Meaning and Structure in Research in Medical Anthropology

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ABSTRACT: In an earlier paper (Dressler, 2001), I suggested that medical anthropology as a research enterprise could not ignore either meaning or structure in human social life in the production of health. Rather, drawing on the early work of Bourdieu, I argued that we need to take into account both how the world is configured by the collective meanings we impose upon it, as well as the social structural (and physical) constraints on our behaviour that exist outside those meanings. Human health can be understood, in part, as the intersection of meaning and structure. Here, my aim is to extend this perspective in three ways. Firstly, I present an expanded theoretical framework within which collective meaning and social structure can be conceptualised. A useful theoretical framework must take into account paradoxical features of culture, including the seeming contradiction that it is a property both of social aggregates and of individuals, and that, ultimately, social structural constraints external to individuals depend on shared meaning. Secondly, I review recent research employing this perspective conducted in Brazil, the southern United States and Puerto Rico. These studies have all employed a ‘structural-constructivist’ theoretical orientation, using especially the concept of ‘cultural consonance’, or the degree to which individuals incorporate shared meaning into their own beliefs and behaviour. Where individual efforts to attain a higher cultural consonance are frustrated by structural constraints, poor health results. Thirdly, I consider some of the policy implications of this perspective. While much work in traditional public health focuses on a highly individualised notion of meaning (as in ‘health beliefs’), it seems unlikely that the health of populations can be altered substantially without taking into account the structures that constrain individual action.

KEYWORDS: Puerto Rico, Brazil, USA, human health, medical anthropology, meaning, social structure, policy

Introduction

The history of anthropological theory, indeed of all social-scientific theory, can be understood in part as a tension between what Boudon (1988, 751–761) refers to as ‘holism’ and ‘individualism’ or what Bourdieu (1988, 780) refers to as ‘structuralism’ and ‘constructivism’. Boiled down to the basics, the holist or structuralist sees human behaviour as constrained by forces outside the control, if not the understanding, of individuals. The constructivist or individualist sees human behaviour as a function of how individuals impose a meaningful structure on the world around them and then behave in accordance with how they understand the world to be, regardless of how it might be structured and differentiated outside of their understanding.
Few anthropologists are likely to be purists in this regard, but rather pragmatists. Outside of theoretical pronouncements, most ethnographers appear to shuttle back-and-forth between perspectives, depending on the demands of their data and what they are trying to explain. Bourdieu, principally in his earlier writings, is one of the few theoreticians to try to grapple with this dualism directly and to incorporate it into his conceptual apparatus. In a passage that I particularly like, he referred to himself as either a ‘structural-constructivist,’ or a ‘constructivist-structuralist’ (1995: 123). That is, individuals cannot help but be constrained by their social position, no matter how marginal and powerless they might be nor, on the other hand, how central and powerful. At the same time, individuals behave in accordance with their personal understanding of socially-shared representations of the world. Innovation, creativity and improvisation occur, to be sure, but they occur within the context of existing social arrangements and collective representations. To account for human behaviour, Bourdieu argued, requires that this intersection be acknowledged and examined carefully.

Some years ago I (Dressler, 2001) argued that anthropologists interested in processes of health and healing should pay particular attention to Bourdieu’s thinking in this regard. The intersection of culture, health and healing is a distinct case in anthropological research, because medical anthropologists are faced with subject-matter in which meaning is encased, as it were, in a specific biological structure. It is true that much useful research in medical anthropology can proceed without reference to the biological structure of humans. Similarly, considerable research on that biological structure proceeds without reference to the systems of shared meaning we call ‘culture’. But, I have argued that eventually, regardless of the specific aim of the research, explanation and understanding confront whichever side of this dichotomy is left out. Furthermore, it is a false dichotomy, because to be human is to be a particular kind of organism that exists in a system of a shared meaning. Our biology is not immune to that shared meaning, and that shared meaning is shaped, in part, by our biology.

My aim in this paper is to examine more closely and extend the line of thought that I began in the earlier paper. As I noted then, I am not arguing merely that studies guided by each orientation are useful; rather, like Bourdieu, I am arguing that both structure and meaning must be taken into account for an adequate description of human affairs. At the same time, some complications are involved in developing such a structural-constructivist account, not the least of which is that within human societies constraining structures are themselves usually dependent on systems of shared meaning. Somehow, shared meaning gets translated into social structures that seem as if they are physical structures. This is a fundamental issue addressed by all theorists working in this area, but their solutions have often led to a critique of sociological reductionism (see Sayer, 1999 and Crossley, 2001). Yet there are other ways out of this dilemma, and these will be explored, along with related theoretical issues, in the following section of the paper. I shall then turn to a review of some empirical work guided by this theoretical orientation. Finally, some of the applied and policy implications of a structural-constructivist orientation will be considered.

