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Commentary

Linking culture and structure: Adding time and environment — A commentary

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Introduction

Professional education and practice in the health fields emphasize cultural competence, where competence is defined not as being competent in one's own culture, but as being able to work effectively in cross-cultural settings, i.e., working with "others", for example, members of racial or ethnic minority groups (Institute of Medicine, 2002). Yet, "culture" represents an extremely complex set of concepts that have been considered extensively and in depth within social science disciplines and sub-disciplines. It is not easy for health professionals with limited training in the social sciences to truly fully grasp what culture means in its various manifestations. Often culture is conceived in a way that ignores its ever changing elements and its relationship to factors such as time, social structures, and environments.

As a person trained in the social sciences but working in public health, I have often found myself wanting to provide a bridge between culture, as understood in anthropology and sociology, and the practical applications of cultural concepts in health promotion and other areas of public health. The need for bridging becomes especially important when focusing on health disparities or health equity. Superficial definitions of culture with respect to ethnic minority or socially disadvantaged populations can lead to an erroneous framing of problems caused by structural or environmental inequities as emanating from the social or culturally-influenced values or behaviors of the affected group. Understanding and being clear about the constant interaction of culture with environmental and structural dynamics is fundamental for health promotion and health care policy and practice, especially when targeting disparities (Dressler, 2005; Institute of Medicine, 2002; Wallace, 2008). My solution, which is presented and explained in this commentary, has been to develop a heuristic that shows graphically the inextricable links between culture, structure, time, and environment in a relatively simple format. This graphic is then used as a tool for talking through the meaning and importance of structure, time, and environment in relation to culture, for example, when teaching public health students or working with health practitioners or researchers to foster cultural competence. The intent is to assist health professionals in recognizing the broader set of variables needed to understand cultural influences and work effectively with them in clinical and community level encounters (Helman, 2000).

The triangular pyramid

The heuristic, a triangular pyramid, is shown in Fig. 1. It symbolizes the virtual or imaginary, constraining space in which we as individuals, as groups, and as nations, exercise our agency — our ability to act (Cockerham, 2005). The four corners of the pyramid—culture, socioeconomic structure, time, and environment—are the determinants of our lived experience; the lines symbolize interactions. We may be able to change the shape of this space (for example, if one of the four corners takes on more importance), or we can expand the space, but we cannot escape it.[1] Following are some reflections on the nature of each element, in general and with respect to health promotion and public health. These reflections provide an idea of how the heuristic can be used as a teaching or discussion tool.

Culture and cultural change

It is hard to describe culture because it is in us, of us, and has fluidity and virtuality (Bourdieu, 1990). We have learned culture, have made it part of our being, and we share it with others over our life course; we are culture, and culture comes to life by our actions, emotions, opinions and goal setting (Kumanyika and Morssink, 1999). Definitions of culture in sociology, anthropology, education, management, fine arts and psychology all emphasize

[1] The heuristic does not include other determinants like genetic codes. For example, race is treated here as a social stratification variable, that, like religion or mother tongue, may lead also to cultural identity. Race or gender as biologically determinants (sickle cell disease, skin cancer, prostate, and hormones) of health, well-being and disease are not considered in the heuristic.

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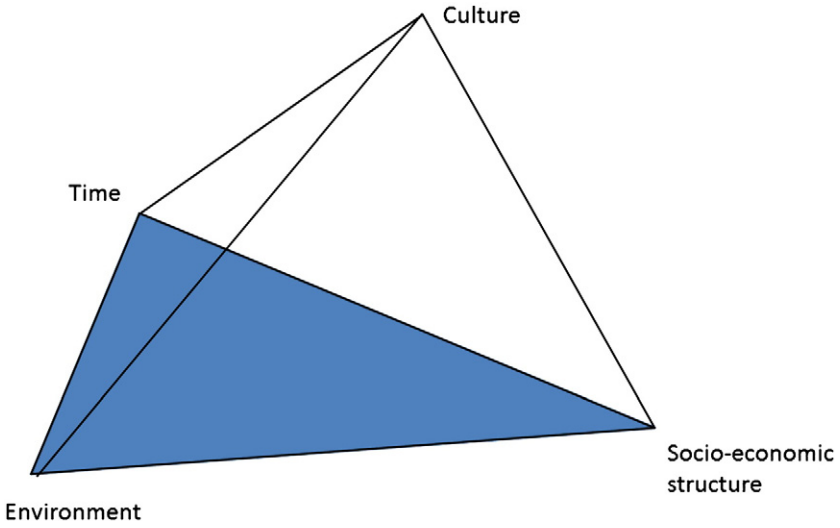

