ədilūč* instrument, or a Hmong sha-

4. The term *healing* has been used to remind the reader that healing interventions, including biomedical practices, are often dissimilar.



The problem-oriented system (Weed 1969, 1978) integrates "social" definitions of illness into problem statements. In addition, Weed encouraged providers to use terminology that fits the patient's circumstances. This allows description of problems which do not fit strict biomedical or mental health terminology. This interaction of problems, and the insistence that they be dealt with in context with one another, forms a natural basis for integrating discrepant cultural definitions and processes into health care settings. Simultaneously, it provides a framework for delivering and studying health care process across cultures in biomedical settings.

**Figure 229.2.**  
The problem-oriented method in biomedical practice.

man's trance, the message is similar.<sup>5</sup> The expectations generated by these practices may lead to puzzlement with biomedical diagnostic practices and/or the attribution of magical qualities to both diagnostic and therapeutic procedures. Extensive questioning at the onset and during the course of an illness may puzzle those whose culture does not prepare them for biomedical methods of problem solving.

*Uncertainty in Cross-Cultural Inquiry*

Faced with uncertainty about what to expect in diagnostic or therapeutic encounters, the patient may withhold personal views of what's wrong or histories of nonbiomedical diagnostic and therapeutic actions already undertaken. Patients may be reluctant to discuss beliefs, herbal therapies, home remedies and practices, and religious efforts at healing. They often fear the practitioner's disdain for these activities. Information may be withheld or altered to avoid labeling, to cope with anxiety about the illness, and at times to comply with provider's wishes. Although scant systematic evidence regarding patient behaviors in different cross-cultural settings is available, the literature suggests that pa-

5. The traditional diagnostic techniques and tools referenced are all still in use. The Nooksak are a Northwest Coastal tribe. Their language is related to the Salish language group (Coastal and Plateau) which extends around the Puget Sound, north into British Columbia, and as far east as northwest Montana. Patients euphemistically refer to the *sg<sup>w</sup>ədilūč* instrument as the "Nooksak x-ray." It is used to hunt for lost objects, find a dead body, or locate spirits (Amoss, 1978). The Hmong are a hill tribe from Southeast Asia. Refugees following the Vietnam war, they represent a small minority group in southern China, and occupied (at one time) the hills and ridges of northern Laos and Thailand (Lewis, 1984). Historically, neither the Nooksak nor the Hmong had written language, and both have relied extensively on shamanistic practices.

tients will report their illnesses differently depending on the behavior, language skills, ethnic identity, and degree of specialization of the biomedically trained practitioners they encounter.

Biomedical diagnostic technique includes history, physical examination, and laboratory investigation. By contrast, in some diagnostic traditions questioning and touching the patient is not a routine. For example, Navajo crystal gazers use quartz crystals to "see" objects shot into a patient, and in Vietnam:

. . . traditional practitioners of Indochinese medicine were not allowed to touch the body of their female patients, except to take their pulse. A female figurine was provided by the physician, and the wise physician could diagnose physical complaints of female patients based on the patient pointing to the area on the figurine corresponding to her own symptoms. (Hoang and Erickson, 1985)

### Alternative Inquiry Techniques

Since the expectations set by traditions vary, the question arises: how does a non-Western traditional patient react to biomedical diagnostic techniques and settings? As the personal experiences and background of provider and patient are increasingly disparate, each participant has diminished ability to relate to the other's perception of the illness experience. As a result, it is useful for the provider to shift the interview focus as follows.

#### BROADEN INQUIRIES ABOUT THE FAMILY HISTORY

The family history is a traditional part of medical inquiry and is crucial in cross-cultural settings. It is a major source of information and simultaneously allows the provider to show interest and become familiar with a patient's background. An expanded family history often reveals information and concerns that are not offered spontaneously. Many traditional cultures are tied to an extended family process in ways that surprise Westerners. For this reason, the inquiry needs to go beyond the "did anyone ever have . . . ?" stage.

It is useful to discuss the whereabouts and current activities of family members. Look for similar symptoms or illness in the family, and establish the dates and possible causes of these events. For example, in Native American and refugee families it is quite common to discover multiple incidents of loss, injury, and illness. Look for problems and events within family and community that the patient ties to the illness experience. Explore life events, day-to-day activities, and interpersonal relationships. Irrespective of the character and source of the current illness episode, narratives regarding prior life experiences help uncover the focus of patient views and explanations.

#### SEEK ALTERNATIVE EXPLANATIONS FOR THE ILLNESS

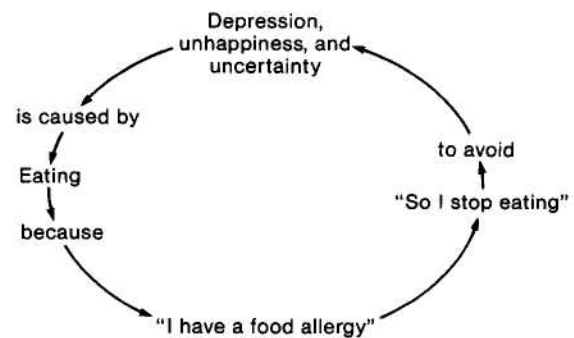
The explanations used by patients are dynamic and change over time. They represent an amalgamation of the patient's life experiences, knowledge, training, and experience with the illness as well as with therapeutic efforts and advice. Some patient explanations and beliefs are based on highly focused cultural constructs of illness. Kleinman et al. (1978) have used direct questioning to elicit these patient "explan-

A 6'2" 25-year-old graduate student presented with complaints of "sluggishness, malfunction, sleepiness, and poor concentrating ability." He had lost weight (165 to 122 lb), and sought care from multiple sources: a family practitioner, a Chinese herbal therapist, a clinical psychologist, and a naturopath who practiced holistic medicine. Unable to resolve his sense of malaise, the patient remained convinced his illness was secondary to "food allergies." Most recently, he had entered a retreat where food allergies were "studied" and treated. Twenty pounds of his weight loss occurred during the program.

His explanations seemed to have evolved from a history of difficult allergies in childhood. He was presented with the following graphic diagram of his own explanation.



He considered the explanation and revised it as follows:



The patient agreed to set his food allergy theory aside. Simultaneously he agreed to eat and look to other issues in his life for a solution. He gained from 124 to 165 lb, secured a new job, and planned for professional licensure and further education. Heretofore, he had treated his life the same way he treated food: uncertainty over what he could and could not do had led to avoidance.

**Figure 229.3.**

A patient's explanatory model for his illness.

atory models."<sup>6</sup> Direct questioning is often revealing and prompts a clear description of how patients view their illnesses. These revelations are often key to problem solving, as illustrated by the case in Figure 229.3.

6. "The wording of questions will vary with characteristics of the patient, the problem, and the setting, but we suggest the following set of questions to elicit the patient explanatory model. Patients often hesitate to disclose their models to doctors. Clinicians need to be persistent in order to show patients that their ideas are of genuine interest and importance for clinical management. (1) What do you think has caused your problem? (2) Why do you think it started when it did? (3) What do you think your sickness does to you? How does it work? (4) How severe is your sickness? Will it have a short or long course? (5) What kind of treatment do you think you should receive? (6) What are the most important results you hope to receive from this treatment? (7) What are the chief problems your sickness has caused for you? (8) What do you fear most about your sickness?" (Kleinman, 1978, p. 256).

