SOCIOCULTURAL FACTORS AND HEALTH CARE-SEEKING BEHAVIOR AMONG BLACK AMERICANS

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This study investigates the health care-seeking behavior of black Americans in the Detroit Metropolitan area. Analyses of 176 semistructured interviews and 27 life history profiles obtained from participants, nonparticipants, clinic coordinators, community leaders, and health care professionals at local screening clinics suggest that black Americans follow a culturally specific health care-seeking pattern, and that such behavior is significantly influenced by sociocultural factors. This information should be particularly useful for health care professionals and educators, because it can help them plan and implement special intervention strategies for the black community.

Health care researchers have noticed a recognizable increase in the use of hospital outpatient departments, especially among the poor, minority groups, and those residing in metropolitan areas.[1] In 1973, blacks were twice as likely as whites to use hospital outpatient clinics.[2] As of 1980, 25 percent of all visits to physicians made by blacks occurred in hospital clinics or emergency rooms compared with 11 percent by whites.[3] The main reasons for this increased demand involve such sociodemographic factors as income, education, employment status, age, gender, insurance coverage, and place of residence.[4]

To analyze health care utilization patterns requires understanding the concept of "culture," a patterned way of life that has special meaning to the individual and his or her social group. Understanding the culture of an individual is of special importance in health-related situations, because it determines whether an individual will utilize or avoid available health care services. One's culture is a system of shared beliefs, values, customs, behaviors, and artifacts that members of a society use in coping with one another and with their world, and that are transmitted from generation to generation through learning.[5] This learned culture guides action and beliefs as the individual meets both familiar and new life situations.[6]

To gain a holistic understanding of the way in which members of any culture pattern their health care utilization, medical anthropologists pay attention to the meanings and life experiences that people ascribe to an illness and to the intricate interrelationship these meanings have with their behavior. This method of analysis involves the use of ethnographic data obtained directly from people, gathered primarily through the observation-participation method. The author participated as a blood pressure screening volunteer so as to gather data to illustrate how qualitative ethnographic data (case studies) can inform health professionals about some of the sociocultural factors that can influence the health care-seeking pattern among black Americans.

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CULTURAL PATTERNS

Berkanovic and Telesky,[7] and Harwood[8] contend that ethnic differences in health care utilization may be based upon culturally determined patterns that were developed in response to a specific historical situation. For many years following slavery, mainstream medical care was often inaccessible to blacks in the United States, primarily because of discrimination and poverty.[9] Washington,[10] for example, stated that in the 1920s, although Detroit blacks had the use of the outpatient clinics in most of the hospitals, they found it increasingly difficult to obtain beds in these facilities except in obstetric cases. Although many of the barriers of accessibility to mainstream health care facilities have been gradually eliminated, many black Americans continue with practices that were adapted in an earlier era and are reflected in their health care-seeking pattern.

Moreover, many cultural traits found among black Americans such as sharing, strong emphasis on family bonding and childrearing, a strong authority structure, the importance of spiritualism, an emphasis on present orientation, trust, and individual moral "strength" generally conflict with mainstream values—individualism, autonomy, achievement, future orientation, and mastery.[11] According to the US Department of Health and Human Services,[3] if health professionals recognize cultural variables as they apply to various ethnic groups, then health education programs can be tailored more carefully to the needs of minorities.

METHODS

The data on which this article is based were collected over three periods, combining both informant-oriented and participant-observation–oriented methods: the first seven months were composed of informal interviews and unstructured observation; the next four weeks were directed toward semistructured interviews and participant observation; and the final four months included informal interviews, individual life history profiles, and participant observation.

In cooperation with the United Health Organization, the author collected ethnographic data from blacks residing in and around seven randomly selected screening clinics in the Detroit Metropolitan area. The Detroit sites included: (1) Crockett Vocational Center, (2) Focus Hope Eastside Center, (3) Franklin-Wright Settlements, (4) Hartford Memorial Baptist Church, (5) Jennings Medical Offices, (6) Kingsway City, and (7) the Second Baptist Church. From September 1985 through March 1986, data were collected informally from respondents using the snowball sampling method.[12] This method consists of interviewing persons in the designated communities, who in turn recommend other persons who could be interviewed, and so on.

During the April 1986 screenings, semistructured interviews were conducted by the author while he participated as a blood pressure screening volunteer. The randomly selected blacks (every other person) were asked a series of questions about their beliefs, values, and behavior regarding high blood pressure. Anthropometric, demographic, and sociocultural data were obtained as were responses to the Health Belief Questionnaire.[13] While most interviews lasted approximately 20 minutes, others took considerably longer because of the open-ended format of these interviews.