A Structuralist-Constructivist Orientation

John Searle (1995; 2006), in his account of the construction of social reality, makes a useful distinction at the outset between ‘observer-independent’ phenomena and ‘observer-dependent’ phenomena. A mountain glacier is an observer-independent phenomenon. It exists as a function of the intersection of a set of elements and conditions quite separate from an
observer’s perception of it. This is not true of a screwdriver. A screwdriver is obviously a hard, durable object, but it exists as a result of the imagination of an observer, presumably someone needing to drive a screw. In any sense of the term, both a mountain glacier and a screwdriver are ‘real’, but they both exist in the world as a function of different processes. The mountain glacier exists as a function of a set of geophysical laws; the screwdriver exists because its users say so.

Much, though not all, of human social life is obviously observer-dependent. To be married, to work at a job, to worship a god, or to visit a healer are all actions that depend on prior definitions of phenomena known as marriage, work, religion and health care delivery. Yet, as anthropology has so ably documented, all of these institutions are quite arbitrary. At different times, in different settings, they may take different forms. At the same time, despite being observer-dependent, these institutions have considerable causal potential in the world. Violating others’ expectations with respect to behaviour associated with any of these institutions can lead to consequences ranging from the merely uncomfortable to the dire.

Searle’s concern over the past forty years has been to work out how these observer-dependent phenomena can have such powerful causal potential when, ultimately, they all depend solely on language. For a relationship to be termed a marriage, it has to conform to a particular definition of what we understand a marriage to be. Searle (1995: 43–48) refers to these as ‘constitutive rules’, because they define a valid instance of, for example, a marriage, an act of worship or a screwdriver. Constitutive rules are the building blocks of much of human social life because they create the world around us. Of course, as Tylor (1871) pointed out in the 19th century, they only can create the world around us if we agree that, in fact, a particular instance of something really counts as that thing.

Consequently, the combination of these constitutive rules and a consensus around them constructs human social life. Up to this point Searle presents what seems to be a relatively straightforward constructivist account. At the same time, however, he argues that human social institutions are also real, or ‘objective’, in the sense that their causal potential exists outside the conscious awareness of any particular actor (Searle 2006). This can occur in a number of ways. Some cultural constructions are institutionalised via the power of the state to wield legitimate force to ensure that norms are followed. Other cultural constructs are not institutionalised so forcefully, but nevertheless carry considerable causal potential due to their being shared so widely. With extensive sharing of expectations of behaviour, an individual’s range of options for action becomes hemmed in by what Bourdieu (1984: 244) refers to as a ‘social space’ created by these intersecting meanings. To act in a way contrary to such expectations is to violate the laws of social geometry.

Searle’s analytical philosophy is a useful background to a structuralist-constructivist anthropological theory. Constitutive rules are the elementary building blocks of human social life, but to understand human social life we have to understand the properties that emerge as these elementary units are combined into ever more complex structures. The orientation in culture theory I find most useful is derived from contemporary developments in cognitive anthropology (D’Andrade, 1995). Ultimately, this orientation derives from Goodenough’s (1996) classic definition of culture as that which one must know in order to function adequately in a social group. Contemporary thinking in cognitive anthropology sees this knowledge encoded in the form of cultural models or schemas (D’Andrade, 1995: 122–179). These are skeletal, stripped-down outlines identifying the salient elements of a particular cultural domain and the relationships among those elements. This gives cultural models one of their key properties, namely, their efficiency and flexibility. For example, we may share a cultural model for small-scale economic transactions. Our under-
standing of buyers and sellers, goods and money, enables us to perform transactions ranging from the purchase of socks to the purchase of pet iguanas, and despite the difference in precise content, the schematised model guides us smoothly through the transaction. Details will vary (e.g. buying a used car requires a more complex set of interactions than buying a pizza), but these can be accommodated within the boundary conditions set for the model. Overall, the cultural model guides our behaviour and enables us to effectively interpret the behaviour of others.