At times, however, direct inquiry is unsatisfactory. Many groups and individuals will not discuss personal or ethnocentric views until the interview technique is altered. Furthermore, some individuals feel that the direct questions about what they think has caused their problem are a sign that the provider is uncertain ("If you don't know what's caused my problem, I'm in the wrong place."). This issue was pointed out by Harwood (1981), who noted that some ethnic groups "expect the physician to be the ultimate experts on diagnosis and treatment."

The following techniques help to obtain information in circumstances in which the patient seems reluctant to provide explanations or historical data:

1. Use an indirect approach, externalize questions by referencing problems in others. Traditional patients who are unwilling to answer questions regarding feelings and fears directly often provide illustrations of their own concerns by discussing illness in others.
2. Acknowledge traditional beliefs, and illustrate them. Reference folk terms in conversation, or discuss what others have said in similar circumstances. For example:

Patients who are	}	as ill as you have been
		ill the way you are
tell me	}	they can't sleep
		they have had trouble with dreams
		(or reference an actual dream)
		friends say they were . . .
		(use a relevant folk term, eg, <i>embruhado</i> )

3. Change direct "questions" into narrative statements (as in the examples given in 2). Information exchanged in this fashion gives patients and families a broadened sense of the practitioner's focus, permits discussion of issues often left undisclosed, and avoids direct inquiry.
4. Inquire about special terminology that may apply to the problem ("What is this called in your own language?"). If the patient doesn't know, ask what a grandmother or an elder would say about the difficulty. This indirect approach sidesteps the unwillingness of some traditional patients to discuss their problems openly and directly appeals to family knowledge and beliefs.
5. Inquire about dreams and difficulties with sleep. Discussion of sleep and dreaming patterns often leads to the revelation of key information regarding the illness's impact and the nature of the patient's concerns. Dreams have increased significance in settings where magical-religious beliefs have played a role in healing and problem solving. They are often critical markers in the assessment of mental status.

#### TAKE LANGUAGE AND COMMUNICATION STYLE INTO ACCOUNT

If a patient's personal vocabulary does not include terms like depression, allergy, cholecystitis, or even gallbladder disease, these words should be avoided. Response times in speech patterns vary. Native Americans often report that "Anglos go too fast," and do not take sufficient time in conversation. Some individuals are perplexed by a provid-

er's insistence on reporting certain details while seeming to ignore others (which may be important to the patient).

Building trust is a major issue. Individuals from small groups or rural backgrounds are accustomed to dealing through family and kinship networks. Help is sought through personal contacts and generally comes from individuals known to the family or community. Health care institutions often represent loss of personal choice in the sense that the patient does not "know" the providers, and vice versa. Breaking this barrier is an essential component of provider-patient interactions and often involves breaking the pattern of neutrality, distance, and noninvolvement that physicians are encouraged to use.

#### Summary

The altered interviewing methods presented here are aimed at encouraging the patient to discuss special life events, issues, or beliefs. These modes of inquiry establish familiarity and acceptance on the examiner's part and simultaneously broaden the database via wider-ranging discussion of the views held by the patient. The establishment of rapport with patients extends the purpose of interviews and the health care process. Elevating patient concerns and views to a level of significance and respect is not only important but requires additional time and a certain level of personal commitment.

#### Problem Description

*Descriptions of "what's wrong" are heavily tied to culture. Differing perspectives on problems and causality require reconciliation and accommodation.*

Decisions about "what's wrong" in cross-cultural settings call for a broadening of the scope of possible problem descriptions. The practitioner must reset the goals of problem description from a classic diagnostic and therapeutic end point toward the balanced management of biological and psychosocial issues, including those issues based on non-biomedical traditions. Remember, disparities in communication style and discrepant expectations may be as critical in the care process as establishing a correct diagnosis.

#### Dealing with Parallel Explanations of Illness

Dealing with discrepancies in problem description is a necessity. One can begin by describing problems in parallel with each other. This is illustrated by the case in Figure 229.4 in which two ethnocentric views of "what's wrong" are recognized and accounted for. The case illustrates a situation in which a biomedical disease has a parallel and totally discrepant explanation within an alternative ethnomedical system. Having determined that discrepant views exist in a clinical setting, problems must be dealt with in context with one another. One is faced with a dilemma: In what ways are both descriptions valid? How can a biomedically trained practitioner deal with constructs about illness and disease that fall outside of the realm of biomedical "culture"? A number of points are raised by this example:

1. Although a biomedical problem may have a parallel, discrepant description in a traditional or popular sys-

A 68-year-old Navajo man with longstanding insulin-dependent diabetes mellitus was admitted for severe ulceration and staphylococcal cellulitis of the left foot. He had experienced prior episodes of ketoacidosis and had a severe peripheral neuropathy. His arteriosclerotic peripheral vascular disease led to a below-the-knee amputation of the right lower extremity.

During his hospitalization, reactivation of pulmonary tuberculosis was discovered and a dispute arose over therapy. The physician wanted to start a drug regimen; the patient insisted that he needed to leave the hospital in order to have a Navajo ceremonial performed:

<i>Physician's view</i>		<i>Patient's view</i>
Left upper lobe infiltrate	PROBLEM	An object in the left lung
<i>M. tuberculosis</i> , reactivated	CAUSE	Exposure to human remains
Three antituberculous drugs	THERAPY	Completion of a ceremony

The patient's view was based on a Navajo diagnosis made 20 years before. At that time, a Navajo diagnostician informed him that his illness began when an object was fired into his chest from human bones he had stumbled upon while herding sheep. He had been told that a therapeutic ceremonial was needed, the first of four that would be necessary over his lifetime. At the time of his hospitalization, the ceremonial had been performed three times and the patient expected that a fourth ceremonial would be necessary at some point. In this instance, biomedical findings served to reinforce a traditional view.

#### Figure 229.4.

Discrepant explanations by patient and physician of a patient's problem, its cause, and appropriate therapy.

tem, traditional diagnoses and therapies often do not match biomedical diagnoses on a one-to-one basis. The tendency of biomedically trained practitioners to look for biologic equivalents in folk theories is confounded by the fact that folk definitions do not match biologic definitions.

2. Popular systems may describe problems that are culture specific. Remember, biomedical problems are not only culture specific when viewed from an outsider's perspective, but biomedical practice itself is culture specific and loaded with the values of Western society.
3. Many traditional systems do not separate religion and healing. This results in etiologic conclusions that have interpersonal, spiritual, and moral overtones and lack the relatively amoral quality of biologic etiologies. An example exists in Asian systems where religion and healing are based on ancestral process. In ancestral systems, illness, causation, and family members (living and dead) are intricately interwoven.
4. Family problems, dreams, and specific events may be viewed as etiologic.
5. Some constructs patients present about illness are descriptive and combine a variety of actions and social relationships with feelings and symptoms. These constructs are often viewed as significant by patients, but may be relatively acausal from a biologic perspective. In addition, they are often difficult to integrate as coherent explanations of "what's wrong," and should be dealt with as valid individual experience and concerns attached to illness and disease.

