

## Caring professions in multi-ethnic society: differences and similarities in representations of Health and Illness

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### Abstract

*This article reviews studies that compare different groups (about culture, national, racial) in order to propose a summary of results about the role played by caregivers' cultural influences in the management of patients. The paper, after a brief introduction, illustrates the research conducted about mental representations concerning the body, health, illness and practices of care. The focus, finally, is on recent studies about caring professions. The Authors also indicate future lines of research.*

Keywords: Health, Illness, Caring Professions.

In all times and in all places,  
it has been the man who has knew how to make his own body  
a product of proper techniques and representations  
(Lévi-Strauss, 1950, p. LVIII)

### 1. Introduction

The demographic changes of recent decades have increased the knowledge of other populations, environments and customs, highlighting the need to examine through cross-cultural studies the influences that these factors have on subjects that live in different contexts, rather than those belonging (Fortier & Bishop, 2003). This new area of research could give us more information in order to understand individual behavior related to issues such

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as health, illness, cure practices. In the meantime, it could produce results that encourage the development of intervention programs in which intercultural attention is focused on “opportunities for dialogue within the existing diversity” (Sordano, 2007; Rüdell, & Diefenbach, 2008).

Specifically, in Europe the presence of migrant workers in many health services, public and private, make this topic more relevant (Aranda, & Knight, 1997). Research results have emphasized the necessity to examine the increasing effects of ethnic diversity, in order to realize the migrant’s ability to use public services, and to explore the opportunity that these new “shared” cure contexts provide for sharing and exchange (Valle, 1998; Janevic, & Connell, 2001; Zavattini, Pace, & Velotti, 2008).

Already, the social sciences have fully documented the role of social learning in regard to behavior concerning the body (Kiviniemi, & Rothman, 2008). “When the eyes of a sociologist, of an ethnologist, and of a historian of ideas or of medicine, examines the representations underlining habits of hygiene, food and sex, techniques of farming or livelihood in the form of scientific knowledge and common sense, his way of moving forward joins that of the psycho-sociologist. These representations are regarded in the same way as the psycho-sociologist view them: as latent models, referring to common systems of thoughts and values, and to ensuring the consistency of attitudes and behavior within a given social system” (Jodelet, 1989, p. 244).

The study of social representations’ is been for many years a rich field of psychological research (Moscovici, 1961, Petrillo, 1994, 1996), in which the research has helped to highlight the presence of differences in the different cultural representations. Particularly, in relation to the way of conceiving body, health, illness and the behavior associated with them (Herzlich, 1983; Sheikh, & Furnham, 2000; Ford, & Kelly, 2005). “What is the meaning of health and illness to us? What for an individual in our society? From each ones personal experience, but also through the information that circulates in our society, shaped by its own values, the images are structured: being sick, being healthy, are images that are primarily created by an individual, that cannot be shared” (Herzlich, 1973).

Moscovici (1961) in his research on the spread of psychoanalysis in French society highlighted how, when a theory is part of common sense, there is a selection of some concepts, as extracted from the original theoretical corpus, which are restated taking into account the existing and familiar knowledge. Overall, studies conduct in this area tried to identify the specific representations relating to concepts of health and illness and also to the diversity in the different social groups. “What we try to find out is how the relationship, socially regulated, with this specific social object - the body - is conveyed and is organized in terms of experiences perceptions, knowledge and normative statements” (Jodelet, 1989).

## 2. Health and Illness: old and new lines of research

Over the last thirty years, the representations of health and illness have been the topic of several studies; following the papers of Moscovici (1961/1976) on the different representations of psychoanalysis in the various social groups, new research had explored how the existing knowledge systems could change (Flick, 1998). Herzlich (1973), in the French context, identified three different conceptions of health and illness that have stimulated further investigation. Jodelet (1991) analyzed the existence of a link between the representation of mental illness and behavior towards patients in a small French village; he showed how a naive theory (fear of contagion, proximity, etc.) of mental illness constituted the key point of the social representation of illness and explained the behavior implemented by the villagers who did not seek integration with the patients. Research has also documented how changes in these representations determine modifications in subjects' behavior.

