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The Cultural Turn In Sociology: Can it Help Us Resolve an Age-Old Problem in Understanding Decision Making for Healthcare?

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Abstract

Culture has long shaped individuals' response to problems. A classic puzzle in the sociology of health and illness is discrepancy between theory and research regarding cultural beliefs and medical care service use. "Utilization research," examining individuals' responses to the onset of health problems, has not consistently affected culture on the uptake of formal treatment. While ethnographic research often describes how culture shapes illness behaviors, survey-based studies rarely find significant effects of predispositions once "need" is controlled. In quantitative studies, individuals report supportive treatment beliefs or predispositions to use services but low utilization levels, reinforcing claims about lack of utility of cultural ideologies in health-care decision making. We ask whether innovations in the sociology of culture and cognition provide the theoretical scaffolding to conceptualize and measure culture in health service utilization. Examining data from the General Social Survey, we focus on how approaches to culture might explain the paradox of high cultural predispositions and low actual use. Children with mental health problems provide a comparison between suggestions and endorsements. Suggestions, sources of care offered by individuals in response to a case description without any other social cues, align with new cultural approaches, and are measured by responses to open-ended questions about what should be done for the child described meeting clinical criteria f or ADHD, major depression, asthma, or "daily troubles"). Endorsements, requiring less cognitive work and cultural resistance, align with traditional conceptualizations of culture, and are measured by closed-ended questions that ask respondents to agree or disagree with seeking help from different treatment options placed later in the survey. We find that suggestions reveal cultural predispositions to use services corresponding closely to reported utilization levels; endorsements reveal high, unrealistic cultural predispositions to use services. Further, suggestions are associated with sociodemographics that proxy culture (e.g., race), while endorsements are associated only with perceived need.

Keywords

cognition; culture; mental health; methodology; survey research; utilization, service use, health care

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INTRODUCTION

A classic puzzle in sociology asks whether research findings based on standard measurement strategies are really telling us about the role of sociocultural factors in social life. Specifically, the sociology of health, illness, and healing has been confronted routinely and regularly with claims that cultural factors are not useful in understanding individuals' use of the formal health-care system. By the late 1970s, even some medical sociologists were skeptical about the utility of sociocultural factors except those that revolved around "need" (i.e., actual or perceived "hurt," "bother," or "worry" associated with physical or mental health symptoms) (Wolinsky, 1978). Specifically, in survey-based research, "utilization research" had failed to show a consistent and significant effect of cultural variables on the uptake of treatment.

The puzzle for medical sociologists targets two discrepancies in empirical research. First, the findings from qualitative and quantitative studies differ. Ethnographic research, often employing observational or in-depth interviews of underrepresented minority groups, described in detail how cultural understandings of the causes and cures for problems shaped illness behaveiors (e.g., Clausen and Yarrow, 1955; Fadiman, 1997; Uehara, 2001). Second, even within the quantitative studies, data on the cultural measures themselves stood in stark contrast to reports of actual utilization behavior. That is, when asked about their willingness to access treatment, overall cultural predispositions are very *high* (i.e., most respondents agree). Yet, rates of treatment use for the same problems are consistently *low*, for example, with only one in four persons considered to be "in need" used any type of formal care for mental health problem s (Kessler et al., 2006; U.S. Department of Health and Human Services, 1999).

These discrepancies raise questions about meaning: What do typical or traditional survey measures on cultural beliefs and predispositions capture when asking people whether they or others would/should use formal services for health problems? From the stockpile of findings, either culture really plays no role in shaping the resort to the health-care system or the typical methodological approaches to tapping cultural beliefs need to be rethought. We argue the latter by drawing insights from the "cultural turn" in sociology and proposing that the mismatch between treatment recommendations, predispositions, and actual utilization has more to do with how we ask our respondents about cultural preferences for healthcare than with the salience of culture itself. In essence, current survey research may have under-theorized the role of culture in medical care preferences because we have been asking the wrong questions in the wrong way. In doing so, we have overestimated the "contents" of the public's "cultural toolboxes" and, as a result, underestimated the role of culture in social actions around health and healthcare.

In this article, we offer a first step toward a theoretical and methodological rapprochement designed to increase understanding of the relationship between culture and behavior in the survey framework generally, and for health-care utilization studies more particularly. We draw from recent sociological, psychological, and anthropological perspectives on culture and cognition to understand the connections between research strategies and cultural repertoires (Cerulo, 2010; DiMaggio, 1997; DiMaggio and Powell, 1991; Strauss and Quinn,

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1997; Swidler, 2001, 2008; Vaisey, 2008a,b). We also take lessons from discussions in the 1990s regarding the theoretical meaning and practical ramifications of ordering in health-related survey instrumenttation (Kessler et al., 1994) and from other analyses that questioned the meaning underlying standard measures (Bearman and Parigi, 2004)

Taking advantage of a module on the General Social Survey (GSS) in 2002 that asked respondents about treatment recommendations for children and adolescents *in two different ways*, we may be able to provide some insight into these discrepancies. In essence, given the largely medicalized context of contemporary U.S. society (Conrad, 2007)[3], we argue that cultural differences between people may not lie in whether a person is willing to "endorse" the potential utility of any particular action, but in his or her individual capability to "suggest" action without options being offered. The National Stigma Study-Children (NSS-C), a topical module on the nationally representative General Social Survey (GSS), offers a unique opportunity to compare responses elicited through different measurement strategies based on different assumptions about belief structures. Analyses center on whether the percentage of respondents reporting cultural predispositions to use services for the described child differ under these measurement strategies and, if so, if they differ in the way expected. That is, in line with cultural theory, old and new, do the "endorsements" draw high percentages of respondents to agree (the typical finding) to seek services or percentages more in line with rates of utilization? Further, are "suggestions" and/or "endorsements" associated with sociodemographic characteristics thought to also tap into cultural cleavages? We begin by providing a theoretical justification of the role of culture for understanding how people think about health care providers as well as how different method-logical strategies capture them. The NSS-C data are used to compare levels and correlates of endorsements versus suggestions. We end by discussing the implications of our findings for future theoretical and empirical work on the relationship between culture and social behavior with the goal of improving measurement strategies in survey research that can better map the effect of culture on the actual utilization of health services.