Many feel that acknowledgment of a nonbiomedical traditional view perpetuates the notions supporting "folk traditions." In the experience of the authors, alternative views are a clinical reality and may be acted upon concurrently irrespective of whether the practitioner recognizes, acknowledges, supports, or denounces them. In situations where practitioners deal with patients who hold traditional, nonbiomedical beliefs, it is necessary to evaluate the impact

of these beliefs on the problem-solving process and, when appropriate, to encourage the concurrent use of these non-biomedical traditions.

#### *Parallel Explanations in Public Health*

Disparate problem description plays a role in public health as well as individual health care process throughout the world. Zola addressed this problem in public health when he pointed out that:

. . . many public health programs flounder when transported *in toto* into a foreign culture. In such a situation, when an outside authority comes in and labels a particularly prevalent condition a disease, and, as such, both abnormal and preventable, he is postulating an external standard of evaluation which, for the most part, is incomprehensible to the receiving culture. To them it simply has no cognitive reality. (Zola, 1966, p 618)

For example, Chinese mothers in Hong Kong have refused to accept measles vaccination because the measles rash was felt to be essential in the life process, representing "the release of a hot maternal poison" during childhood or adolescence (Topley, 1976).

Similarly, in spite of multiple public health campaigns and efforts at education, one of the authors (MJ) had great difficulty getting rural fishing villagers in India to accept the smallpox vaccination. Lack of acceptance of the vaccination program was based on a widespread belief that smallpox was caused by the Goddess Kali and not by a virus. Out of desperation, the author promoted the vaccination in a different light: "This vaccination can be considered a mark of respect to the Goddess Kali. You will notice that those who have this mark do not need to be taken by the Goddess as a sacrifice." Within weeks, villagers attended clinic to acquire "marks of the Goddess" and village acceptance of immunization was no longer a problem. This accommodation allowed villagers to see things in a cultural context and allowed biomedical intervention in a culturally acceptable mode. It was a pragmatic approach, and did not deal with the longer-term issues of religious beliefs and their relationship to education, science, and societal structure.

In the United States, major groups of "true believers" describe problems in the context of fundamentalist religious beliefs that may restrict certain biomedical interventions. "Thou shall not heal by the arm of the flesh" is a phrase used by a fundamentalist group in southwestern Colorado to explain its rationale for disallowing immunization. Deaths from diphtheria in nonimmunized children in these communities were perceived as "acts of God" (Clausen, 1977). The state's ability to cope with these deaths and with the nonimmunized schoolchildren was limited to screening, quarantine, and antibiotics for carriers. "These events have led to much soul searching . . . throughout the state. Issues of the inviolability of religious belief are in conflict with beliefs in preventive health care for children. We cannot but expect other tragedies to occur; if not diphtheria, then tetanus, polio or measles deaths" (Colorado, 1976). Examples of similar problems in Western peoples arise in the care of Jehovah's Witnesses and Christian Scientists. The latter groups use religious traditions to explain and focus their views regarding acceptable health care interventions around illness and "healing."

### Summary

A number of observations are useful here. First, cross-cultural negotiation is not always successful. Either the patient or the provider has failed to communicate or has taken a "true believer" role, and has refused to accommodate to an alternative view. Second, when accommodation is reached, either or both sides may have to bend important "givens" and "truths" about what is right in order to cope with "what's wrong." Third, there are times when alternative therapies and theories seem dangerous, and in these circumstances, the provider's skill at education, negotiation, and manipulation across cultural boundaries is tested. Fourth, acknowledging the use of coexisting explanations and therapies for an illness is necessary to establish a basis for cross-cultural understanding and negotiation.

### Plans for Care

*In planning for care in cross-cultural settings, disparate views of risk and the perceived responsibilities of the individuals surrounding an ill friend or family member must be taken into account. Individuals surrounding an ill patient are all potential survivors of the illness and traditional, nonbiomedical systems often seem to meet essential needs of this group.*

The problem-oriented method describes nine separate steps for establishing and carrying out patient care plans. These begin with goals, or "aims" for problem management.<sup>7</sup> Special attention should be focused on setting goals for therapy, how a problem contributes to the patient's "sickness,"<sup>11</sup> the effects/disabilities produced by a given problem, and the use of education in the therapeutic process. All of these issues relate to the process of negotiation and accommodation that is necessary in cross-cultural care.

The basic goals and implications of therapy may be widely divergent. Consider the following dichotomy:

Therapy affects the group ↔ Therapy affects the individual

Biomedicine assumes that most disease is an individual issue. What's wrong, from a biomedical perspective, invokes a therapeutic response aimed at the individual. Only in circumstances that involve genetic or infectious disease, environmental problems, or threatening mental health behavior will biomedicine intervene on behalf of the group. This is an extraordinarily different perspective from that seen in traditional therapies, which are often aimed at the group as well as the individual. By involving multiple individuals in the therapeutic process, traditional therapies

7. Weed's description of the planning process is paraphrased below. Each step in planning includes a subset detailing its implications for planning and care.

1. State aims (goals) for problem management.
2. Check how the problem may be related to the patient's "sickness."
3. Check for effects/disabilities produced by the problem.
4. Check for function/status of systems involved with the problem.
5. Assess and follow course.
6. Investigate the problem and its etiology.
7. Watch for/prevent complications of the problem.
8. If indicated, institute and monitor treatment.
9. Use patient education wherever appropriate. (Weed, 1978, pp. 5, 202)

often neutralize perceived threats to the group posed by an individual's illness.

For example, in Thai treatment of soul loss, community and family actively participate in therapy by praying for restitution of the patient. Strings representing the lost soul are attached to the patient's arm, symbolically attaching a blessing and reattaching the soul. Similarly, Nooksak spirit dancers may burn gifts for ancestors either to ward off trouble or to treat an illness in a family or community member. "Burning" is carried out in a group setting in which dancers and members of the family and community participate. There is a common Nooksak perception that the group as well as the individual are treated, cleansed, and protected by this process. There is a remarkable parallel between the Nooksak system and similar attempts to placate the dead via ancestral meals and gifts in Asia. When healing is tied to an ancestral religious process, an individual's illness (or disease) is woven into the family fabric in ways that make the Western focus on the individual extraordinarily difficult for some patients and families to understand.

### Negotiation over Illness and Disease

It is important to negotiate a balance between the management of biomedical problems and traditional illnesses. Margolin (1975) presented a 58-year-old Spanish American man whose complaints of nocturnal episodes of nausea, vomiting, abdominal pain, and inability to sleep led to extended emergency room and clinic visits. He had a remarkably complicated health history (Figure 229.5). The patient believed that his illness was the result of being *embruhado* ('bewitched'), and his explanation was based on folk beliefs that date to the fifteenth century and the system of *curanderismo*. His illness had begun after a dispute with an older neighbor, a woman felt to be a *bruha* ('witch'). Some members of his family concurred with his beliefs.

