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Multicultural Aspects in Functional Gastrointestinal Disorders (FGIDs)

Carlos F. Francisconi,[1,*] **Ami D. Sperber**,[7,*] Xiucai Fang,[2] Shin Fukudo,[3] Mary-Joan Gerson,[4] Jin-Yong Kang,[5] and Max Schmulson[6]

[1]Department of Internal Medicine, Universidade Federal do Rio Grande do Sul, Gastroenterology Division, Hospital de Clínicas de Porto Alegre, Porto Alegre, Rio Grande do Sul, Brazil; [2]Department of Gastroenterology, Peking Union Medical College Hospital, Chinese Academy of Medical Sciences, Peking Union Medical College, Beijing, China; [3]Department of Behavioral Medicine, Tohoku University Graduate School of Medicine, Sendai, Japan; [4]Advanced Specialization Program in Couple and Family Therapy, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, Division of Gastroenterology, Mount Sinai School of Medicine, New York, New York; [5]Parkside Hospital, London, United Kingdom; [6]Laboratorio de Hígado, Páncreas y Motilidad–Unit of Research in Experimental Medicine, Faculty of Medicine–Universidad Nacional Autónoma de México, Hospital General de Mexico, Mexico City, Mexico; and [7]Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel

Cross-cultural factors are important in functional gastrointestinal disorders (FGIDs). In the setting of FGIDs, the aims of this review were as follows: (1) to engender interest in global aspects; (2) to gain a clearer understanding of culture, race, and ethnicity, and their effect on patient care and research; (3) to facilitate cross-cultural clinical and research competency; and (4) to improve and foster the quality and conduct of cross-cultural, multinational research. Cultural variables inevitably are present in the physician–patient context. Food and diets, which differ among cultural groups, are perceived globally as related to or blamed for symptoms. From an individual perspective, biological aspects, such as genetics, the microbiome, environmental hygiene, cytokines, and the nervous system, which are affected by cultural differences, all are relevant. Of equal importance are issues related to sex, symptom reporting and interpretation, and family systems. From the physician's viewpoint, understanding the patient's explanatory model of illness, especially in a cultural context, affects patient care and patient education in a multicultural environment. Differences in the definition and use of complementary and alternative medicine and other issues related to health care services for FGIDs are also a relevant cross-cultural issue. This article highlights the importance of cross-cultural competence in clinical medicine and research.

Keywords: Culture; Explanatory Model; Cross-Cultural Competence; Cross-Cultural Research.

The inclusion of a new chapter in the Rome IV book devoted to multicultural aspects in functional gastrointestinal disorders (FGIDs) attests to the growing recognition of the importance and value of a global perspective in addressing these disorders. The Rome Foundation has expanded its scope and global outreach greatly in the past decade. Various initiatives undertaken in recent years, collectively called the Rome Foundation Global Initiative, show this concern for the dissemination of knowledge on and appreciation of the relevance of FGIDs at a global level (Figure 1).

The aims of this review were as follows: (1) to engender greater interest in the global aspects of FGIDs; (2) to gain a clearer understanding of culture, race, and ethnicity, and their effect on patient care and research in FGIDs; (3) to facilitate cross-cultural clinical and research competency in FGIDs; and (4) to improve the quality of multinational research in FGIDs and foster collaborative international research networks for the conduct of cross-cultural, multinational research in this area.

Figure 2 presents a conceptual model of the interaction of factors that have been identified as central to understanding the influence of multicultural factors on FGIDs. Obviously, reality entails greater complexity than any model can capture, but Figure 2 attempts to incorporate salient factors and the interactions between them, as discussed in text later. The model highlights the following: (1) the centrality of the patient, the physician, food and eating, and culture in symptom interpretation and clinical manifestations; and (2) the other factors that feed into these central aspects. These other factors are shown in association with the central items to which they would seem most linked, although in reality there are multiple avenues of interaction and mutual influence. This article focuses on individual factors and the interactions between them.

Definitions

Culture has been defined as the values, beliefs, norms, and practices of a particular group that are learned and

***Authors share co-first authorship.**

Abbreviations used in this paper: **CAM, complementary and alternative medicine; FD, functional dyspepsia; FGID, functional gastrointestinal disorders; 5-HTT, hydroxytryptamine transporter; IL, interleukin; IBS, irritable bowel syndrome; PI-IBS, postinfection irritable bowel syndrome; TCM, traditional Chinese medicine; TNF, tumor necrosis factor.**