THEORETICAL BACKGROUND

There is a long history of research in the sociology of health and illness that relies on social locations as proxies for culture, regardless of whether survey or ethnographic methods were employed to document the complexity of cultural responses to illness (Pescosolido et al., 1998; Stiffman et al., 2004; Uehara, 200 1; Vera et al., 1998). Both approaches have improved our understanding of cultural groups, especially ethnic and racial minorities that were relatively ignored in the past, but they also present problems. Ethnographic research provides rich and textured views of utilization, but cannot offer generalizable findings of how culture structures lay responses. Conversely, large surveys offer generalizability, but have failed to capture cultural differences, often concluding that "need" (i.e., "appropriate" dimensions of medically relevant severity) is the sole predictor of service use.

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[3] In societies where medical norms are less dominant in structuring people's lives, the gap may not be as large. However, one might argue that modern Western medicine has often been a symbol of the "good" of modernization, even in the imperialistic/colonial era (Berliner, 1985). Early on, Hamnett and Connell (1981) suggested that this results in complex "layers" of beliefs in all societies.

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The Failure to Tap Culture: Traditional Theories, Traditional Measurements

Most existing surveys simply ask respondents closed-ended questions about whether or not they would use a certain provider (e.g., medical doctor, counselor, or psychiatrist) in general or with regard to a described symptom or situation. This way of asking the question implies an inactive approach to measuring culture. It assumes which elements of culture permeate and dominate social life. It also makes strong cognitive assumptions (Di Maggio, 1997). As Gilbert (1991) argues, the rejection of an idea or option commonly held in a social context takes more effort than its acceptance. Those who reject the possibility of a practitioner or practice under this method are likely to hold strong negative preferences, but those who respond positively to a particular practice or practitioner may represent a mix of those who actually value the treatment option and those who are simply not strongly opposed to it. Thus, this approach tends to m ark what is *not* valued by an individual or social group. However, it fails to distinguish between value and indifference.

Accordingly, traditional survey strategies may operationalize the classic view of culture, more closely aligned with Geertz's (1973) definition of “culture as meaning.” Closed-ended questions, which we refer to as “endorsements,” reflect only the larger cultural value put on different providers by respondents. They represent a passive approach to measuring culture from the viewpoint of contemporary theories. As a result, the high endorsement of formal medical providers traditionally found in studies of behavioral preferences are not only to be expected but are more likely to reflect the general commitment to the scientific medical model in Western societies than any store of cultural knowledge or willing-ness to actually do something that may rationally follow from them (i.e., actually use services).

This measurement strategy may have “worked” in eras of contested medicine (Starr, 1982), but current realities in the United States largely reflect medicalized realities (Conrad, 2007). The general public has more or less accepted modern medicine as appropriate for providing solutions to a wide array of problems, including children's mental health problems. It makes sense, then, that asking individuals in a survey format if they or others should or would use services would produce high levels of agreement; and, as a result, not be particularly useful in separating those who actually use services from those who do not.

This is further com pounded by the layout regularly used in health survey research, where treatment preferences are frequently asked after a series of question s that may imply the relevance of or the need for a modern medical framing. Past research on epidemiological issues in mental health has suggested that individuals do “learn” during the process of an interview and may alter their responses accordingly (Kessler et al., 1994; Regier et al., 1998). In our case, when prefaced by questions that ask about severity, attributions of genetics and biology as well as character, or evaluations of the situation as indicating a disease or disorder, it may trigger a schematic organization that cues expected responses tied to the acceptability of or support for formal health-care options.

The “Cultural Turn” and the Need for Different Measurement Approaches[4]

More recent conceptualizations see culture as more complex – less shared, more fragmented, and used strategically by individuals as they engage in social action. Referred to as the

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"cultural turn" (Bonnell & Hunt, 1999; Hunt, 1984; Sewell, 1980) in sociology, this perspective looks to variation in beliefs, attitudes, and predispositions as critical to understanding individual choices. Swidler's (2001) conceptualization of culture suggests different health care options, such as use of a medical doctor or counselor, are thought of as a resource that individuals hold or not in a cultural toolbox. Asking respondents to volunteer possible responses reflects healing strategies that individuals have in their cultural repertoire.

Accordingly, questions that simply ask respondents what they or others would or should do if they confronted the described scenario require them to offer options. We refer to responses to such open-ended questions as "suggestions" and argue that they reflect what people "know" (repertoire) and are more aligned with what people might "do" as a result of ideological structures in which they are embedded. Because open-ended questions represent a more active approach to measuring culture, and require more deliberative processing, responses to these questions line up more with contemporary sociological views of culture. Further, notions of fragmentation reinforce the idea that actual toolkits, rather than sociodemographic proxies, are required to understand contemporary culture and its influence on social action. It becomes important to understand what is *in* individuals' repertoires and to socially differentiate individuals with rich cultural toolboxes from those with more limited ones. For example, an individual who suggests only a medical doctor has a more limited toolbox than one who suggests the use of a medical doctor, psychiatrist, and counselor. While socio-demographic characteristics may no longer be useful as cultural proxies, understanding whether cultural repertoires are constrained by membership in social groups remains an important task.