The negotiation regarding therapy involved a number of issues. First, the patient was offered a referral to a *curandero* ('folk healer'). He declined, acting on the advice of family members and being aware that Margolin had successfully treated one of his relatives for a similar illness.

Date	Problem	Inactive/Resolved Problems
1970	Coronary artery disease Inferior wall myocardial infarct	
1960s	Angina pectoris, chronic	
1/73	Crescendo angina	Resolved, no infarct
Years	Insulin-dependent diabetes mellitus	
	Positive tuberculin skin test	Isoniazid for one year, 1970-71
5/72	Diverticular abscess	Three-stage sigmoidectomy May-August 1972
7/72	Cholelithiasis Choledochocutaneous fistula	Cholecystectomy 7/72 Fistulectomy 8/72
11/74	Nausea, vomiting, abdominal pain Excessive Excedrin use	
11/74	Inability to sleep	

**Figure 229.5.**

Medical history of a patient seeking repeated treatment. The patient was a 58-year-old Spanish-American man who made numerous visits to the emergency room during the fall of 1974.

Second, it was essential to separate his active biomedical problems (diabetes and coronary disease) and his culture-bound explanation of his problems with sleep, pain, nausea, and vomiting. It was agreed that the therapy was aimed solely at the *brujeria* ("witchcraft") problem and that he would continue to use his insulin and cardiac medications on a regular basis. The patient was treated with a combination of hypnosis and suggestion, and was instructed in the use of a prayer directed to St. Cipriano (a saint occasionally used by folk healers). He responded immediately. Over a 4-year follow-up period he continued to use his prayer and had not had a recurrence. It was felt likely that he would use the same system to explain serious disruptions in his life or health in the future.

The goals for management in this case involved careful attention to the patient's medical problems and incorporation of his beliefs into a therapeutic plan. A number of issues are raised by this case.

1. Patients with complex medical problems may use traditional explanations to deal with them.
2. Traditional explanations of illness may remain hidden from the view of practitioners, even after extensive evaluations of illness episodes.
3. The inability of biomedically trained practitioners to resolve an illness may support the family's belief that the patient is "sick in some other way." In this way, biomedicine is often used as a testing ground for folk diagnoses.
4. There is often an option to treat the patient in either or both systems, and judgments must be made about needs. (Margolin's patient was using excessive Excedrin to cope with his nocturnal symptoms. The Excedrin may have contributed to his nausea, vomiting, and abdominal pain. The physicians involved in the therapeutic decisions thought that stopping the drug might help resolve his gastrointestinal symptoms, but would not deal with the considerable fear and anxiety provoked by his beliefs.)
5. Explanation and negotiation between systems is essential. In this instance, the fundamentalist view of "healing" after treatment, which included the use of a prayer, might have led the patient to discontinue essential medications on a trial basis.
6. Referrals for issues related to traditional beliefs are often made through an extended family network.
7. At times, therapy for culture-bound syndromes can be provided on a cross-cultural basis.

### Summary and Guidelines

There is no simple formula for establishing plans in cross-cultural health care settings. However, assuming that the data collection methods and problem description have allowed for the recognition of psychosocial problems, the following general guidelines for the planning process should allow the provider to deal with the complexities of cross-cultural care settings:

1. Planning involves negotiation with the patient and family over issues related to both the biomedical disease processes and the patient's views and experience of illness.
2. Family involvement in therapy should be encouraged at all levels of care, both popular and biomedical—

technical. In the latter instance, health care providers can support and empower families and patients in the care process. This can be accomplished by means ranging from simple instruction to monitor and adjust therapy for hypertension or diabetes at home, to keeping records of weights, dietary intake medications, and playing therapeutic roles in complexly ill patients.

3. Illness creates the risk of loss, and providers must take the needs of potential survivorship (following another's death or disability) into account. Encourage family actions that will meet people's need to participate, to help, and to neutralize fears related to traditional beliefs as well as to biomedical diagnoses. The survivors need to know that they have "done what they can." Having biomedically trained personnel shoulder this burden (as is often the case in ICU care) is an error and may deny family members a sense of participation. It also places practitioners at risk of becoming targets of anger in the face of loss.
4. Compare explanations of illness with the patient. Mold your therapeutic plans to accommodate special beliefs and perceptions held by the family. When alternative therapies seem clearly to put the patient at risk, use education and justification of biomedical process as a counter.
5. Look for unusual perceptions of "what's wrong," discrepancies between biomedical goals and patient-family goals, and difficulties that relate directly to communication style or to miscommunication across cultural boundaries.

### Follow-up

*Assessments of process and measurements of outcome vary across cultures. What is deemed a cure in one system may be viewed as a failure by another. The means of assessing success or failure may seem mutually exotic or bizarre.*

Viewed from a biomedical perspective, traditional systems often seem to lack models for chronic disorders. A Sioux medicine man commented that his therapy works because none of his patients had to come back. A physician commented that his therapy works because his patients always come back. What's going on here? These boasts of therapeutic efficacy reflect disparate expectations about illness and therapy. The physician sees the patient's return as evidence of success in the face of ongoing process. The medicine man's cure often appears to leave no need for further therapy. It should be clear that their methods are entirely discrepant, and are based on different expectations. The circumstance is further complicated by patient wishes and expectations that therapy will provide a permanent relief or cure. Patients often reject and struggle with chronic illness and do so in a manner that challenges healers in any tradition.

### Discrepant Models for Chronic Disease and Illness

People with diseases such as diabetes mellitus, cardiac or renal failure, severe hypertension, or myxedema had little chance of survival under prebiomedical conditions. However, nonlethal, chronically bothersome, and disabling dis-



eases have posed a major problem for both biomedicine and traditional healing systems. The traditional therapies aimed at chronic diseases are frequently useful in that they provide recognition of the illness and a social context for care, hope, and ongoing support. In addition, there is evidence that when these illnesses are primarily self-limiting or represent mild psychosocial disruptions, traditional therapies are often successful. On the other hand, it is difficult to demonstrate curative success when traditional therapy is used for disruptions that are biologically based. The models that do exist for long-term "maintenance" in traditional systems are generally social, herbal, physiologic, and magical or religious orientations.

Traditional systems may insist that treatments be undertaken over prolonged periods of time. It is said that failure to do so may cause new trouble, a recurrence of the illness, or have serious implications for the family. For example, in the Hmong system, soul loss is an etiologic explanation for a variety of illness problems. Recurrent soul loss is prevented by a *Keeglaw* ceremony:

The souls of some people do not like to stay with them, but want to go out from their bodies all the time. If this happens the owner of the souls will be in continuous ill health and a shaman may advise the holding of a healing *Keeglaw* ceremony for him. If the ceremony is successful, the shaman will recommend him to hold the *Keeglaw* ceremony each year for the rest of his life, otherwise his souls will keep going out from his body and then he will be sick and may even die. (Chindarsi, 1978, p 104)

The Hmong concepts parallel a widespread belief system tied to Buddhism and spirit cults in Southeast Asia. In Thailand, for instance, "the *Khawn* ['one of the body's souls'] . . . takes fright and leaves its owner's body when he is frightened, sick or in trouble, or *caj bau dee* ['mind not good']. The very act of its fleeing exposes the owner to suffering illness and misfortune" (Tambiah, 1970, p. 58). The notion that chronicity is associated with recurrent soul loss provides an explanation of a chronic illness state. Therapy in this circumstance is aimed "not so much to cure the patient as to reconstitute the morale of a very sick person. . . . When the elders call the *Khwan* and restore it to the body, it is they who are charging the patient with the vital social force of morale" (Tambiah, 1970, pp 227, 243). The portions of the Hmong and Thai traditional care systems we have referenced react to ongoing dysfunction by therapies based on sacred traditions. These approaches have a socializing effect and incorporate the family in treatment activity.