From May to August 1986, informal interviews were continued. Individual life history profiles and participant observation methods were documented at the United Health Organization's headquarters and at three of the seven sampled screening clinics. The total sample from all clinics and the three periods of data collection consisted of 176 semistructured interviews and 27 life history profile analyses.[14,15] Only the qualitative ethnographic data are reported.

RESULTS

From the 203 sampled blacks (39 percent male and 61 percent female), this study identified a cultural pattern of health care-seeking as detailed in the following six steps:

1. Illness appears (perceived symptoms associated with high blood pressure);
2. Individual waits for a certain period (delays days or weeks);
3. Allows body to heal itself (prayer or traditional regimens);
4. Evaluates daily activities (reduces work or stress);
5. Seeks advice from a family member or close friend (church leader and/or traditional healer included);
6. And finally, attends health clinic or family physician.

The sequence of this health care-seeking pattern is highly contingent upon a number of sociocultural factors, most important of which is the fact that be-

tween the 1920s and 1940s, 80 percent of elderly Detroit blacks came North from rural and urban areas of southern states.[16] Although this percentage of the southern black migration has decreased over the decades, living under a sociocultural system that traditionally denied blacks equal access to health care, black Detroit migrants hold a negative attitude about the health care system. This attitude, in turn, leads to a tendency not to seek help or to delay seeking help until the condition is too serious to ignore.[4] The following six cases of participants and nonparticipants in the United Health Organization's screenings are prime examples of the patterns of black responses to high blood pressure.

Case 1. A 54-year-old black woman, who migrated to Detroit in the late 1940s, stated that there are certain illnesses a person must "live with." Because of her low income and a good rapport with an elderly physician, this woman continued her traditional self-care regimen by taking a pinch of garlic immediately following a meal to treat her blood pressure. The most intriguing aspect of this case is that the woman's physician, originally a southern resident also, prescribed the traditional self-care regimen for her. She attended the screening only after her perceived symptoms, associated with high blood pressure, became too serious to neglect.

Case 2. A 79-year-old black woman, who migrated from Arkansas in 1927 and has a physician at a local health clinic, did not feel that it was necessary to attend a screening clinic. She followed the typical health care-seeking pattern by maintaining a traditional self-care regimen (sassafras tea and lemon juice) and hours of prayer before attending the clinic. Although the physician had not given her a precise diagnosis of her illness (high blood pressure), this woman insisted that she must continue to trust her physician despite minor communication problems between the two parties.

Case 3. A 35-year-old male health professional's preventive health care practices involved living his life according to the Lord's standards and not overexerting himself. Because this individual feels that he's "in tune" with his body and because his mother has never sought a physician's care (traditional regimen), he will seek a physician's care only as a last resort.

Case 4. A 59-year-old black female participant, who practices a traditional self-care regimen (vinegar and herbal teas) in treating her high blood pressure, believes that one's health is the responsibility of the individual, not the physician. Moreover, her lack of information about the seriousness of high blood pressure and the hereditary component of hypertension had delayed her from seeking health care from medically trained professionals.

Case 5. A 29-year-old black male participant felt that his health was in the hands of God and not in the hands of a mere mortal. Thus, he maintained that his lifestyle is in accordance with the Scripture.

Case 6. Although a 73-year-old black female participant believed that blacks need more education about health care practices, she stated that "we are raised not to question the doctor even if the information is not totally understood."

DISCUSSION

The preliminary findings of this study suggest that among this sample of black Americans, sociocultural factors influence health care-seeking behavior. From the preceding cases, it is apparent that such sociocultural factors as being a southern or southwestern migrant, maintaining a traditional health care regimen, believing in spiritualism, trusting in individual moral strength, and believing in obedience to authority structures affect the use of the health care system. Moreover, Harrison and Harrison[17] note black Americans have culturally developed an increased tolerance for illness. Actually, major health care culture differences exist between ethnic groups in terms of health-related knowledge, attitudes toward health and therapeutics, health care-seeking behavior, and the use of local health care facilities.[18] Certainly, the foremost cultural factor that affected health care-seeking behavior among this study's informants was self-care.

Self-Care

Self-care involves the attitudes and techniques by which individuals assume responsibility for maintaining health and treating illness. Sidel and Sidel[19] state that one purpose of self-care is to remove healing from professional control and to foster the capabilities of clients and support groups to care for themselves. The data from the study indicate that blacks utilize various self-care regimens primarily because of the perceived absence of access to medical care and the cultural trait of individual moral "strength."