Cultural Expectations for Endorsements and Suggestions

In sum, "endorsements" and "suggestions" reflect two different representations of culture and require respondents to call on different information-processing mechanisms. *Endorsements* tap into larger cultural values because they are offered in a schematic context that implies a medical problem, requires only a passive stance, and represents a low-level cognitive task (automatic cognition). *Suggestions* tap into individuals' repertoire or cultural toolboxes because they more accurately portray what individuals face in the real world-a set of behaviors, without cues as to their origin or meaning. With no labels, the schema is not imposed, requiring an active search of cultural options known to and/or supported by the respondents, and represents a higher-level cognitive task (deliberative cognition) (DiMaggio, 1997).

If this conceptualization is accurate, then data comparing responses collected under these two strategies should reveal certain regularities. On the one hand, reflecting larger medicalization processes in advanced societies, *endorsements* should show that a majority of respondents see some value in formal services when directly asked after questions about

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[4] We do not refer to the open-ended question as a "new" strategy given its long history of use in social science interviews and questionnaires. However, given the increasing cost of fielding nationally representative surveys (e.g., in 2006, the GSS was estimated to cost $14,000 a minute, not including the expense of coding open-ended responses), there is resistance to using open-ended questions. In addition, health surveys designed outside of social science (e.g., medicine, public health) rarely, if ever, include open-ended questions.

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medical/social attributions, perceived severity, and likely impact of medical treatment. On the other hand, reflecting knowledge stored in individuals' toolkits, *suggestions* should reveal lower population predispositions and be closer to actual utilization rates. Based on this, the Endorsement/Suggestion Hypothesis (H1) is: The overall percentage of individuals offering suggestions is lower than the overall percentage of individuals offering endorsements with the former more closely matching typical utilization rates.

Finding Culture in Social Location

It is important to accurately portray cultural tendencies to seek help from medical "advisors" (Pescosolido, 1991) of service use, in and of themselves; however, inaccurate measures may also lead to either under- or overestimated associations between theorized factors. For example, as Bearman and Parigi (2004) found in a somewhat similar case, the relationship between gender and discussion networks has more to do with how men and women define important matters than real gender differences. In our case, research relying on the traditional operationalization of endorsements may have suppressed the role of cultural proxies in action and predisposition (i.e., use and tendencies to use) in help- seeking in two ways.

We agree with early network researchers that social location, at best, serves as a crude proxy for cultural location (White et al., 1 976), but most survey research using the traditional approach fails to even find consistent modest or small relationships between the most basic cultural proxies (e.g., race/ethnicity) and behavioral recommendations for healthcare. Yet, some regularities have emerged that set the list of most relevant proxies to be considered. Previous studies of lay beliefs and preferences show that the elderly appear to be less likely to endorse treatment than younger people (Angermeyer et al., 1999). Younger individuals may have larger and more diverse cultural toolboxes regarding mental health treatment (Swindle et al., 2000). While women are more likely to receive treatment for mental health problems than are men (Greenley and Mechanic, 1976; Kessler et al., 1981; Veroff et al., 1981), some studies suggest that women are also more likely to endorse treatment than are men (Angermeyer and Matschinger, 1999) but others find no significant differences (Angermeyer et al., 1999; Furnham, 1997). Findings on race are mixed. African American s report a greater willingness to use services but a greater suspicion of some available treatments (e.g., psychoactive mediations) (Schnittker et al., 2000), and prefer medical doctors or counselors over psychiatrists (Schnittker et al., 2005). Finally, research on preferences related to education and income also reveal mixed results (Angermeyer et al., 1 999; Schnittker et al., 2000).

Taken in the context of our earlier discussions of culture, such findings on the relation-ship between social location, cultural predispositions toward, and actual use lead to our second hypothesis, the Culture Proxy Hypothesis (H2): Suggestions are more likely to be associated with cultural differences based on social location than endorsements. More specifically, if endorsements reflect larger cultural value, they are less likely than suggestions to be associated with cultural cleavages such as age, gender, race, and education.

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“Need” as Control—As noted earlier, research has concluded that “need” is the single best predictor of health services use (Green ley and Mechanic, 1976; Pescosolido et al., 2008; Portes et al., 1992). Such results evoke a classic rational actor model where only the relevant dimensions of the medical situation are relevant to what individuals consider in their decision making (Parsons, 1951). A service need hypothesis (H3) must be considered in any analysis, if not as an explanatory factor, then as a necessary control: Perceived/evaluated need is associated with both endorsements and suggestions.

The Case: Children's Mental and Emotional Problems

Recent decades have witnessed a dramatic shift in the social and medical construction of children's emotional and mental health problems. Children who previously were considered “bad” are now considered “sick” (Conrad, 1975, 2007). The earliest onset of depression is no longer considered to be late adolescence or early adulthood. Routinely, children are diagnosed with ADHD by five years of age, and autism by three, both with the hope that, under current neuroscience theories of brain plasticity, even earlier “identification” and treatment will facilitate “recovery” (Anderson et al., 2008). Stimulant medications for ADHD and the class of selective serotonin reuptake inhibitors (SSRIs) for depression are recommended effective treatments for symptoms. In addition, social skills training or cognitive behavioral therapy (CBT) provide approaches to counter “deficits” (U.S. Department of Health and Human Services, 1999, 200l). However, both the medicalization of and response to behavioral “problem s” in children and adolescents is contested in U.S. culture. Public concerns allege that ADHD simply reflects contemporary intolerance to let “boys be boys” (Will, 1999), that overly ambitious parents and students are requesting stimulant medications to provide a cognitive advantage in academic contexts for “normal” children (Diller, 1996), and that the ready access to medications like Ritalin and Adderall increase their misuse as recreational drugs among teens (Diller, 1996). Further, there is considerable controversy over appropriate treatments and the influence of both medical culture and insurance reimbursement, both of which are thought to push medication strategies over counseling or other “talk therapies” (McLeod et al., 2004).

