NATURE OF SOCIETY
Lecture 2

CULTURE AND SOCIAL ROLES

CULTURE

Introduction
We are all affected by a myriad of different influences and, above all, each of us has our own unique personality. But our culture, the culture of the society or community in which we grew up, is one of the key influences on the way each of us sees and reacts to the world, and on the way we behave. In some ways the effects of culture on each of us cannot be overestimated. Almost everything in our behaviour is influenced by our culture. At the same time it is important to bear in mind that culture is a framework, not a straitjacket. Within our own culture there is a wide range of choices and options for each of us, a million ways in which we express our individuality and live our unique lives. When working across cultures, therefore we need both to be aware of the possibilities that may exist within a culture another than our own, and to avoid assuming that any individual will conform to a particular cultural pattern.

What is Culture?
Culture is a shared set of norms, values, assumptions and perceptions (both explicit and implicit), and social conventions, which enable members of a group, community or nation to function cohesively. Our culture vitally affects every aspect of our daily life, how we live, think, and behave and how we view and analyse the world. But because, like the air we breathe, our culture is all around us from the day of our birth, and because we acquire almost all of it unconsciously in early childhood, most of us grow up unaware that we have a culture at all. We often also find it hard to distinguish, even in ourselves, what is cultural from what is individual or personal (Helman, 1986; Hoecklin, 1993; Hofstede, 1991; Keesing, 1981; Reber. 1985; Trompenaars, 1993). We may not realise that we regard as normal, universal values and ways of behaving are in fact cultural, and may therefore be normal only to us.

Culture consists of the shared ***norms and values*** of our group, community or society; shared ideas about how people should behave, about right or wrong, good and bad. These can usually be put into words when necessary, though within any culture most people take them for granted as normal and even universal. Culture is not genetically inherited. It is acquired during childhood when we absorb the basic values and norms by which our family, our society and community live.

Within every society there are a number of distinctive smaller cultures called ***subcultures***. These develop their own particular cultural patterns. A true subculture develops when its members as a group work or live in relative isolation, such as village of fishermen; when a group perceives external threats to its welfare, for example battered

wives or homosexuals; or when a group has a common interest to defend against others, such as black minorities in European societies. As subcultures develop their members may develop norms, values and attitudes of their own. Organisations to have their own subculture which people adapt to often unconsciously, when they join. Each of us is therefore not only affected by the wider culture of our society or community, but also by several subcultures.

Cultural differences

The cultural values and norms that individuals learn differ from one society to another. What makes sense is normal and acceptable to people in one culture may be odd, shocking or even completely abhorrent to people in another. Few values are universal. Every culture makes sense to the people within it (though they may not like every aspect of it). Part of treating individuals with respect involves respecting and trying to understand their culture and values as they see them.

Changes and variations within cultures

Culture is not fixed or static. The culture of a nation varies between and within regions. Cultures also change over time in response to new situations and pressures. Frequently the practical adaptations that people have to make in response to external circumstances then seep into and change their culture. Some societies and communities change faster than others. Some societies are more conservative, either because they are not confronted by the same pressures to change, or because their culture contains strong features that enable it to withstand such pressures. Societies that are more religious may for example be slower to change.

Attitudes towards different cultures

Us and them

> *However we conceive of our group, whether a class, nation or a race, we define it by those we exclude from it . . . However we define them, we perceive them as an undifferentiated mass with no individual variations*.
>
> (Littlewood and Lipsedge, 1989).

We learn about our own culture from a very early age. Babies and young children are acute observers. We copy the things that adults say and do, and the way that they say them. If we behave in ways that do not fit in with the culture of our family or peers, we are left in no doubt about their disapproval. So we are strongly encouraged to conform, to fit in with accepted, though often unspoken norms of right and wrong, of behaviour, speech, dress, language and manners. A child from as religious family is taught an additional and specific set of values and beliefs and learns what is acceptable to her or his particular religious group.

As we learn what is acceptable within our own culture and/or religion, the foundations for regarding difference with suspicion are laid. If we are taught that what we do and how we do it are 'correct' and 'right', we can be forgiven for assuming, however unconsciously, that people do things differently are wrong and less deserving our respect.

In extreme cases differences may be labelled pathological. In societies where one ethnic group is dominant, the cultural practices and values of groups which differ from the majority 'norm' are all easily regarded as deviant, wrong or pathological, and there is but a small step from 'cultural' to clinical pathology (Smaje, 1995).