Of course, for cultural models to be useful, they must be shared. While terms such as ‘sharing’ and ‘consensus’ are used (appropriately) in relation to cultural models, ‘distributed’ is a much better term (Sperber, 1985). That cultural models are distributed within social groups does not imply that everyone knows them completely, nor even that there are not whole segments of a social group that dispute all or part of a model. A cultural model may be widely understood without contention; a cultural model may be narrowly distributed, but still with little contention; a cultural model may be widely shared and hotly contested; or, a cultural model may not be well-articulated and hence subject to varying interpretations. These are all empirical questions and in turn may alter the implications of a model for the members of a society, but the point is that a theory of cultural models is a useful way of conceptualising culture.

A common, but mistaken, criticism of cognitive theories of culture over the years has been that such theories smack of psychologism or reductionism (e.g. Geertz, 1973: 87–125). It is true that a cognitive theory of culture locates culture in the minds of individuals, because not to do so leads to complex and ultimately insurmountable ontological problems. At the same time, the distributive quality of cultural models extends the locus of culture to the group level (Dressler 2007: 183). Culture is the knowledge that constructs the world around us on the basis of a shared understanding that this is, indeed, the world and the way it works (D’Andrade, 1984). Individuals are variably able to reproduce that group knowledge, based on their own socialisation and their position in the social structure. Given the incomplete nature of any individual’s knowledge, the overall structure of the environment of meaning within which social life proceeds is a function of how shared knowledge is distributed across individual minds. Culture is, therefore, both a property of individuals and a property of aggregates.

My argument thus far has been that a theory of cultural models is a useful way of understanding how humans construct the world around them, and how the world around them takes on the characteristics of an observer independent phenomenon. One more theoretical step is necessary to enhance the utility of this framework. As Bourdieu (1988: 782–783) has reminded us, perhaps more than anyone else in recent years, people do not just know and think things, they do things as well. Cultural models are self-motivating; at the very least, cultural models provide an initial roadmap for action in any given situation. This does not mean that every individual will be successful in the eyes of the world in the enactment or performance of that cultural model. There are likely to be degrees to which individuals are able to approximate in their own beliefs and behaviour the prototypes for belief and behaviour encoded in cultural models. I refer to this approximation as ‘cultural consonance’ (Dressler, 2007; Dressler, Santos and Balieiro, 1996).

In a series of studies we have found low cultural consonance in a variety of domains to be associated with higher blood pressure, chronic systemic inflammation, body composition and depressive symptoms.

Understanding these associations depends on the structural-constructivist perspective just outlined. Individuals share an understanding of the world and the way in which it works as this is encoded in cultural models. As they attempt to implement this prototypical under-
standing in their own lives, they often will face barriers, not the least of which are in place because of institutionalised, structured inequalities. Enacting cultural construction collides with social structure, the result being a chronic psycho-physiological stress that leads to adverse outcomes. The empirical basis for these claims will be selectively reviewed in the next section.

Cultural Consonance and Health Outcomes

Studies of cultural consonance and health outcomes have been conducted in Brazil, the African-American community of the southeastern United States and the Caribbean. In the following I shall review some of the results of each of these studies to illustrate the empirical utility of this perspective.

Brazil

Our first study of cultural consonance in Brazil was conducted in 1991 in a city in the state of São Paulo (Dressler, Balieiro and Santos 1997, 1998, 2002). This research was initiated using a related, but somewhat different model. That model was a more conventional psycho-social stress model, but implemented in such a way as to take into account special characteristics of a society undergoing economic development. Specifically, we were examining the inconsistencies between an individual’s economic status and his/her material aspirations to a particular lifestyle (defined in Bourdieu’s (1984) sense of accumulating socially valued material goods and engaging in leisure activities). Our inventory of goods and activities was large enough to take into account potential differences by social class in material aspirations, but nevertheless, one question bothered us: how could we be certain that members of different social classes actually shared a lifestyle model, especially in a society as highly stratified as that of Brazil? Similarly, in keeping with the stress model, we hypothesized that access to help and support from others could moderate a stressful inconsistency between lifestyle aspirations and economic status. Yet how could we be sure that a cultural model of social support was shared throughout the community under investigation?