Similar concerns arise with regard to the conceptualization and response to depression in children. In fact, our previous analyses of data from the General Social Survey indicate that Americans react to “depression” in children and adolescents as more serious, more in need of treatment, and more stigmatizing than similar but age-appropriate clinical descriptions for adults (Perry et al., 2007). Sociologists suggest that the medicalization of “sadness” in contemporary society represents a uniquely U.S. cultural phenomenon (Karp, 1996). Others argue more forcefully that U.S. psychiatry's repackaging of human differences and problems as biomedical disease subject to psychopharmaceutical intervention has homogenized a profile of mental illness across cultures and, in essence, “created” mental ill ness, replacing other cultural schemas that did not have long-term stigmatizing consequences (Watters, 2010).

Despite all the social and medical differences from adult mental health concerns, the same mismatch appears in research between apparent cultural beliefs regarding children's issues and service use. That is, a large proportion of Americans endorse service use for children

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with mental health problems (McLeod et al., 2007; Pescosolido et al., 2008), yet only a minority of children experiencing mental health problem s receive services (Burns et al., I 995; Kenny et al., 2002). Research on service use among children with mental health problems indicates that "need" plays an important role in predicting services. Yet, only 40% of children defined as seriously emotionally disturbed receive services (Burns et al., 1995). Studies that include less severe mental health problems report even lower levels of utilization, with depression seen as more serious and more in need of formal health-care services than ADHD (Kenny et al., 2002; Pescosolido et al., 2008). That is, parents' perception of the severity of the problem increases likelihood of services (Wu et al., 2001). With regard to sociodemographics, girls are more likely to receive professional help than are boys, African-American children are less likely to receive help than white children. More specifically, for children diagnosed with ADHD, research has found few sociodemographics related to these preferences (McLeod et al., 2007) or their associations to be complex and inconsistent (Pescosolido et al., 2008).

Based on past research, then, we tailor the analyses to the situation of child and adolescent problems by considering sociodemographic factors that may differentiate respondents in terms of their social location (age, race, gender, education, and income), "need" (type of problem presented; evaluated severity), and child's characteristics (age, race, gender) (Stiffman et al., 2004). Since children do not decide on their own service use, but are guided into it by parents or other adults in their lives (Stiffman et al., 2004; Costello et al., 1998), the general attitudes of adults toward services use for children, rather than children's views themselves, set the cultural context.

DATA AND METHODS

The National Stigma Study-Children (NSS-C) provides a unique opportunity to explore cultural differences in responses stemming from two methodological approaches in survey research. Data come from the 2002 General Social Survey (GSS) ad ministered by the National Opinion Research Center (NORC). The GSS is a nationally representative face-to-face survey of noninstitutionalized U.S. adults, conducted between February and June 2002. The 2002 GSS-NSS-C averaged 90 minutes in length and produced 1,393 completed interviews. The response rate was 70.1% and, with the exception of gender, the sociodemographic profile is within sampling error of the 2002 Current Population Survey. We use weights to correct for a potential bias resulting from GSS multistage cluster design (Davis et al., 2002).

Since our primary interest is in treatment predispositions for children's mental health problems, we include only respondents who received mental health vignettes or the "daily troubles" control. Respondents who randomly received a physical health "control" (asthma) were excluded. Respondents with missing values on any of our independent or dependent variables (12.55%) were excluded from the analysis. These two exclusion criteria resulted in an effective sample size of 820.

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Vignettes

Studies of health care utilization preferences typically focus on a specific medical problem, name the problem, and often describe symptoms for respondents. This is problematic since the public has been sensitized to know what “correct” responses are, particularly for stigmatized conditions such as mental illness. To avoid this, the NSS-C followed an earlier vignette-based strategy developed in the 1996 National Stigma Study (Swindle et al., 2000). Vignettes were initially composed by a child psychiatrist, modified for use in a survey framework, and reassessed for clinical fit. Because “cases” are not labeled, it allows respondents to frame the underlying meaning of the scenario.

Two vignettes described children meeting criteria for DSM-IV mental health disorders: (1) attention deficit hyperactivity disorder (ADH D), and (2) major depression. For comparative purposes, a reference vignette described a child experiencing more-or-less routine sub-clinical problems; that is, “daily troubles.” For exact wording of vignettes see www.indiana.edu/~icmhsr.

Measures

Respondents were asked twice during the interview what they would do for a described hypothetical child if they were responsible for his or her care. Immediately after the case was read, respondents were allowed to offer open-ended *suggestions* about appropriate actions. Later, after being asked about severity, likely outcomes, attributions, and utility of treatment for the child's case, they have the opportunity to offer close-ended *endorsements* when directly asked whether they would consult a specific provider. Based on this, we argue that simply agreeing to use a provider offered by a social researcher does not reflect respondents’ store of cultural knowledge, resources, and preferences. To more accurately measure these, we draw from recent theoretical developments.