Inaccurate information about other groups

Much of the information we get from the media, our peers and our families about societies and groups other than our own is also inaccurate. It often focuses on differences and on negative characteristics while ignoring the qualities we all share. In many cases it plays on our fears. Few of us would want to be judged on the basis of the most extreme or notorious members of our group or society.

Assumptions and stereotyping

Stereotyping is an intellectually crude and limiting way of understanding (or seeming to understand) individuals (Modood, 1990). We all use stereotypes and assumptions to make sense of the world, and to save time and effort. We make assumptions on what we know or what we think we know. This can be particularly true of health professionals who are traditionally expected (by themselves and by society in general) to have all the answers and always to know what to do and when to do it.

The further people are from our own experience and the less we know about them the more we tend to stereotype them. We tend to stereotype people in groups that we do not belong to and that we know little about. The less we know about a person the more we tend to rely on stereotypes in deciding what they are like and what they need, especially if there is also a language barrier (Bowler, 1993). But stereotypes have a life and quality of their own. They are often negative, belittling or even hostile (Green, et al., 1990). They are useless as a basis for delivering sensitive individual care.

People whose needs and behaviour are unfamiliar to health professionals are often treated as if they are strange or abnormal, or are regarded as a nuisance. Nobody should be labelled difficult simply because of his or her culture, religion or skin colour. Each person should be seen as and individual who deserves respect and responsive and appropriate care.

CULTURE AND HEALTH CARE

Different Beliefs and Systems

Now we are going to discuss how people from different backgrounds may have different views and expectations of health care.

Our beliefs about health and about what makes us ill, where to seek treatment for what, and how to prevent illness are as much influenced by our culture as our views on family patterns, acceptable dress and what constitutes normal behaviour (Mares et al., 1985). For people who have grown up in societies where Western medicine and maternity care are taken for granted as uniquely effective, the existence of other flourishing systems can be a surprise. Many Westerners assume, for example that when people have access to Western medical care they will gladly abandon the system they grew up with.

But even within Western medicine, which is considered to be purely scientific and therefore impervious to culture, there are variations in practice and attitude. For example, in much of Europe, low blood pressure is regarded as dangerous and requiring treatment; in Germany drugs for low blood pressure account for the third largest percentage of all drugs prescribed. In contrast in the UK and the USA people with low blood pressure are regarded as fortunate and may get lower insurance premiums. In some countries breast cancer has been treated with radical surgery; in France where the quality of life has more to do with having an attractive body, breast cancer is usually treated with the minimum possible surgical intervention (Payer, 1989).

In Britain allopathic medicine and practitioners have been dominant for some time and have driven other systems into the fringes of society, though they are now making something of a comeback. In most of continental Europe, systems such as homeopathy and herbal medicine have always been important. Many European pharmacists are trained to give homeopathic and herbal advice as well as advice on allopathic preparations. In most parts of the world allopathic and local medical system exist side by side. People select which system and practitioner to use depending on the condition, its seriousness, and on the costs and accessibility of the different options.

Culture and experience

Both people's culture and their previous experience of health care systems influence the way they relate to health professionals and what they expect of them. When a woman visits the doctor expecting a prescription for her sore throat, she may feel neglected and uncared for if all she receives is information and advice. Another woman may be dismayed to be given antibiotics when all she wanted was advice and reassurance.

Culture influences what people regard as healthy and normal in terms of the way their body functions. For example, the English are said to be preoccupied with their bowels. In some cultures menstruation is seen as a means of cleansing the body from impurities. Culture also influences what people see as causing illness. Depending on the condition, most Western Europeans see illness caused by some combination of bad luck, external

factors and individual behaviour. In other societies the causes may be seen as, for example bad behaviour, spiritual affliction, emotional stress, or the ill-will. People's view of the cause obviously affects what they regard as sensible methods of diagnosis and treatment. In the Western bio-medical system, biochemical and other physical tests are very important. In other systems practitioners spend a lot of time finding out about what is happening in the patient's life and relationships. Physical methods of treatment also vary. Multinational pharmaceutical companies are careful to market their products in whichever form will be most acceptable in each country and will therefore sell best.