Of course, this problem was hardly unique to our research, but is rather one that has plagued traditional ethnography. Our interviews with key informants and our observations of social life convinced us that we were on the right track, but we sought a more systematic confirmation of these ethnographic observations. At this point, we resorted to the (then) relatively new cultural consensus model (Romney, Weller and Batchelder, 1986). Conceptually, the consensus model is straightforward. Ask a relatively small set of informants to evaluate a set of statements about how things are done in their community (e.g., which lifestyle items are valued? Or, who is an important potential source of social support?). The more that these informants (selected, of course, to sample major dimensions of intra-cultural diversity) agree with one another, the more reasonable it is to infer that they are all working from a single cultural model. Conversely, the less they agree, the more likely it is that a cultural model is not well-articulated, or that there may be more than one cultural model, or the model may be contested. All of these possibilities can be assessed using the cultural consensus model, and within the consensus model degrees of agreement among informants can be quantified.

We found, somewhat surprisingly, that across a socio-economically diverse set of key informants in an urban Brazilian community, there was considerable agreement concerning what kind of lifestyle represented a culturally-defined ‘good life,’ and what kinds of supporters were likely to be asked for help in relation to common problems of varying severity (Dressler, Santos and Balieiro, 1996; Dressler, Balieiro and Santos, 1997). It was at this point that our thinking shifted from the conventional stress model to what I now refer to as a theory of cultural
consonance. Given this broad sharing of an understanding of lifestyle and social support, what about those individuals who, in their own beliefs and behaviour, do not match that understanding very well? Such individuals would be living at the margins of the space of cultural meaning that defines their world. This could be problematic in two ways. First, given the broad sharing of the model, the individual unable to enact that model might also suffer the chronically stressful psychological state described by Antonovsky (1981) as a lack of ‘sense of coherence’. Antonovsky defined a sense of coherence as the belief that, under the circumstances, things were working out as well as could reasonably be expected. But in the case of low cultural consonance, things are not working out in accordance with expectation. Secondly, even if an individual herself, in her own personal model of the world, rejected a larger, shared cultural model, she would still be subject to the evaluations of others in mundane social interaction. As Veblen (1899) pointed out many years ago, the importance of lifestyle in mundane social interaction is that it enables us to project into that interaction a claim to a particular social status. Even if we valiantly reject the way in which we are being evaluated by others, that lack of social confirmation can take a toll (see de Botton, 2005 for a recent discussion).

We tested these hypotheses using arterial blood pressure as an outcome. Blood pressure rises precipitously in response to stressful experiences. Repeated reactivity over the long term can result in sustained high blood pressure. In an epidemiologic survey of blood pressure, we operationalised cultural consonance in each domain, asking individuals if they owned the items or engaged in the behaviour collectively identified as important with respect to lifestyle in the cultural consensus analysis, and we asked them if they would seek social support in a way described in the cultural consensus analysis. We found that individuals who were low in cultural consonance in lifestyle and cultural consonance in social support had higher blood pressure than persons higher in cultural consonance, after controlling for relevant co-variates (Dressler et al., 1997, 1998).

Additional hypotheses were formulated, employing the concept of cultural consonance to address other issues. For example, in the western hemisphere, there is a strong association between darker skin colour and higher blood pressure (Dressler, Oths and Gravlee, 2005). Persons phenotypically identified as being of African descent have higher blood pressure and higher rates of essential hypertension than individuals of European descent. The argument has raged over the racial-genetic versus the socio-cultural basis for this association. Brazil is an interesting context within which to examine the association. It is well-known that there is greater variation in both phenotypical skin colour and the terms used to describe skin colour in Brazil than there is in the U.S. There is also a phenomenon known as ‘embranquecimento’, or ‘whitening’. This is usually used in the phrase, ‘money whitens’ (Harris, 1964: 59). That is, persons who are of phenotypically African descent in Brazil are treated in social interaction literally as being less ‘black’ if they are also of higher social status. If higher cultural consonance in lifestyle truly represents a way of claiming a culturally-valued status in mundane social interaction, then cultural consonance should moderate the association of skin colour and blood pressure. This is actually what we found (Dressler, Balieiro and Santos, 1999). Afro-Brazilians have substantially higher blood pressure than European-Brazilians; however, Afro-Brazilians with high cultural consonance in lifestyle actually have lower blood pressure than European-Brazilians (see Fig. 1, relevant co-variates controlled for).

These findings are consistent with the hypothesis that Afro-Brazilians experience on a regular basis racist social interactions in which their stigmatised and under-valued skin colour places them in a position of lower status; however, if their presentation of self demonstrates a high cultural consonance with widely shared
understandings of how life is to be lived, this can fundamentally alter the nature of the social interaction, making it less stressful, the end result being fewer episodes of blood pressure reactivity and, in the long run, lower blood pressure.