Endorsement of services is captured with four variables from the set of closed-ended treatment preferences: doctor, hospital, counselor, and psychiatrist. These binary variables were coded 1 if a provider was endorsed; 0 otherwise.

Suggestions of practitioners and services are measured with four variables coded from the open-ended responses. These include: whet her respondents suggested: (1) doctor, physician, pediatrician; (2) the general medical system more broadly (e.g., doctor, clinic, emergency room; “get medical help”); (3) counselor; or (4) the specialty mental health system more broadly (e.g., counselor, psychologist, psychiatrist, mental hospital). The broad and narrow categories were designed to capture respondent variation in the open-ended responses. The original verbatim responses were provided to the authors by the GSS, approved, independently coded by two trained coders, checked for reliability by the field director of the Indiana Consortium for Mental Health Services Research, and disagreements corrected by the authors.

Independent Variables

The means and standard deviations as well as the metric and descriptive statistics for independent variables are provided in Table 1. Three variables capture respondents’ reports

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of perceived need: the condition itself (ADHD, depression as binary variables with daily troubles as omitted category), perceived severity, and how respondents labeled the problem – as a mental illness, physical illness, both, or neither.

We focus on seven sociodemographic variables describing GSS respondents: age, gender, race, family income, education, marital, and *parental status.* In addition, three child characteristics randomly assigned to each vignette were also coded as binary variables: *gender*, *race,* and *age.*

Analyses

We first examine weighted frequency distributions from closed-ended questions *(endorsements),* comparing these to frequency distributions from the open-ended question *(suggestions).* Weighted binary logistic regressions compare correlates of both sets of behavioral preference questions. We focus on the similarity or difference in significant correlates across the three sets of analyses (i.e., closed-ended; narrow open-ended; and broad, open-ended responses). Overall goodness-of-fit statistics for the models are reported, and for individual effects, logit coefficients, associated tests of statistical significance, and odds ratios are provided.

Finally, we present a more specific examination of whether the sociodemographic correlates of cultural preferences are statistically different across *suggestion* versus *endorsement* measurement options. Here, our focus is restricted to the subsample of respondents who endorsed a specific option in the closed-ended question. We code respondents as 0 if they only *endorsed* that option, but as 1 if they previously *suggested* as well as “endorsed” that option. As would be expected given the high frequency of positive responses to closed-ended questions, there were no respondents who initially mentioned an option but rejected that option when offered later. Thus, in this final analysis, we have a direct comparison of individuals who spontaneously suggest an option compared to those who only endorse it upon specific prompting.

RESULTS

Table 2 presents the public's treatment predispositions for children with mental health problems that are assessed by the two different measurement strategies. Four results stand out in this table. First, as expected, the percentage of Americans who “endorse” specific options when offered is high. A large proportion of respondents (more than three-quarters) indicate that if the child were theirs, they would seek doctors, counselors, or psychiatrists. Only the hospital stands out as an exception; but, for depression, nearly half endorse even this option. Second, the percentage *endorsing* care *across* the vignettes differs. Just over half (54.3%) endorse a doctor even for the child with “daily troubles;” many more do so if they received the ADHD (83%) or depression vignette (91.2%), a hierarchy also evidenced in responses to the open-ended question. Third, when asked to actively offer options, respondents mention both medical and mental health options. However, overall, only 17.3% suggest a doctor visit, while fewer than one-quarter suggest talking to a counselor. For A DH D, only 22.3% suggest a physician. More do so for depression, with a counselor as the most frequent option offered. Fourth, and most important for our concerns, the percentages

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of suggestions differ, often dramatically, from endorsements. For example, while almost all Americans endorse use of a counselor for the child in the depression vignette, fewer than half suggested this possibility on their own. Similarly, while 83. 1 % endorse a doctor for the child with ADHD symptoms, less than a quarter suggested this possibility. These results clearly support the *Endorsement/ Suggestion Hypothesis*, showing that while a large proportion of Americans endorse treatment options for children experiencing mental health problems, many fewer can actually suggest these same treatment options.

Table 2 presents the weighted binary logistic regression analysis focusing on comparing suggestions and endorsements from the general medical system and its providers. Two results are notable. First, the patterns for endorsing a doctor *as compared to* the patterns for suggesting a doctor or the medical system differ. The only factors separating those who *endorse* a doctor from those who do not target “need,” and some of the effects are larger than those seen with suggestions. Respondents who see the situation as more serious, only as a physical illness, or as both a mental and physical illness were significantly more likely to endorse a doctor. Respondents who received the depression vignette were also more likely to endorse the use of a doctor. No respondent or child sociodemographic characteristic was associated with endorsing a doctor. These results, in line with typical findings in utilization research, support the *service need hypothesis* and attest to the utility of this data set to address our more nuanced questions.

Second, the correlates for *suggesting* general medical care, whether narrow (i.e., doctor), or more broad (i.e., contact with the medical system), are similar to each other and, importantly, different from the findings of endorsement analyses. African-American respondents were significantly less likely to suggest a doctor or the medical care system. Further, parents were two and a half times more likely than nonparents to suggest medical options (e.g., clinics, “get medical care”), but not specifically a doctor. Finally, respondents who received a vignette describing a girl were less likely to suggest a doctor. While the findings are not consistent across the board, this provides at least some support for the *Culture Proxy Hypothesis* by showing that social demographics that do not matter for *endorsement* come into play when cultural predispositions are based on *suggestions.* However, like the earlier *endorsement* analyses, “need” plays a role.