People's confidence in health care often depends to a large extent on whether it fits in with what they have come to expect. We tend to have faith in the system we have grown up with. We assume that practitioners in this system know what they are doing often mistrust practitioners who do things differently. For some immigrants this can pose a real problem. They may have little faith in the effectiveness of diagnostic methods and treatments in their new country. They may prefer to find a practitioner who understands their culture and assumptions, from whom they can get care that makes sense to them. Where there is a language barrier this can be particularly important.

Nurses' attitude to people from different cultural groups

Many people find it quite difficult to be completely honest, even to themselves about their views on people from other racial groups. However, most of us, if we were completely truthful would find elements of racism in ourselves, whatever cultural group we belong to.

What we have to do as nurses is to see beyond the prejudice to some of the problems it presents for us in practice. We want our clients to feel comfortable with the care we provide, to feel they have some control over their own health and the treatment they receive.

SOCIAL ROLES

The study of roles

An initial definition of a role is that it represents the way that someone is expected to behave in a particular social situation. The concept of role implies not only an expected pattern of behaviour but also the role incumbent- shows appropriate feelings and values. Patients are expected to comply with doctors' orders, but they are also expected to feel that is right and proper that doctors issue such instructions. For patients to tell doctors how to treat them or to refuse to accept a doctor's prescription would be regarded as inappropriate behaviour or non-compliance.

Multiple roles

The concept of role has a theatrical analogy (Goffman, 1971) in that we are all engaged in acting our various roles. The role is like the part in the play, while the way that the individual acts the role is analogous to the performance of the part by a particular actor.

In real life, as on stage, we can act more than one role. We act some roles, such as gender roles, throughout our lies while others, such as those of parent; occupational therapist, nurse or goalkeeper will be acquired. We all act multiple roles. At the same time as being a doctor a woman can be a feminist, daughter, mother, ratepayer, preacher, car driver and patient (Bond, 2000).

Role-set

Merton (1957) coined the term role-set to describe the array of roles and expectations that any individual will confront while taking a particular role. The female doctor, while acting as doctor and not in any of her multiple roles, will be interacting with several others playing roles: pharmacist, hospital administrator, nurse, dietician, physiotherapist, patient and patient's relatives. When she acts the role of mother the role-set will include other mothers, son, daughter, daughter's friend, son's teacher. A more complex example of a role-set is illustrated by Runciman (1983) in her study of the work of the ward sister. As a ward sister her own role-set consisted of over 100 role relationships indicating the complexity of the sister's work.

These formal descriptions of multiple roles and role-sets give an impression that roles are uniform and static. Turner (1962) emphasises the important distinction between role-taking and role-making. The idea of role-taking suggests that all roles are prescribed and defined by a specific set of rules which all actors comprehend and which they conform. In contrast the idea of role-making suggests that actors will usually create and modify roles according to their own interpretation of the role and their own roles in the role-set. This is especially the case when new roles are merging in organisations – roles such nurse practitioners or clinical specialists in nursing organisations.

It is useful to see roles as dynamic and something people themselves develop rather than as static features of people's lives to which they mould their performances. Nevertheless, roles are to some degree constrained by the social environment and there are limits to the behaviour tolerated by others in their expectations of appropriate role behaviour. Bond (1978) observed that some nurses strongly criticised one member of staff who regarded it as within her interpretation of the nurse's role to tell patients with cancer their diagnosis if they asked her. Others regarded this as medical prerogative and exerted sanctions to persuade their colleague to limit this kind of behaviour.

Role Conflict

Most of us will act multiple roles throughout our lives, such as doctor and mother, and as a result will experience ***interrole*** conflict. Holding a perception of the role of the doctor, which differs from official ideology or of mother, which differs from traditional beliefs, can lead to ***intrarole*** conflict.

Interrole conflict means conflict between two simultaneously held roles. A doctor who has to be at work on the afternoon of a child's birthday party experiences interrole conflict between the role of doctor and parent. The degree of conflict will reflect strength of attachment to the two roles.

In contrast, parents who disagree with the expectation that a parent should be present at a child's birthday party will experience ***intrarole*** conflict. Their interpretation of the role of parent conflicts with dominant view of other similar role incumbents – other parents. In other words, they do not agree with the general consensus of their social group about the patterns of expected behaviour in parents.

Conclusion

Values, norms and roles make social life easier. When one knows what is expected in different social situations, one can behave in a confident manner. Also understanding more about how others see us as well as how we see other people will help us provide better care for our patients.

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