In a follow-up to this research we initiated a new project in 2001. This project had three aims. The first was to improve the measurement of cultural consonance, principally by carrying out a much more extensive cultural domain analysis prior to developing measures for use in epidemiologic surveys (Dressler, Borges, Balieiro and Santos, 2005). The second was to extend an examination of the effects of cultural consonance to additional cultural domains and additional health outcomes (Dressler, Balieiro, Ribeiro and Santos 2005, 2007a; Dressler, Oths, Ribeiro, Balieiro and Santos 2008). And, the third was to examine the effects of cultural consonance longitudinally (Dressler, Balieiro, Ribeiro and Santos 2007b). Briefly, more extensive methods of cultural domain analysis lead to an improvement in the measurement of cultural consonance. The basic findings regarding the association of cultural consonance in lifestyle, cultural consonance in social support and blood pressure have been replicated. We discovered new associations with other health outcomes, including both immunological status and body composition. We also found that changes in cultural consonance over a two-year period are associated longitudinally with depressive symptoms.

**The Southern United States**

Findings from the Brazil study informed a study of cultural consonance and blood pressure in the African-American community in Alabama (Dressler, Bindon and Neggers, 1998; Dressler and Bindon, 2000). As noted above, African-Americans are at much higher risk of high blood pressure than European-Americans. Our aim in this study was to determine: (a) if there were widely shared cultural models of lifestyle and social support in the community; and (b) if lower cultural consonance in each of these domains was associated with higher blood pressure.

Our cultural domain analyses were based on a long-term ethnographic study of the black community of a small U.S. Southern city (population approximately 85,000, 35–40% of whom were black). With a small sample of key informants, we asked people to rate the importance of a variety of material goods and leisure activities with respect to having a ‘good life’. We also asked them to rate the importance of different kinds of persons as potential sources of social support in response to a variety of common problems. As in Brazil, we found broad consensus within each domain. Some of the cultural differences with respect to the Brazil study were also interesting. For example, in the cultural model of lifestyle, the item ‘achieving a leadership position in your church’ was rated as very important in the African-American community, reflecting the importance of religion and the church in organizing everyday life in the Southern black community. Similarly, the nuclear and extended family were regarded as central sources of social support for every kind of problem, while sources of support from outside the family tended to be associated with specific kinds of problems. In Brazil, the nuclear
and extended family were more strongly associated with socio-emotional problems, while relationships outside the family were associated with practical or instrumental problems.

Again, data were collected on blood pressure in an epidemiological survey in the community. Cultural consonance was operationalised by determining how individuals' own behaviour matched the cultural models in each domain. Higher cultural consonance in each domain was associated with lower arterial blood pressure (net of standard controls; Dressler and Bindon, 2000).

It is important to emphasize that, in the domain of lifestyle, the cultural model for the African-American community does not describe a lifestyle of conspicuous consumption. Quite the contrary, the lifestyle described is one of domestic comfort and middle-class propriety (hence the item dealing with the church as a part of lifestyle). This was also the case for both studies in Brazil. Given this fact, why is there such variability in individuals' abilities to attain the lifestyle? When the structural position of the African-American community in the overall system of racial and economic inequalities is taken into account, the basis for this variability becomes clear. Nearly one-third of persons in the community live at or below the poverty level. Unemployment rates tend to be twice those of the white community. Median household income is about 60% of white household median income. There is a persistent gap in hourly wages and the economic return on investment in education. In other words, the economic resources required for attaining even the modest lifestyle that is collectively valued in the community are limited. Yet, the representation of this lifestyle is widely shared. Cultural construction collides with structural constraint resulting in a chronically stressful circumstance that can only be partially moderated by the supportive bonds of social relationships.

Given the social construct of race in the United States versus Brazil, it would be more difficult for cultural consonance to overcome the stigmatizing effects of skin colour in American society; nevertheless, we also explored this in these data. For one community sub-group, men aged 25–44, there is an interaction between cultural consonance in lifestyle and blood pressure (see Fig. 2). Lighter-skinned men tend to have lower blood pressure overall in this age group.

For darker-skinned men, blood pressure declines dramatically as their cultural consonance increases. As in Brazil, I would argue that this is the case because persons with higher cultural consonance embody (in Bourdieu’s sense of the term) that status in mundane social interaction, especially with whites, making those interactions less acutely stressful. Specifically, where African-Americans embody their achievement of a middle class status in mundane interactions, the whites with whom they interact will behave less in terms of the cues of social status transmitted by skin colour, and more in terms of cues of social status transmitted by cultural consonance. The result will be a less stressful social interaction.