Individuals who rated the situation as more serious, as well as individuals who believed the condition is both mental and physical, were more than two times as likely to suggest medical options. Compared to respondents receiving the “daily troubles” vignette, individuals who received the A DHD vignette were significantly more likely to suggest the medical system.

Table 4 presents parallel weighted results for the specialty mental health system and providers. While no sociodemographic characteristics were associated with endorsing a counselor, older individuals were less likely to suggest one, as were respondents who received a vignette describing an African-American child. Without overstating the findings, they do provide some, even if limited, support for the *Culture Proxy Hypothesis*.

The effects of assessments of the child's situation and perceived need are more complex. Respondents who see the child's situation as more serious are almost twice as likely to

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suggest counselors and/or suggest the mental health system. Similarly, those who view the situation as more serious and those who see the problem as mental illness, physical illness, or combination of both were more likely to endorse a counselor. However, only respondents receiving the depresssion vignette were significantly more likely to suggest a counselor or the mental health system, but no more likely to endorse a counselor than those who received the “daily troubles” vignette. Despite these complexities, the findings support the *Service Need Hypothesis.* Further, individuals who received the ADHD vignette were nearly three times more likely to suggest the mental health system.

The results thus far reveal some differences between those who only *endorsed* the use of services when offered and those who *suggested* such treatment on their own. Table 5 further explores those differences. This analysis includes only those respondents who endorsed a medical or mental health option, examining the sociodemographic differences between those who only endorsed an option and those who both endorsed and suggested an option.

The key sociodemographic difference between those who suggest and those who endorse the general medical system is race. Specifically, African Americans were significantly less likely than whites and others to suggest either a doctor or the medical system more broadly. In addition, parents were almost three times more likely than nonparents to suggest the use of the medical system, perhaps given their familiarity with the routine medical visits required for children but, paradoxically, not more likely to specifically suggest a doctor. The results for the specialty mental health system show that older individuals were less likely to suggest a counselor. Other sociodemographic characteristics are not significant.

As a direct comparison of endorsements and suggestions, this analysis provides the most direct support for the *Culture Proxy Hypothesis* by showing significant differences based on age, race, and parental status. If endorsements reflect larger cultural values, we argued that they should be less likely than suggestions to be associated with cultural cleavages such as age, gender, race, and education. While not found with each and every sociodemographic variable considered, this is indeed the case. More notable is the total absence of correlates regarding endorsements.

DISCUSSION: INCORPORATING CULTURE INTO SURVEY RESEARCH

In this article, we addressed the troubling but consistent finding that reported cultural preferences in general and for healthcare in particular seem unrealistic and relatively useless in marking cultural receptivity to different options for solving social problems. Finding high reported levels that respondents would seek out institutional solutions in population-based surveys is not uncommon. In the case of healthcare, when faced with a hypothetical illness scenario for themselves or another person, individuals are likely to agree that a physician, a clinic, or some other form of formal healthcare should be or would be sought. Yet the glaring discrepancy between levels of endorsement and the low levels at which individuals actually receive services for mental health problems (e.g., one in four or five children “in need ”) (U.S. Department of Health & Human Services, 1999) led many to consider cultural beliefs and attitudes as no longer useful in researching and understanding decision making for health problems. Given the “cultural turn” in sociology, such findings led us to doubt the

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ability of such questions to measure cultural context or to tap cultural variations among population groups.

Overall, our findings do not indicate that large-scale surveys are incapable of capturing the cultural climate for health-care utilization. In fact, behavioral predispositions to use services (i.e., “What *would* you do? Would you visit a physician in this situation?”) can be understood as components of culture, but their location in the survey or interview, as well as *how* they are asked, is critical. Designed in traditional ways, research instruments (including some of our own) often place utilization preferences or intentions late in the interview sequence, after more epidemiological sections used to determine or describe medical problems. If respondents do *learn* through the interview process, by the time interviewers ask about treatment options, many may have been led to agree. In the National Stigma Study-Children, many did. In this case, what distinguished those who supported possible sources of advice or treatment from those who did not were “rational” issues of evaluated need (i.e., severity) for the child or adolescent.

Recent theoretical innovations in sociological and social science approaches to culture suggest to us that such closed-ended questions on the willingness to use health services placed after others that cue respondents tap into what individuals value. Closed-ended questions that list possible health-care providers or practices, and ask only whether a respondent agrees about an option's potential utility, require only a passive posture on the part of respondents and access only automatic processing. These “endorsements,” as we referred to them, do not require the same cognitive digging into one's “cultural toolbox.” At least implicitly, the list of possible options, coupled with questions that typically precede the list (e.g., attributions, severity), hint at a medical frame. Responses obtained from this passive reporting reflect larger, dominant cultural values toward the efficacy of modern medicine. In sync with classic approaches to culture, such measures target tacit agreement and are unlikely to line up with the actual use of services.