Patients are often pragmatic and will seek help from multiple sources when confronted with ongoing illness or failure to recover satisfactorily. This is illustrated by the patients in Figures 229.3 and 229.4. The Navajo grandfather (Figure 229A.4) left the hospital against medical advice in order to complete a ceremonial. He later surprised his physician by returning after the ceremonial, completing his antistaphylococcal therapy, and continuing his antituberculous medication. At the same time, he used daily herbal therapy prescribed by a Navajo medicine man.

Traditional therapy may consist of advice, prayer, herbal therapy, or even physiologic treatments (such as sweats or a massage therapy). Even herbal therapies deal with the notion of chronicity. "Chinese medicine is reputed to act slowly. Because it is believed to treat the 'underlying cause' rather than symptoms, patients usually are willing to wait for considerable periods, even in the face of persistent

symptoms, before deciding that a Chinese medicine has failed to work" (Kleinman, 1980, p. 194). Therapy that has either religious or social/moralistic overtones is often aimed at what one must do to improve, or to remain safe over time. Once the advice is given or correct procedure is followed in treatment, patients are often left to their own devices.

Measures of outcome vary. For example, the Navajo occasionally use a Shock rite to determine patient response to therapy. Its use is based on mythologic teachings, and involves placing the patient (toward the end of a 5- to 9-day ceremonial) in a structure that represents the Home of Snake. The test is carried out by two men dressed as Bear and Holy Boy. If the patient fails to respond properly (by fright), the medicine man may decide to stop and establish another diagnosis, and/or seek a different, correct ceremonial therapy. Explanations based on religious dogma often make judgments regarding outcome that are heavily dependent on magical-religious premises and process.

### *Therapeutic Failures and Death*

The question remains with chronic or recurring conditions and failure to respond: What shall we do? Biomedically trained practitioners should be prepared for disparate views within the family about what to do. Families exposed to multiple healing traditions, or to the variety of choices within one system, may disagree among themselves. For example, the grandson of an Arapaho medicine man was torn between advice to use the Native American Church, or a Protestant church, or the grandfather's traditions in dealing with a chronic medical problem. Other family members thought the solution lay with biomedically trained physicians and that the traditional solutions were unwarranted. *Family disputes over an illness often reflect preexisting or current family dynamics and struggles. When they come to the attention of health care providers, they are often garbed in the cloak of culture.* It is often useful to sort these issues out, as they may be key to negotiating a solution.

Death, loss, dysfunction, and disability often bring blame and guilt into the illness picture. Many systems do not accept natural death as defined by biomedical process. Individuals and families will seek a cause within their own social fabric and belief structure. Individuals and/or events may be blamed. Practitioners need to take these issues into account in dealing with the potential survivors. People need to be reassured that they have "done what they can."

Therapists can neutralize blame by discussing cause of death or disability with the family together so that everyone receives the same messages, including messages that defuse blame. This is especially important in settings where a monolingual family is using one of the family members to interpret. In these instances it is critical to deal with care issues through a trained interpreter who is not a family member. Failure to do this will result in a skewing of the information exchanged and places an extraordinary burden on the family member who has acted as interpreter.

### *Summary*

The influence of the family on the decision-making process should not be underestimated. Illness is experienced and acted upon by those around the sick individual in a fashion that can alter the course of evaluation and therapy. Faced

with a poor response to biomedical inquiry and therapy, it is useful to reexplore patient and family perceptions. Search for undisclosed or unresolved issues relating to "what's wrong." Misconceptions about symptoms and about what is likely to happen can lead to serious disruptions of the care process. These issues are generally related to the illness experience and are often key to problem resolution. When patients and families ascribe therapeutic success or improvement to nonbiomedical therapies, it is useful to listen nonjudgmentally. The message may reflect a variety of views, for example, mistrust of biomedicine, rejection or fear of a diagnosis, the existence of parallel explanations, a fundamentalist religious stance, or a focus on a broader scope of illness-related issues.

It is important to take the lack of a model for chronic disease into account in cross-cultural therapy. Patients often hope for a quick response to Western therapy and may be unaware of the implications of chronic disease management. Explanation is essential in these instances. Failure to set expectations of therapeutic outcome may lead to a patient conclusion that the treatment did not work. Death and dysfunction call mechanisms of blame and guilt into play. Both biomedical explanations and traditional means should be used to help those around a sick patient to neutralize these issues.

## Conclusion

Problem orientation offers a means of adapting clinical methods in biomedical practice to cross-cultural care and study. Each step of the problem-solving process has parallel activities in traditional and family systems of care. At each step, discrepant expectations, practices, family function, and communication style highlight areas of potential concern in clinical problem-solving. Problem-solving across cultural boundaries often involves seeking help from members of the community, from the sociologic, anthropologic, and ethnographic literature, and from anthropologists. In addition, patients become an invaluable source of information and, when sick, often reveal issues that might otherwise never be disclosed.

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## Language in Cross-Cultural Care

*The physician speaks a strange and often unintelligible dialect [which] creates a communication gap between physician and patient that is acknowledged by neither.* (Kimball, 1971, pp. 137–8)

Patients and providers often speak different languages, even when both are using a common tongue. Both meaning and intent are problematic. Each message or complaint may stand for a spectrum of unspoken issues. The issues patients attach to illness episodes are far more diffuse than the confines of biologic dictates. These issues are experiential, arising from life process, family events, and circumstances as well as special perceptions of what causes illness. These attachments to illness episodes may go unrecognized or remain as the unspoken focus in verbal exchanges regarding illness.

The health care provider's views are complicated by the use of special language and a focused methodology. Patient complaints are interpreted to match recognizable biomedical patterns and disease processes. Unfortunately, biomedical focus is such that it operates to exclude consideration of diverse interpersonal, psychologic, and social components that patients attach to illness.

### Personal Vocabularies and Special Terminology

*Biomedical training develops special knowledge about methodology and meaning. At the same time, it alters and narrows focus. Even when the same language is being used, special terms often require explanation.*

Individuals often have personal vocabularies that do not include the terminology used by health care providers. Personal vocabularies can vary based on language skills, ethnicity, intelligence, education, and socialization. Prior life experience may lead an individual to attach special meanings to a specific term or circumstance. "Terms such as 'diabetes,' 'rheumatoid arthritis,' or 'multiple sclerosis' may seem deceptively simple. Careful analysis will disclose that they represent a complex set of physiologic, chemical and structural facts" (Fabrega, 1975). Terms that seem common to providers are often perceived and understood in a fashion that does not match the originally intended meaning.