**Puerto Rico**

The work of Gravlee and his associates in Puerto Rico is also relevant here (Gravlee, 2005; Gravlee, Dressler and Bernard, 2005). Gravlee was interested the association of skin colour
and blood pressure, but he modelled the attribution of skin colour in a much more systematic way. In both the Brazilian and U.S. studies, we had observer-interviewers assigning skin colour. In Brazil, we used common terms from everyday speech to assign skin colour, while in the U.S. we simply had interviewers rate skin colour on a 5-point scale from light to dark. In both cases, these ratings were intended to capture a sense of how the respondent would be viewed in mundane social interaction.

Gravlee approached skin colour (or color in Spanish) as a cultural domain. To do so, he elicited the terms used to describe skin colour in a free-listing task. He then had a sample of key informants pile sort images of faces varying in skin colour and a number of other characteristics (e.g., hair) and found that resulting categories varied primarily as a function of skin colour. Furthermore, three overarching categories dominated: blanco (or white); trigueño (literally ‘wheat-coloured’); and negro (or black). When informants were asked to sort faces in terms of these three categories, there was a strong consensus among them (Gravlee, 2005).

Next, Gravlee carried out an epidemiological survey in a small city on the south side of the island. In addition to blood pressure, he assessed phenotypical skin colour in three ways. He and a research assistant assigned the respondents to one of the three skin colour categories derived from the cultural consensus model of color. This represented how respondents would be perceived by others in mundane social interaction. He also asked respondents to rate their own skin colour. And finally, he used skin reflectometry to measure the actual amount of light reflected by the skin (darker skin colour reflects less light). When analysed in relation to blood pressure, the skin colour category assigned by the observers based on the cultural model of skin colour was associated with blood pressure in interaction with socio-economic status, controlling for relevant co-variants and skin reflectance. That is, for persons classified as blanco or trigueño, as socio-economic status increases, blood pressure declines. For persons classified as negro, increasing socio-economic status is associated with higher blood pressure (see Table 1).

While the study of Gravlee, et al. is broadly consistent with the framework being presented here—in the sense that blood pressure is again a function of the intersection of cultural construction and social structure—it also appears paradoxically to contradict the other two studies. That is, in the other two studies, increasing cultural consonance in lifestyle blunted the association of darker skin colour with blood pressure. In Puerto Rico, the association of darker skin colour with blood pressure is enhanced by higher socio-economic status. This is paradoxical in that, unsurprisingly, cultural consonance in lifestyle increases with increasing socio-economic status. The biggest difference among these studies is that there is little ambiguity regarding the meaning of the measurement of cultural consonance in lifestyle in Brazil or the African American community in the Southern U.S.A. Key informant interviews defined important components of lifestyle; cultural consensus analysis confirmed the shared understanding of the domain; and, in the epidemiologic survey, cultural consonance in lifestyle was assessed precisely in relation to the cultural domain analysis of lifestyle. While the cultural domain of color was examined in precisely this way in the Puerto Rican study, we do not know as precisely what socio-economic status signifies in this community. That is, in this Puerto Rican city, what

### Table 1: Systolic and diastolic blood pressure by categories of color and socio-economic status in Puerto Rico

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<thead>
<tr>
<th>Categories of socio-economic status:</th>
<th>Categories of color:</th>
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<tbody>
<tr>
<td>Low</td>
<td>Blanc/Trigueño</td>
</tr>
<tr>
<td>Moderate</td>
<td>128.4/83.5</td>
</tr>
<tr>
<td>High</td>
<td>123.1/79.7</td>
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<td></td>
<td>117.8/76.0</td>
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<td></td>
<td>127.5/80.5</td>
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<td></td>
<td>137.2/84.0</td>
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<td></td>
<td>146.8/87.6</td>
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Source: Adapted from Gravlee, Dressler, and Bernard 2005
exactly does it mean to be simultaneously negro and of higher socio-economic status? One hypothesis is that this actually increases the likelihood of stressful, racist encounters in the workplace and in residential areas. Regardless of the precise interpretation, however, these results provide intriguing avenues for future research.