However, at the beginning of the NSS-C module, immediately after the scenario with no research-imposed “leads,” respondents were asked to offer suggestions in an open-ended format. Questions placed directly after a hypothetical scenario offer no clues or cues to respondents; rather, they require respondents to actively search for possible options and to engage in deliberative processing. These “suggestions,” as we refer to them, are more likely to reveal a catalog or toolbox of possibilities that individuals carry cognitively and, on a larger scale, reflect collective cultural differences in the repertoire of available and appropriate strategies. Mentions of formal, institutional providers were lower and more in line with actual utilization rates, and the correlates of treatment predispositions reflected key fault lines of culture (e.g., age, race, parental status). Finally, we show that the importance of need appears to be greater for endorsements than for suggestions, implying that traditional approaches may overestimate the importance of need and underestimate the role of various social and cultural factors. These insights represent a limited first step toward considering culture and survey research in new theoretical and methodological ways. Our data are not on actual use or decision making, but on cultural predispositions. Yet, we argue that it is an important step. Recent policy calls to understand health and illness behavior “in context,” especially for disadvantaged minority groups (Smedley et al., 2002), only increase the need

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to reconsider the conceptualization and measurement of the cultural evaluation of medical resources that individuals, theoretically, have at their disposal when confronted with a health problem. As Cerulo (2010) recently reminded us, sociologists such as Mannheim, Berger and Luckman, Cicourel, Bourdieu, and Zerubavel have long suggested the important role of cognition in social behavior and of sociologists' unique contributions to conceptualize and examine it as a relational phenomenon (also DiMaggio 1997). What we have examined may be a look at individual "habitus" as a subjective aspect of culture.

Five specific limitations are notable. The NSS-C targeted substantive questions that have methodological implications, but not strict methodological ramifications. It was not expressly designed to set up an experiment in survey methods, but to examine individuals' help-seeking tendencies. We cannot separate out the specific influence of question format versus question placement because earlier placement occurred with the open-ended format, while later placement occurred with the forced-choice responses. Further, the findings do not support or refute any particular studies of children's mental health care utilization (e.g., Kelleher et al., 2000). In addition, the NSS-C targeted only two of a number of mental health problems that children experience, leaving open to question how the public would respond to other mental health problems (e.g., obsessive compulsive disorder, conduct disorder). Similarly, we have not taken into account the larger health-care context in which our respondents are situated. Although the GSS allows identification and linking to the regional level, this is not sufficient to answer critics who would argue that all of these data are shaped by the health-care markets and neighborhoods in which our respondents live. Finally, as a study of public attitudes, we cannot directly examine the link between culture and behavior for individuals who actually face the possibility of child and adolescent mental health problems.

Nevertheless, our findings suggest that design changes, even large-scale surveys, offer a promising start for integrating new conceptualizations of culture directly into research on how individuals respond to the onset of social problems. While engendering slightly greater field time and higher back-end costs, strategically placed open-ended questions may be able to capture whole cultural systems, avoiding the use of weak proxies and reflectors of dominant medical values. To move the survey forms a step beyond would require an approach that includes if and how subjective reports mirror network cultures, both shaping and transforming the process of social influence; and to a dynamic approach that addresses concerns with when automatic cognition gives way to deliberative cognition, or when decision making based on habitus turn into rational choice (Heimer, 2001; Pescosolido, 1992).

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Table 1

Descriptions, Weighted Means, and Standard Deviations of Independent Variables: National Stigma Study-Children (2002 GSS; *N* = 820)

Variable	**Description**	**Metric**	**Mean**	**SD**
Condition Characteristics[+]				
ADHD	Symptoms of person in vignette	0 = other vignette; 1 = ADHD	.30	.46
Depression	Symptoms of person in vignette	0 = other vignette; 1 = depression	.36	.48
Seriousness	Response to “how serious would you consider [name's] problem?”	1 = not at all serious; 4 = very serious	2.97	1.11
Mental illness	Recoded variable measuring whether R believes that [name's] condition is only a mental illness	0 = no; 1 = yes	.16	.37
Physical illness	Recoded variable measuring whether R believes that [name's] condition is only a physical illness	0 = no; 1 = yes	.14	.34
Mental and physical illness	Recoded variable measuring whether R believes that [name's] condition is both a mental and physical illness	0 = no; 1 = yes	.29	.45
Sociodemographics				
Age	Respondent's age	Years	44	16
Female	Respondent's sex	0 = male; 1 = female	.55	.50
Black	Respondent's race	0 = white; 1 = black	.15	.36
Education	Respondent's education	Years	13.58	2.77
Family income[++]	Respondent's family income	Tens of thousands of dollars	5.38	4.10
Married	Respondent's marital status	0 = not married; 1 = married	.55	.50
Parent	Respondent's parental status	0 = not parent; 1 = parent	.74	.44
Female character	Sex of vignette child	0 = male; 1 = female	.49	.50
Black character	Race of vignette child	0 = white; 1 = black	.51	.50
14 years old	Age of vignette child	0 = 8 years old; 1 = 14 years old	.49	.50

[+] Omitted categories are “nor mal troubles” (condition in vignette), neither mental nor physical problem (label of condition), and white (race).

[++] Income values are based on midpoints of GSS response categories.

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Table 2

Weighted Comparison of Americans' Endorsement of Specific Sources of Help and Their Suggestions for Sources of Help for Children Experiencing Mental Health Problems: National Stigma Study-Children (2002 GSS, *N* = 820)

	Overall		**"Daily Troubles"**		**ADHD**		**Depression**	
	% Endorse (1)	**% Suggest (2)**	**% Endorse (3)**	**% Suggest (4)**	**% Endorse (5)**	**% Suggest (6)**	**% Endorse (7)**	**% Suggest (8)**
General Medical System								
Doctor	76.4	17.3	54.3	3.1	83.1	22.3	91.2	26.2
Hospital	22.8	.7	7.8	.00	16.5	.5	42.4	1.5
Other medical provider/place	---	7.5	---	1.6	---	9.0	---	11.7
Mental Health System								
Counselor	77.9	23.0	52.2	5.5	84.2	20.3	96.2	41.4
Psychiatrist	62.0	3.9	34.1	.0	63.5	3.4	86.6	7.9
Psychologist	---	3.5	---	.0	---	3.6	---	6.6
Other mental health provider/place	---	5.3	---	.4	---	11.5	---	4.7