Each biomedical term has a complex meaning, a meaning that continues to evolve from its historic origins or that may be replaced as biomedical research refines our perception and understanding. When health care personnel discuss illness with patients, they use biomedical terms. At the same time, they often fail to use explanation and justification as part of their therapeutic armamentarium. As a result, patients often remain uninformed about the meaning (either the biomedical view or the practitioner's) of what is wrong.

Medicine, like any other subculture, not only has a complex lexicon, but also has its own jargon and folk speech. Institutional processes and places are often reduced to initials—ER, ADL's, ASAP, PRN—or brief terms such as *chemotherapy* or *work-up*. Some terminology deals with the stresses of health care settings. Dying patients are said to be going *down the tubes*, and irritating patients may be described as

*umps, gomers, or crocks.* These latter descriptions of patients by health care personnel represent a "rich albeit esoteric folklore" that "flourishes providing a much needed outlet for doctors and nurses who are under almost continual round-the-clock pressure" (George and Dundes, 1978). It should be noted that the folklore and its attendant language is no less esoteric than the language of biomedicine itself.

### Folk Terminology

*People's health beliefs and activities interact with secular or sacred healing traditions to produce a rich terminology about human disruptions.*

Communication problems in medicine are a two-way street. For example, a Chinese American patient referring to *cold* or *hot* features of an illness may have special notions about the meaning of the message. Alternatively, the message of hot or cold may be hidden in a comment or question about a food that is thought to play a role in illness. Hot and cold theories about illness are widespread, vary from group to group, and may change with time and across geographic boundaries.

The interaction between folk notions and biomedicine is demonstrated by the term *hypertension*. Hypertensive patients may view their illness as related to being *hyper* and/or *tense*, and to *stress*. All three terms are related in American idiom. The juxtaposition of common idioms and a common diagnostic term have thus provided a folk definition of etiology. Another term for hypertension, *high blood pressure*, often leads to concerns over life's pressures and their relationship to the diagnosis. "High blood pressure" becomes, "I'm under too much pressure."

At first glance, *high blood pressure* appears to have been foreshortened by both urban and rural blacks to the term *high blood*. The term actually reflects a notion that certain foods can cause the blood to rise up in the body, or cause the blood volume to "go up." The close parallel between the biomedical term and the folk term results in an interesting interaction between biomedicine and a subculture. When patients use the term, they may be referencing either notion—that they have "too much blood" or that they have high blood pressure. However, they may simultaneously reference a special idea about etiology and treatment, for example, that certain foods such as "lemon juice, vinegar, pickles, olives cut the blood and bring it down" (Snow, 1976). The terminology can cause confusion. For example, problems may arise:

. . . when the individual is advised that his or her blood count is low and the blood pressure is high: since in folk nosology, high blood and low blood are obviously mutually exclusive the physician making this diagnosis will be thought a fool and the patient may not return for treatment. (Snow, 1976).

The rich and special terminology used within the black community offers an interesting example of folk terminology in a subculture (Table 229.1).

**Table 229.1**  
Influence of Traditional or Folk Terminology and Beliefs on the Understanding of Physical Problems: American Black Terms for Some Medical Conditions

Folk term	May describe	Folk view
Low blood	Anemia Low blood pressure Lack of energy	Not enough blood to allow the body to function; lack of iron/nourishment causing improper bodily function
Bad blood	Prior hematogenous infection Prior diagnosis of syphilis A prior blood test abnormality	A diseased condition of the blood from various types of contamination. Too many sexual partners
Falling out	Seizures, faints, passing out Religious spells, or faints	A sudden collapse, eyes open but not seeing and with intact hearing. Antecedent weakness, or "swinging," or "swimming in the head." May be caused by <i>high blood</i>

Source: Snow (1974, 1976); Weidman (1979).

Providers who are familiar with folk terminology may inappropriately assume that they are attaching the meanings that patients intend. Thus a patient's statement that "I fell out," like the statement "I've taken cold," has a meaning that requires exploration. To *take cold* alludes to a commonly held belief that *cold* is causative of health problems. It references a widespread etiologic notion that may be used to explain any number of illnesses. Like the report of a prior episode of "double pneumonia" or prior "nervous breakdown," these terms may stand for a variety of human experiences.

Beware! Patients and practitioners alike attach special

meanings to their language, meanings that are often unspoken. To attach simple or brief translations to these terms is only a start. Full elucidation of meaning often requires a broad-based explanation of the patient's intent, beliefs, or circumstance. Folk terminology is special in regard to both origin and usage. Usage varies with the circumstance, and some usage is idiosyncratic. Elucidation allows the practitioner to understand an "individual in his own idiom before attempting to treat his complaints" (Kimball, 1971).

### Complex Terms and Special Usage

*Specialization fosters a complex lexicon. Biomedicine and traditional health systems are specialized, each in its own right.*

Terminology and purposes may seem hard to understand across cultural barriers. As the gulf across cultures increases, terms may appear more exotic. In part, this is an artifact created by lack of familiarity. New terms in one's own language generally appear in a context of readily available associations, whereas first exposure to a term in another language lacks the easy attachments of familiar language. Terms are always somewhat out of context across language barriers.

In addition, cultural theories regarding illness produce a complex set of behaviors and an entire supporting lexicon. These constructs about illness produce special terms and meanings that are often hard to understand without a broad defining process. For example, the Hmong, a refugee hill tribe from Southeast Asia, have a rich terminology that appears to tie the "liver" to psychosocial disruptions (Table 229.2).

These Hmong terms imply a special set of definitions for human disruptions. Like folk terms in any language (e.g., *susto* or *embruhado* for Mexican-Americans), they reflect a portion of an entire historic tradition. Hmong ter-

**Table 229.2**  
Illustration of Cultural Differences in the Understanding of Physical Problems: Hmong Terminology for Liver Problems and What They Signify\*

Hmong term	Translation	Causes	Symptoms
<i>siab phem</i>	'ugly liver'	Congenital, early learning, spiritual causes, natural disaster (e.g., lightning), injury, great personal loss	Destructive behavior, verbal abuse or inability to verbalize, disorientation
<i>nyuab siab</i>	'difficult liver'	Loss of family, status, home, country, or any important item	Excessive worry, crying, confusion, disorganized speech, loss of sleep, poor appetite, delusions
<i>tu siab</i>	'broken liver'	Loss of or quarrel with spouse, sweetheart, family member, or friend	Grief, worry, loneliness, guilt, insecurity
<i>siab luv</i>	'short liver'	Congenital, hereditary, early experience, trauma, severe illness	Extreme temper, violent behavior, restlessness, sweating, flushed appearance
<i>kho siab</i>	'murmuring liver'	Separation, loss of loved one, guilt	Nervous habits (e.g., whistling, pacing, humming, eccentric or deviant actions)
<i>luj siab</i> *	'rotten liver'	Stressful family relations, unfulfilled goals	Memory loss, short temper, delusions

\*Hmong is an unwritten language. The Hmong terms are written in arabic characters using a missionary-developed system but are not strictly phonetic (the last consonant is silent and indicates the tone in which the word is to be spoken).