Discussion

The aim of this paper has been to elaborate some earlier suggestions for theoretical development in medical anthropology, and to illustrate the utility of this perspective for research on health outcomes. Following Bourdieu (1990), I refer to this as a ‘structural-constructivist’ perspective, based on his arguments that to understand human behaviour requires the analysis of the intersection of social structure and cultural construction. This can hardly be an alien notion to most anthropologists, since many implicitly incorporate this scheme in their own research in any event. Aside from Bourdieu, especially in his earlier work, there has been surprisingly little formal development of this as a research orientation (although see Giddens, 1984 and Bhaskar, 1989). As I have argued (Dressler, 2001), research on culture, health and healing is a special kind of topical area in anthropology that virtually demands the integration of these perspectives.

The development of the cultural constructivist side of this orientation is relatively straightforward. Some kind of constructivist perspective has been implicit in virtually all forms of culture theory since the inception of anthropology as a field of study, since our main aim is, after all, to document how diverse peoples carve up their worlds differently (Kuper, 1999: 227). Developments in cognitive anthropology over the past twenty-five years have been particularly useful for refining this framework. ‘Cognitive anthropology’ and ‘cultural constructivism’, spoken in the same breath, will strike some anthropologists as odd, but a cognitive orientation has always been concerned with the discovery of the systems of meaning that people impose on the world around them (D’Andrade, 1984; 1995). Cognitive anthropology has become less strictly tied to the linguistic theories that inspired ethno-semantics (Bloch, 1994). The more flexible construct of cultural models enables a cognitive orientation to incorporate a broader range of processes by which people construct meaning. Additionally, theory and method in cognitive anthropology have enabled the approach to deal more effectively with persistent problems involving the culture construct, not the least of which are understanding intra-cultural diversity and understanding the relationship of the individual to the aggregate. The ability of a cognitive orientation to deal with these problems attests to its strength and flexibility.

Another persistent issue in culture theory has been the relationship between culture and behaviour. Some theorists have argued that behaviour should be included in the definition of culture (Harris 1979). A cognitive cultural constructivist perspective, on the other hand, clearly defines culture as the knowledge that individuals share. But as Sapir (1949) pointed out long ago, there are elements of behaviour that can been seen as being more directly organized in relation to shared cultural models, and this is what I refer to as ‘cultural consonance’. Cultural consonance is clearly a construct that describes the performance of cultural models in mundane social interaction.

As Bourdieu (1988) has argued, cultural constructs are partly a function of the position of individuals in the social field, while at the same time structuring that social field. The issue then becomes one of conceptualising the social structure. On one level, social structure is created by the distribution of expectations of behaviour that are encoded in shared cultural models. When these models are strongly shared and widely distributed, such expectations can become a potent structuring force. At the same
time, cultural models need not be widely shared throughout a society in order to be potent forces in creating structure. We have evidence, for example, that changing concepts of food and health in Brazil are a function of the adoption of ideas among socio-economic elites, with a kind of ‘cultural trickle-down’ effect occurring (Newkirk et al., in publication). Even though lower-class groups do not share this model of food and health as strongly among themselves or with the elites, expectations for their behaviour are changing. Finally, of course, social structure appears in ‘bricks-and-mortar’ form as social expectation becomes institutionalised and codified in law and public policy, something that often obscures its origins in a cultural construct. My point, however, is that, even though social structure is a function of observer-dependent cultural construction, it assumes the causal status of observer-independent structure.

Understanding human behaviour in general, and human health in particular, thus requires that we examine how shared cultural constructs, realised as cultural consonance in behaviour, meet social structure. This perspective has been illustrated here with studies from Brazil, the African-American community of the southern United States and Puerto Rico. These studies have shown that a variety of health outcomes are associated with cultural consonance. They have emphasized the cultural domains of lifestyle and social support, principally because these are how broader constructs of status distinction and affiliation are culturally constructed in contemporary societies. Results from the United States and Brazil show that lifestyle is culturally constructed in terms of broadly shared models of a domestic comfort and middle-class propriety. But however modestly lifestyle is conceptualised, economic marginality prevents some individuals from being able to enact that lifestyle, the result being a chronic sense of exclusion from their own society. We argue that this is a chronically stressful experience resulting in poorer health. This effect can be moderated if the individual sees himself/herself as able to participate in a culturally-defined set of supportive relationships, but both cultural consonance in lifestyle and cultural consonance in social support are constrained by a person’s position in the social structure.