These early works are followed both by studies on the social representation of the *disease* - which focused on a variety of illness - and by studies on *health* that, on the basis of the work of Herzlich (Herzlich, & Graham, 1973), have attempted to identify different conceptions belonging to different cultures. Flick (2000) found different representations in samples of German and Portuguese women and in samples of professional nurses of East and West Germany and he has connected the differences observed to the dissimilar contexts where the subjects belonged.

In other studies the focus of these investigations - that have identified a direct or indirect involvement of specific factors on individuals' behaviors - regarded topics such as how to ask for help, the medical services availability, the *compliance* of patients, the correct behavior related to health, etc.; and results showed that aspects such as socio-demographic characteristics, social and cultural factors, seems to be related to health- behaviors implemented by the people (Radley, & Billig, 1996; Galli, 1998; Jovchelovitch, & Gervais, 1999; Fasanelli, Galli, & Sommella, 2005; Dixit, Mishra, & Sharma, 2008). These data have subsequently oriented scholars to develop appropriate programs of intervention.

Each study has attempted to examine how the possible differences between individuals are related to the different cultures and how recent changes in cross-culture might give reason for the variations in health status and for the modifications in the subjects' care behavior (Fox, Hinton, & Levkoff, 1999). At the same time, it showed that the diseases' representations also have strong implications in the type of answers that people, in general, give to patients (Barrowclough, Lobban, & Hatton, Quinn, 2001).

Among the theories most used there is the self-regulation model of Leventhal (Leventhal, & Diefenbach, 1991; Leventhal, Musumeci, & Contrada, 2007) for which the answer of subjects to the disease is considered the re-

sult of a process through which each individual integrates – in the cognitive structures that give meaning to the experience – the internal and external stimuli with the preexisting information.

### 3. Caring professions: an area of particular interest.

Understanding how people in general, and health care workers particularly, explain the factors that determine health and disease is particularly interesting for the promotion of public health. If people that work in health care structures or individuals who use these structures do not have the same opinion about the assumptions of the medical practice – i.e., if they do not believe that smoking is injurious to health – there is little possibility that these people can persuade or could be persuaded to adopt the lifestyles suggested. Referring to Leininger's trans-cultural model of nursing (Leininger, 1991; Leininger, & McFarland, 2002), recent works confirm the need for physicians to understand the perceptions of illness of patients, in order to provide health care services that are consistent with the norms and values of the patient's culture. This model considers the concept of cultural competence, which requires that doctors should be aware of specific cultural values, traditions, beliefs and health of their patients (Mahoney, Clutterbuck, Neary, & Zhan, 2005).

The quantity and quality of care provided by public services to their customers have been evaluated in several studies, comparing the ability of professionals to keep costs within budget by a rational, efficient and complete number of "correct" performances (Lawton, Rajagopal, Brody, & Kleban, 1992; Connell & Gibson, 1997); at the same time, is widely acknowledged the role played by ethnic and cultural differences of the "caregiver" and the "patient" in the treatment (Barrett, 2001).

In fact, focusing on the role of ethnic differences with respect to the ability to access and quality of care received in health services (Geiger, 2003; Hannum Rose, Bowman, O'Toole, Abbott, Love, Thomas, & Dawson, 2007), many studies have investigated: 1) the ways in which institutions, in turn, tend to exclude minorities from the services and resources (Wallace, & Wallace, 1998); 2) the way in which various ethnic groups are at risk of discrimination and exclusion from public services; or finally; 3) the way in which specific cultural identities reinforce or protect their members from the disease (Shadlin, & Larson, 1999; Sondik, Lucas, Madans, & Smith, 2000; Tang, Cross, Andrews, Jacobs, Small, Bell *et al.*, 2001).