Source: Modified from Bliatout (1982).

minology richly illustrates the problem for patients and providers in cross-cultural medicine. How does someone from a Hmong background relate to a Western health care provider's reference to liver trouble of any sort? How does a Westerner deal with Hmong views of psychosocial disruptions? What special meanings do the terms imply? How does an interpreter handle the situation? This circumstance is illustrated by a parallel problem in Vietnamese, where the word *hepatitis*:

. . . is very often loosely translated into "liver disease." There is a widely accepted notion that "liver disease causes itching." A reported history of hepatitis may mean that the patient has had a symptom of "itching" which may, in fact, be secondary to a superficial dermatitis. (Hoang and Erickson, 1985)

Western-trained providers need to be made aware of these differences in language and explanatory systems and must learn to deal with the difficulties they present.

Complexity of meaning varies with usage. For example, the Lakota (a Sioux dialect) term *i'yuhimiq*, which translates 'distorted/twisted face,' appears on the surface to describe individuals with a stroke or Bell's palsy. Its use as a phrase of warning in Lakota idiom broadens its meaning: "Don't do that, you'll get *i'yuhimiq*." However, its use in special situations like death and dying has more complex implications.

An 18-year-old Sioux woman was confronted with the impending death of her 34-year-old step-mother, L. For months prior to her death, L. had been angry and difficult. The daughter approached her father about her concern: "What will happen when L. dies? I wonder if she'll *i'yuhimiq* us." Her father brought this comment to the attention of the physician and nurse caring for his wife. When asked what it meant, he indicated that the twisted face was caused by a ghost, or "spirit of the dead," and that some ghosts were known to be dangerous. He stated that L. intended to "watch over me" after her death. L.'s comment and his daughter's observation had caused deep concern on his part.

The Lakota term, explained in this context, provided insight into special meanings L.'s eventual death might have for the survivors. Her ongoing care and eventual death had to be discussed in terms that took into account difficult interpersonal relationships and Sioux beliefs. It was necessary to defuse the sense of blame and guilt felt by family members who, while providing L.'s day-to-day care, had been the target of her anger. A direct discussion of Sioux beliefs regarding interactions with the dead was undertaken.

To interpret *i'yuhimiq* as an abstraction for impending loss, stress, grief, frustration, and anger misses the concrete Sioux concern about interference from the dead and the Sioux experience with ghosts or spirits. There was clear evidence that the family's views were not idiosyncratic. According to Buechel (1970), *i'yuhimiq* is also used in the longer phrase *wana'gi i'yuhimiq*, which literally translates 'ghost distorted/twisted face.' L.'s husband had also referenced this term, further clarifying the nature of his concern. For these reasons, the discussions held with the father included reference to the prayers and practices differing Plains Indian

peoples have used to protect the living from the potentially malevolent influence of the dead.<sup>1</sup>

### Lack of Linguistic Equivalency

*Many concepts about "what's wrong" are sufficiently ethnocentric that they lack equivalents in other languages.*

Cross-cultural care is replete with terms and ideas that may seem close in that they describe a similar behavior or physiologic state, but they are often different by definition or common usage. For example, the Navajo term *ich'aa* (moth sickness) describes a form of mental illness. It is seldom referenced by interpreters, however, because it implies an etiology that relates to incest. It is not a generic term for mental illness, and in common Navajo usage it may relate to epilepsy or epileptiform attacks. It is an example of the difficulty going from a common English term to its parallel in a language that lacks a clear equivalent.

Lack of linguistic equivalency is complicated by the fact that biomedicine has not been a model in many societies, and the major segments of biomedical lexicon may be missing from the language or target populations. This problem is illustrated by an attempt to produce a term for *allergy* in a Vietnamese-English medical guide. There is no equivalent term in Vietnamese. In the 1980 Vietnamese edition of Wagner's *Medical Guide and Glossary*, we find "*allergy—di u'ng*." Back-translation of the Vietnamese phrase reads 'unusual reaction.' *Di u'ng* replaced a phrase from an earlier edition that back-translated to mean 'a kind of symptom that is easy to get.' The translators were clearly having difficulty creating a Vietnamese equivalent to a biomedical term. Attempting to coin a new Vietnamese term is not a solution; the phrases developed as Vietnamese "equivalents" clearly miss the special meaning and intent of the term *allergy*. Clinically, *di u'ng* is useful only in the context of a broader, more descriptive defining process.

Health care providers often cope with language issues by the use of written instructions, questionnaires, and educational materials. This became a major effort in clinics and health care systems that had to deal with the influx of refugees from Southeast Asia in the 1970s. A number of issues are operative here. First, a significant subset of the group (e.g., the Hmong and Mien hill tribes) came from nonwritten language backgrounds. Second, a subset of those from rural backgrounds may have used languages that are written (e.g., Lao or Khmer) but are themselves functionally illiterate. Third, references to special terminology, terms such as *anxiety*, *allergy*, *contagious*, and *pap test*, involved a complicated process of translating these ethnocentric concepts into languages that have no conceptual models for comparison.

1. A Cree prayer illustrates some of the historical tradition associated with rites at the time of death in Plains and Woodland Indians (Dusenberry, 1962):

*Go. Go straight ahead.  
Do not take anyone with you.  
Do not look back.  
When you reach your destination, talk for us.  
Tell them not to trouble us.  
Or not to come here and take anyone else away.*

In an interesting and informative example, Werner and Campbell (1973) describe preparation of an interview schedule to be used as a guide to assist bilingual interpreters in performing a Navajo health survey. The survey included the question: "Did you ever have measles?" The nearest literal translation into Navajo follows:

		<b>Navajo</b>		
<i>lichíí'</i>	<i>'qah</i>	<i>ha'ajeeshish</i>	<i>lah</i>	<i>nudooná?</i>
		<b>English</b>		
'red'	'on something unspecified'	'comes up and out in plural form'	'at one time'	'it caught you?'

Werner points out that the three terms *lichíí'*, *'qah*, and *ha'ajeeshish* are translated together as measles in most Navajo dictionaries. In common use, however, they indicate any kind of rash!

### Special Use of Language, Dreams, and Hallucinations

*Lack of familiarity with communication style robs communicants of the ability to interpret meaning and to be predictive about what someone will say or do.*

Nonliterate societies use language in ways that surprise outsiders. Verbal interchanges become the basis for agreements. People who use written languages, in contrast, frequently view verbal exchanges as casual and often will not commit to or believe something until they "see it in writing," since religious and healing practices are based on oral traditions in nonliterate societies, the spoken word is often imbued with power. A Cree couple explained that words have power:

It's not just words. It is meaning. For example, a person wants to get a job. He goes out and looks for work. Someone else is saying he won't get it. That is witch talk, for then he won't. There is no special language a person uses. It can be done regardless of race, creed or color. That is why one must be careful what he says. (Dusenberry, 1962)

Thoughts, intuition, dreams, and hallucinations are also regarded in a different light. Dreams may be predictive, hallucinations the source of great interest, and intuition may be attributed to an external source.