Jenkins[20] notes that health professionals who serve black communities must realize the significance of the perceptions surrounding self-care concepts. Al-

though self-care programs may compete with neighborhood health care centers or screening programs, they have been successfully introduced as special intervention strategies.

According to Campbell,[21] intervention strategies are plans placed in action to change outcomes of a particular circumstance. From a health care education perspective, intervention strategies are programs planned and implemented for a target group with the intention to produce beneficial and desired changes in health behavior. Specifically, intervention strategies alert people to health care issues, inform them of the most straightforward and effective behavioral alternatives for health promotion, help them to make choices, maintain some of their traditional health care practices, and reinforce new behavioral patterns.[22]

Yet, for intervention strategies to work in the black community, educators need to: (1) know what the people are thinking; (2) have a broad definition of health and an understanding of the breadth of those factors that have an impact on health; and (3) realize the everlasting effects of discrimination. Once educators address these issues in the black community, perhaps the more basic problems of availability, accessibility, accountability, and acceptability of the health care system will be resolved.

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Literature Cited

1. National Center for Health Statistics. Health, United States, 1983. DHHS publication No. (PHS) 84-1232. Government Printing Office, 1984.

2. US Department of Commerce. The Social and Economic Status of the Black Population in the US: 1974. Government Printing Office, 1975, p 128.

3. US Department of Health and Human Services. Report of the Secretary's Task Force: Black and Minority Health, Executive Summary, vol I. Government Printing Office, August 1985, pp 187–194.

4. Neighbors H. Ambulatory medical care among adult black Americans: The hospital emergency room. J Natl Med Assoc 1986; 78:275–282.

5. Leininger M. Nursing and Anthropology: Two Worlds to Blend. New York: John Wiley & Sons, 1970.

6. Plog F. Anthropology: Decisions, Adaptation, and Evolution. New York: Alfred A. Knopf, 1980.

7. Berkanovic E, Telesky C. Mexican-American, black-American and white-American differences in reporting illnesses, disability and physician visits for illness. Soc Sci Med 1982; 20: 567–577.

8. Harwood A. Ethnicity and Medical Care. London: Harvard University Press, 1981.

9. Jackson J. Urban black Americans. In: Harwood A, ed. Ethnicity and Medical Care. London: Harvard University Press, 1981, pp 37–129.

10. Washington F. The Negro in Detroit: A Survey of the Conditions of a Negro Group in a Northern Industrial Center During the War Prosperity Period. Detroit: Associated Charities of Detroit, 1920.

11. Pinderhughes E. Afro-Americans and the victim system. In: McGoldrich M, Pearce J, eds. Ethnicity and Family Therapy. New York: The Guilford Press, 1982, p 109.

12. Bailey K. Methods of Social Research. New York: The Free Press, 1982.

13. Becker MH, Maimen LA. Patient perceptions and compliance: Recent studies of the health belief model. In: Haynes RB, ed. Compliance in Health Care. Baltimore: Johns Hopkins Press, 1979, pp 78–81.

14. Becker HS. The relevance of life histories. In: Bensin NK, ed. Sociological Methods: A Sourcebook. Chicago: Aldine Publishing, 1970, pp 419–428.

15. Leininger M. Life health-care history: Purposes, methods, and techniques. In: Leininger M, ed. Qualitative Research Methods in Nursing. New York: Grune & Stratton, 1985, pp 119–132.

16. Koening R, Goldner N, Kresojevich R, Lockwood G. Ideas about illness of elderly black and white in an urban hospital. Aging and Hum Develop 1971; 2:217–225.

17. Harrison I, Harrison D. The black family experience and health behavior. In: Crawford C, ed. Health and the Family: A Medical-Sociological Analysis. New York: Macmillan, 1971, pp 175–199.

18. Hogle J. Ethnicity and Utilization of Health Services: An Urban Response to a Community Health Center. Ann Arbor, Michigan: University Microfilms International, 1982.

19. Sidel B, Sidel R. Reforming Medicine. New York: Pantheon Books, 1984.

20. Jenkins R. The impact of health education on black communities without changes in the external environment. In: Centers for Disease Control. Health Education and the Black Community. US Department of Health and Human Services, Government Printing Office, 1980, p 12.

21. Campbell A. Hypertension control—A categorical approach to comprehensive health promotion and disease prevention. In: Centers for Disease Control. Health Education and the Black Community. The Government Printing Office, 1980, p 37.

22. Mittelmark M. Community-wide prevention of cardiovascular disease: Education strategies of the Minnesota Heart Health Program. Prev Med 1986, 15:1–17.