On the other hands, there are fewer studies concerning the different attitudes, beliefs and values in the ethnic groups and examining the role of these in facilitating or limiting the quality of care provided. For example, Bruce et colleagues showed that the patient ability' to understand non-verbal communications of and his/her emotional expressions is greater when

there is a “congruence” between the different cultures (patient and practitioner) compared to when this congruence is not present (Bruce, Beard, Tedford, Harmon, & Tedford, 1997).

In literature many studies were focused on non-professional care provided by family members of patients or volunteers (Sokolovsky, 1990; Fox *et al.*, 1999; Navaie-Waliser, Feldman, Gould, Levine, & Kuerbis, Donelan, 2001; Pinguart, & Sörensen, 2005; Li & Fries, 2005; Wallhagen & Yamamoto-Mitani, 2006; White-Means, & Rubin, 2008; Yaffe, Orzeck, & Barylak, 2008, Wells, Cagle, Bradley, & Barnes, 2008) regard to specific diseases (dementia, mental illness, AIDS, etc.). These works, mainly focused on the differences between whites and blacks, have come to identify several explanations of the “racial” differences in the quantity and quality of care provided to patients. Miller and his colleagues (Miller, Campbell, Farran, Kaufman, & Davis, 1995) have reported lower levels of stress in African-Americans caregivers compared to whites and, considering the amount of variance not explained by other factors (socio-economic levels, resources, etc.) they concluded that the Afro-Americans seem to perceive the task of caregivers as less stressful because they are accustomed to harsh living conditions. Gaines (1995) has attributed to the “Mediterranean” culture a different role in ‘reading’ the disease and providing care; in this tradition, in fact, there would be *less* emphasis on the intellectual aspects rather than emotional ones that have an effect on care. The author has tried to go beyond the dualism white / black considering some features as typically of all the Southern cultures, in which there are whites and blacks. Ikels (2002), in a cross-cultural study has reported that dementia, as a disease, is perceived as psychologically less threatening in China than in U.S.; in fact, the Chinese context seems to maintain longer a sense of self-esteem of patients and at the same time it seems offer more awards to families who care for them.

#### 4. Conclusions

Therefore, understand how different ethnic groups mean “the care” is now a problem of great interest (Dilworth-Anderson, Williams, & Gibson, 2002). The various existing gaps in research need to be overcome. They could determine confusion between different aspects (i.e., cultural *versus* social) or generalizations between different migration situations (neo-migrants *versus* old-migrants), finally, they could underestimate aspects such as religion or gender. In the meta-analysis of Pinguart *et al.*, (2005) the authors concluded that the lack of a theoretical model on the predominant role played by ethnic differences in caregiving is problematic and must be overcome through research targeted to specific population samples in order to identify similarities and differences with respect to a wide range of variables.

The literature has, in fact, emphasized that in the ‘care relationship’ further aspects of the caregiver personality are involved, such as empathy, acceptance, warmth, willingness to learn and to understand the different cultures, etc; these aspects – such as “cultural congruence” – seem to have a role in the formation of the relationship of care (Proctor & Davis, 1994; Balk, 1997; Burman, 1999). In the first exploratory phase, research (Stephenson, 2000) analyzing different variables (nationality, place of birth, race, region of residence, history of migration, language membership, years lived in the new country, religion, occupation, etc), with the purpose of understanding the differences in the ways of perceiving and/or in the behavior of individuals. Thus, to assess the effect of “culture” in the jobs related to health.

Finally, emerges in literature, the necessity of greater awareness of diversity *within groups* of different populations. For example, samples that are generally classified in research as “Latin”, really includes people from different places of origin such as Central America, Caribbean, Spain. (Aranda & Knight, 1997; Connell & Gibson, 1997; Delgado & Tennstedt, 1997; Gallagher-Thompson, 2000; Morano & Bravo, 2002). In the future, only a greater characterization of the target population on respect to the country of origin, residence (urban or rural area), period of migration will allow more detailed conclusions.

Now, the challenge is to integrate this knowledge in appropriate theoretical models that take into account the cultural changes resulting from migration and also the constant ‘contact’ of the individuals (healthcare workers and patients) to different models than their own.

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