Fig. 1. The pyramid symbolizes the virtual or imaginary, constraining space in which we as individuals, as groups, and as nations, exercise our agency.

different aspects. A definition that can work well for the health fields is "the collective programming of the mind distinguishing the members of one group or category of people from another" (Hofstede et al., 2010). The "category" can refer to nations, regions within or across nations, ethnicities, religions, occupations, organizations, or the genders. We live culture; we reconstruct it daily and we have developed a system of emotional and intellectual existence based on it (Dressler, 2005). Culture is a system of values, beliefs, judgments, and behavioral compasses for setting norms and shaping our feelings of shame, guilt, remorse, pride, honor, disgust, taste and social worth, shared in "the moral circle" (Hofstede, 2009). Somewhere in there, we have a value and norm system about health, our health and the health of the other. Somewhere in our cultural being we make room for rationality and we place some value on it. But there are many more variables in our cultural construct than rational reasoning and linear pursuit of desired outcomes. Through culture, we have the sense of belonging. We create and recreate our culture in a dynamic interplay of social and environmental forces. We can be respectful or disdainful and we may feel comfortable or uncomfortable in the lived arrangements that bring us into daily contact with those of other cultures (Anderson, 2011).

Health promotion involves interactive interventions and may lead to cultural changes among the populations served, as well as among the cultures of the professionals who deliver these interventions. These will however not be the only cultural changes that we see happening. Cultural change arises from many stimuli; stresses result, new norms develop, and old habits are shed, but nothing about cultural change is linear, predictable, effortless or even.

Socioeconomic structure

The simplest description of socioeconomic structure is the organization of our collective existence over our lifespan and how individuals are positioned within organizational processes. The social forces that we are shaped by and that we reshape in our daily actions can be grouped around divisions of labor, structuration (the process whereby structures are (re-)created) of power systems, stratification, knowledge acquisition and dissemination, communication capacity and access, and the accumulation of wealth and the rules of transfer of such wealth. We all have a place in the structures of our groups or our societies. We can sometimes change these places or positions (and sometimes not). They can be ascribed, like a family membership, or achieved, like a professional title. Gender is ascribed, but the gender policies of a group or a nation can make that gender ascription a problem (or not). Social mobility refers to the idea that people can move on the stratification "ladders" of society. Each of us goes through life as a member of society, of groups, and each of us will have to understand our relative position, our space of maneuverability that comes with that position, and that of others in the structuration of our humanity (Dressler, 2005).

In health literature, socioeconomic structure is often considered in terms of economic (Sachs, 2005) and social determinants of health (World Health Organization, 2008). Determinants are frequently presented in a socio-ecological model with individuals and family in the center, surrounded by neighborhoods, schools, and work places in the middle-layer and with distal forces of globalization and world order issues in the outer layers. Factors such as types of taxation, level of public administrative control over the health arena, structuring of professional education in health, and barriers or lack thereof for entrance into that education, are in the middle layer. There are many socioeconomic determinants of health or health care, and often they are described in the form of attributes: being poor, black, homeless, or having a certain education level. Dialectic dynamics of social stratification and its impact on health, as between rich and poor, are discussed by scientists like Paul Farmer, when applying a perspective of 'structural violence' (Farmer, 2004). Most consideration of social determinants, however, starts and finishes with attributes as they relate to the position on the social gradient, from lower to higher echelons of society.

Time — chronology and the life course

Time is linear; it does not repeat itself. How we measure time depends in large part on technology (nanosecond is a relatively new word). I cannot overemphasize the importance of paying attention to time. All human actions, indeed all natural processes, happen through the use of time; hence all interactions imply time as a constant present variable (Cornish, 2004). Much public health work is critiqued as descriptive, with an emphasis on structural–functional analysis and lacking a sense of evolution and historical understanding (Glass and McAtee, 2006). The emphasis on having the most recent data reflects what Geert Hofstede calls the cultural managerial attitude towards time, which in America is comparatively very short (Hofstede et al., 2010). We tend to treat history as a stand-alone topic. Accounting for sociopolitical history is particularly important when addressing