This use of language leads to a certain level of caution in inquiry, agreements, and interpersonal interactions. Many traditional patients are uncertain about the intense interest shown by practitioners. Positive interest may be mistaken for the willingness or ability to do or to act on something. For example, the comment "We might do something about that" means "we might, . . . if" to the practitioner. It is often misinterpreted by traditionalists to mean that "they said they were going to do something about it, they'll take care of it." This miscommunication of intent is common enough between English speakers. It is magnified in cross-cultural settings and in any circumstances that are unfamiliar.

Assessment of mental status becomes difficult. For example, in "some non-literate societies there is anxiety-free acceptance of and willingness to describe hallucinatory ex-

periences . . . hallucination *per se* is seldom disturbing; its content is the focus of interest" (Zola, 1966, p. 618). Hallucinations, like dreams, may take on concrete meanings. Since neither is likely to have played a major role in the training and life experience of biomedically trained practitioners, they are often missed as the keys to an illness pattern:

A 52-year-old Inupiat Eskimo hunter/trapper and minister had unrelenting flank pain. Extensive inpatient evaluation in three different institutions, including a university referral center, had failed to reveal a diagnosis. After two and a half months of inpatient care, he was being managed as a chronic pain problem. The inability of physicians to resolve his problem led to a period of marked anger and panic. He threatened to leave the hospital and discontinue evaluation, and demanded increased medications. He became disruptive on the ward.

An interview undertaken at this juncture revealed that he had dreamed about his deceased relatives (parents and a brother):

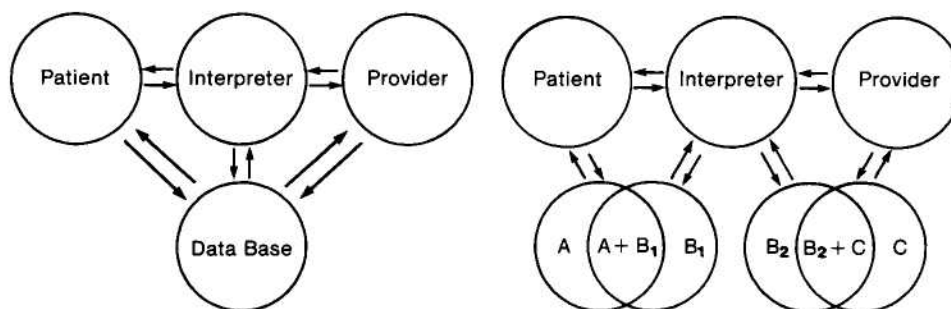
"My mother and father were sitting on the ice with wet clothing . . . they asked me to help change their clothes . . . I sat down and changed my own socks."

"My brother was setting a seal net, he asked me to help . . . I sat down on the shore and told him what to do . . . but I didn't touch the net."

His concern over the dreams had led to a long distance radio phone call to his wife. She shared his fears; "You didn't touch their clothes did you?" When asked what would have happened if he had touched the net or his parents' clothes, he quickly stated: "Then I would have been like them." He had clearly become convinced that his own death was imminent. (Putsch, unpublished, 1980)

The dreams were telling the patient what's wrong, what's going to happen—things the doctor didn't know about. He was using his dreams, language, and thoughts in a concrete, predictive fashion. Thus the formula, *to think/wish/dream something = to cause it = to do it*, a formula for magical thinking, seemed to be playing a role in his illness. His revelation of the dreams was induced after multiple prior attempts to assess his mental state had been unsuccessful. The key was a shift in interviewing that took his disparate language use into account. He was told that the interviewer knew a man who could hunt caribou by dreaming. This comment prompted dreaming stories from the patient and eventually the story of his own dreams. He subsequently reported a long history of events that led to his illness and that involved a traditional explanation of the entire process. The discussions led to the loss of need for pain medication. Previous assessments were based on direct inquiry about feelings, something Eskimo individuals are socialized to keep to themselves.

Native American patients are reluctant to tell health care providers about a hallucination or dream experience. The risk of labeling is too great, and there is concern that the dominant society would take such talk as evidence of psychosis. This is no surprise; Westerners also avoid discussing hallucinatory experience. Rees (1971), in a study of the "hallucinations of widowhood," found that, with one exception in 137 cases, Welsh widowers and widows never discussed their hallucinatory experiences with either health care providers or ministers. Those who had talked about it



**Figure 229.6**

Cross-cultural communication is strongly influenced by the extent to which the patient, the provider, and the interpreter share the same understanding and beliefs about the medical problem under discussion. The ideal model shown on the left is seldom achieved in practice, where the situation shown on the right is more often the norm. (See text for details.)

did so only with friends. The Welsh experiences of hallucinatory phenomena remain within the framework of acceptable “folk” expression and interchange. They are simultaneously excluded from formal interchange with authority figures.

In clinical settings, dreams often play a role in patient concerns, and this is true of patients from a wide variety of backgrounds, written language or no. However, in rural patients and nonliterate groups, dreams may be viewed as predictive. Individuals and groups have used dreams to hunt, to diagnose, and to predict the future. It is clear that dreams are often key to the assessment of mental status of Native Americans. This may also hold for evaluating mental status and health concerns of otherwise somaticizing Asian patients.

### Monolingualism and Interpreter-Dependent Health Care

*“Cross cultural interpretation . . . requires special training and highly developed skills. Just any bilingual person, chosen at random, is not sufficient.”* (Young, 1968, p. 17)

Interpretation in health care is a difficult task and requires exceptional skill. Monolingual providers who work in settings where other languages are in use should use trained interpreters whenever possible and simultaneously should attempt to upgrade their own skills in both language and interpreter-dependent transactions. The presence of an interpreter adds a whole new aspect to provider–patient exchanges.

Two diagrams of the patient–interpreter–provider communication triad are presented in Figure 229.6. The diagram on the left presents a hypothetical situation in which all three parties are contributing to the same database, considering the same events, and discussing the same questions and answers. “Same” in this context implies a relatively high degree of equivalence in each participant’s view of the content of the exchange. This hoped-for situation is not borne out in actual practice. The diagram on the right more closely approximates interpreter-dependent information exchange. One database is shared by the patient and the interpreter, and a second by the interpreter and the provider. But note that each participant also has an independent view of the transaction (represented by the nonoverlapping areas

marked  $A$ ,  $B_1$ ,  $B_2$ , and  $C$ ). At issue is the degree to which  $A + B_1$  and  $B_2 + C$  are equivalent.

Studies of recorded back-translated materials reveal a number of common problems that interfere with the generation of equivalent messages. Many information transfer problems are linguistic: bad paraphrasing, lack of linguistic equivalency, substitution or addition of terms, incorrect numbers and names, and garbling of the message. Other issues include interpreter beliefs, biases, emotions, disparate views of meanings (of events, terms, and transactions), and the personal image of the interpreter. Messages and meaning can be distorted for a wide variety of reasons.

### Summary

Miscommunication is often a source of provider–patient difficulties. Discrepant meanings and intent are often at the root of the trouble. These discrepancies often go unrecognized. The special character of cross-cultural communications makes it imperative that providers address these issues with care and work to develop their own communication skills.

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