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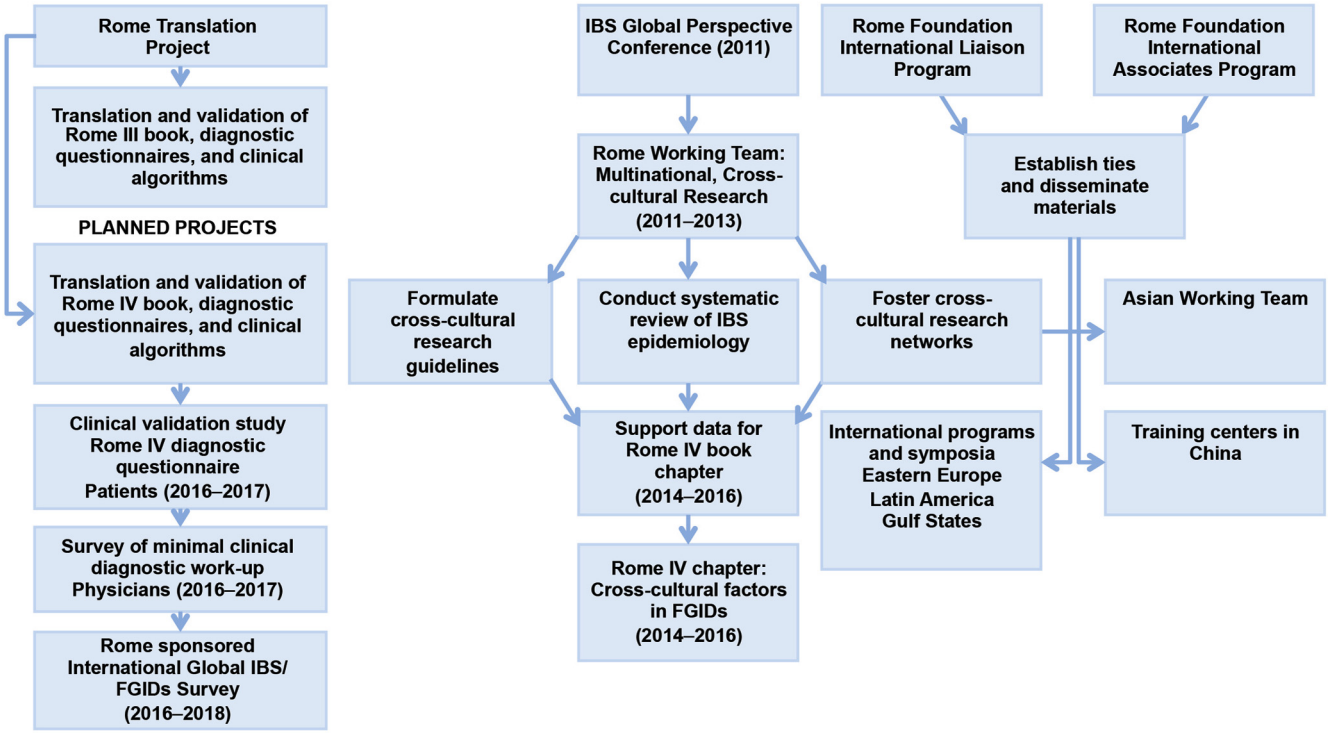

Figure 1. The Rome Foundation's global initiative began with the Rome Translation Project and the Global Perspective conference held in Milwaukee in 2011. Since then, it has branched out in many directions, encompassing outreach educational programs, Rome-sponsored symposia at international meetings around the world, fostering of cross-cultural research networks, and a planned global epidemiology study.

shared, and that guide thinking, decisions, and actions in a patterned way.[1] Individuals within social networks share ideas and values, which create order and further adaptation to local surroundings.

The terms *culture*, *ethnicity*, and *race* often are used interchangeably, although each has a specific definition and reference. Ethnicity can be thought of as a measure of cultural heritage, in contrast to race, which is based more on phenotype (eg, skin color).[2,3] The term *race* is considered controversial and may not reflect biologic difference owing to the complexity of the human genome. Although there is some recognized overlap between ethnicity and race in this article, the term *race* will refer to the conventional phenotype definition, and in all other category designations, ethnicity is intended.

Ethnocentrism is defined as judging another culture solely by the values and standards of one's own culture,[4] which can be an impediment to effective clinical practice and research. Beliefs and definitions may have an impact on symptom interpretation. For example, a doctor may ask a patient if they suffer from bloating, but the patient may think the doctor is asking about abdominal pain.

Ethnic identity can be defined as that part of an individual's self-concept that is derived from his or her knowledge of membership in a social group, together with the value and emotional significance attached to that membership.[5,6]

A patient's culture is related closely to religious principles, language (implicit expression of symptoms and feelings), and explanatory models of illness. The effect of culture on health and health care can manifest itself in illness beliefs,[7] symptom expression, and learned coping patterns. Cultural and ethnic factors also may affect pathophysiology, the patient–physician relationship, the diagnostic process,[8] openness to treatment modalities such as complementary and alternative medicine (CAM) and psychotherapy,[8,9] and health outcomes.[10]

Gender generally is used to refer to the nonbiological aspects of being a woman or man, such as the social or cultural expectations associated with femininity or masculinity.[11] The term *sex* generally is used to refer to a person's biological femaleness or maleness. However, most differences between men and women are known to be a function of the interaction between biology and the environment.[11] In this review, the term *sex* will be used as a more inclusive term. The term *sex* will be used for the classification of individuals based on their reproductive organs and function, as assigned by their chromosomal complement. Gender roles are based on sex stereotypes, which are socially shared beliefs that biological sex determines certain qualities.

Symptom Interpretation and Reporting

The manner in which symptoms manifest and are reported varies between groups. Evidence exists that African Americans have lower pain tolerance and higher ratings of suprathreshold stimuli than non-Hispanic whites, with greater symptom severity and increased functional