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Table 3

Weighted Binary Logit Regression of Endorsement of Doctor and Suggestion for Doctor or Medical System on the Characteristics, Attributions, and Beliefs about the Condition, and the Sociodemographics of the Respondent and Vignette Child: National Stigma Study-Children (2002 GSS, $N = 820$)

	Suggesting Doctor		**Suggesting Medical System**		**Endorsing Doctor**	
	b	**Odds Ratio**	**b**	**Odds Ratio**	**b**	**Odds Ratio**
Characteristic of Condition						
ADHD	.83	2.29	.90*	2.45	.47	1.60
Depression	.45	1.57	.55	1.73	.80*	2.24
Seriousness	.93*	2.54	1.00*	2.71	.39*	1.48
Only mental illness	.60	1.83	.25	1.29	.43	1.54
Only physical illness	.62	1.86	.63	1.87	1.55*	4.69
Both mental and physical illness	.83*	2.30	1.08*	2.95	1.75*	5.74
Sociodemographics						
Age	−.00	1.00	−.00	1.00	.00	1.00
Female	−.06	.94	−.08	.93	−.33	.72
Black	−1.36*	.26	−1.10*	.33	−.08	.92
Education	−.07	.93	.01	1.01	.03	1.03
Family income	−.02	1.00	.01	1.00	−.02	1.00
Married	−.07	.94	−.11	.90	.31	1.36
Parent	.52	1.68	.92*	2.50	−.27	.76
Female character	−.44*	.64	−.38	.68	.08	1.09
Black character	−.28	.76	−.38	.68	−.10	.90
14 years old	.24	1.27	.12	1.13	.18	1.20
Constant	−4.62		−5.80		−.95	
Wald chi-square	75.70		129.00		108.80	
	$p \leq .05$		$p \leq .05$		$p \leq .05$	
Cragg and Uhler's R^2	.19		.24		.21	

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[*] Significant at the .05-level.

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Table 4

Weighted Binary Logit Regression of Endorsement of Counselor and Suggestion for Counselor or Mental Health System on the Characteristics, Attributions, and Beliefs About the Condition, and the Sociodemographics of the Respondent and Vignette Child: National Stigma Study-Children (2002 GSS, *N*= 820)

	Suggesting Doctor		**Suggesting Medical System**		**Endorsing Doctor**	
	b	**Odds Ratio**	**b**	**Odds Ratio**	**b**	**Odds Ratio**
Characteristic of Condition						
ADHD	.62	1.85	1.04*	2.83	−.19	.83
Depression	1.38*	3.96	1.49*	4.43	.46	1.58
Seriousness	.68*	1.97	.69*	1.99	1.02*	2.78
Only mental illness	−.03	.97	.63*	1.88	1.39*	4.01
Only physical illness	.06	1.06	.21	1.23	1.27*	3.55
Both mental and physical illness	.14	1.15	.81*	2.25	1.61*	5.00
Sociodemographics						
Age	−.01*	.99	.00	1.00	.00	1.00
Female	−.05	.95	−.05	.95	−.14	.87
Black	.17	1.18	−.08	.92	−.18	.83
Education	.00	1.00	.01	1.01	.03	1.03
Family income	.04	1.00	.05	1.00	−.02	1.00
Married	.09	1.10	−.18	.84	.21	1.24
Parent	.36	1.43	.10	1.11	−.32	.73
Female character	.27	1.30	.34	1.41	.20	1.22
Black character	−.47*	.62	−.20	.81	.11	1.12
14 years old	.02	1.02	.20	1.22	−.10	.91
Constant	−4.19		−4.78		−2.32	
Wald chi-square	117.76		164.14		156.88	
	$p \leq .05$		$p \leq .05$		$p \leq .05$	

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	Suggesting Doctor		**Suggesting Medical System**		**Endorsing Doctor**	
	b	**Odds Ratio**	**b**	**Odds Ratio**	**b**	**Odds Ratio**
Cragg and Uhler's R^2	.17		.24		.36	

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[*] Significant at the .05 level.

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Table 5

Weighted Binary Logit Regression of Suggestion for General Medical System and Specialty Mental Health System- Subset of Respondents Endorsing Doctor (*N* = 629) or Counselor (*N* = 639): National Stigma Study-Children (2002 GSS, *N* = 820)

	Endorsing Doctor				**Endorsing Counselor**			
	Suggesting Doctor		**Suggesting Medical System**		**Suggesting Counselor**		**Suggesting MH System**	
	b	**Odds Ratios**	**b**	**Odds Ratios**	**b**	**Odds Ratios**	**b**	**Odds Ratios**
Age	−.00	1.00	−.00	1.00	−.01*	.99	.00	1.00
Female	−.06	.94	−.09	.91	.02	1.02	−.01	.99
Black	−1.29*	.28	−1.09*	.34	.25	1.28	−.03	.97
Education	−.06	.94	.03	1.03	.00	1.00	.01	1.01
Family income	−.03	1.00	.01	1.00	.04	1.00	.05	1.00
Married	−.18	.84	−.20	.82	.10	1.11	−.19	.83
Parent	.56	1.76	1.04*	2.82	.31	1.36	−.03	1.03
Constant	−3.87	5.3	−5.22	.4	−3.02	11.5	−3.52	
Wald chi-square	55.27		92.92		60.42		81.27	
Cragg and Uhler's R^2	.14		.18		.10		.15	

[+] All models control for vignette condition, vignette characteristics, seriousness of condition and the label assigned to the condition.

[*] Significant at the .05 level.