Cultural consonance in these domains interacts in complex ways with another set of cultural constructs, those surrounding the concept of race. In discussing these results, I used the term ‘race’ with little comment. Elsewhere, we argued that this term is really a rough gloss for the more precise term ‘ethno-racial categories’, since all racial categories are cultural constructs (Dressler, Oths and Gravlee, 2005). Research in the Brazil and the United States discussed here emphasises the notion that race is really culture masquerading as biology. The biological significance of ethno-racial categories can be modified by individuals’ abilities to enact widely shared cultural models in their own lives. The results from Puerto Rico move the concept of ‘the cultural construct of race’ from mantra to operational research model, showing that there is, in fact, a shared cultural model of color that overlaps with objectively-assessed (via reflectometry) phenotypical variation, but this is not explained by that phenotypical variation. Ultimately, the cultural construct of color is more important in understanding health outcomes than is objectively-assessed phenotype. At the same time, however, it is the cultural construct of color only in the context of social structure that matters (although precisely how that works still needs to be sorted out).

Emphasis has been placed in this review on a few dimensions of social structure (mainly socio-economic stratification) and a few cultural domains (lifestyle, social support, race). It should be noted, however, that these domains do not exhaust the reach of a structural-conceptivist perspective. For example, in research in Brazil we extended our studies of cultural consonance to domains as diverse as family life, national character and food (see Dressler, Balieiro, Ribeiro and Santos, 2007a). Interestingly, cultural consonance in the domains...
of national character and food are strongly influenced by socio-economic status, though not cultural consonance in family life which proved to be the strongest predictor of depressive symptomatology during a two-year follow-up period (Dressler, Balieiro, Ribeiro and Santos, 2007b). It appears that cultural consonance in family life is affected by a different set of structural constraints than cultural consonance in other domains, and these are as yet unidentified. This represents another interesting avenue for future research.

Would a structural-constructivist perspective make a difference with respect to public policy and applied work? In its most narrow focus, public health seeks to educate the public regarding health risks and hence influence behaviour. Despite gains in public health education that are modest at best, the approach still remains focused on individuals. At the very least, policy concerns from a structural-constructivist perspective require a three-way focus: on shared understanding in the aggregate; on how individuals do or do not enact that shared understanding in their own behaviour; and, on the structural forces that intervene either to reduce or enhance an individual’s cultural consonance with a shared understanding. For example, in Brazil we have found that individuals who are more consonant in their behaviour with shared cultural models of food also have a lower body-mass index and waist circumference. This association is stronger for women than for men, and those individuals who eat what are considered to be high status or prestige foods have the lowest body-mass index (Dressler, Oths, Ribeiro, Balieiro and Santos, 2008). In other words, this association is less about eating and being healthy than it is about living up to the cultural ideal of a slim body type, an expectation that devolves more strongly on women than men. Changes in Brazilian society over the past twenty years, furthermore, have led to notions of health and prestige in food becoming interrelated. Obviously, individuals from the lower socio-economic strata are less likely to be able afford the healthier, high-prestige foods that are, in turn, associated with lower body mass.

My point here is that a typical public health approach that treats eating behaviour and the risk of obesity as purely a function of an individual’s knowledge of healthy eating or attitudes to nutrition, is uninformed regarding existing shared cultural models of food. In this specific example, there already exists an understanding of healthy eating, and, in many respects, that model converges with professional, public health, scientific models of healthy eating. Recognition of these shared models is omitted from public health interventions, nor is there an appreciation of how these models are further linked to cultural constructs of a good life and the structural constraints on achieving that shared representation of how life is to be lived. Selecting one point for intervention, that of the individual and his/her beliefs, might achieve the intended results, but it seems unlikely. Public health interventions that at least acknowledge the wider set of influences on any health outcome would seem more likely to be successful.

My aim in this paper has been to elaborate a particular perspective in research on culture, health and healing and to review a set of studies guided by that perspective. Thus far, a perspective that examines health as the outcome of the intersection of shared cultural construct and social structure appears promising.

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Acknowledgements: Research on which this chapter is based was funded by the National Institutes of Health, U.S.A. (HL56663), and the National Science Foundation, U.S.A. (BNS9020786 and BCS0091903). These studies were conducted with my long-time collaborators James R. Bindon, Mauro C. Balieiro, Kathryn S. Oths, Rosane P. Ribeiro and José Ernesto dos Santos. At
times in the text I have used both the singular and plural personal pronoun; the latter pays due respect to my collaborators.

Notes

1. Other recent thinkers who have notably addressed this dualism include Giddens (1984) in his theory of ‘structuration’, and Bhaskar’s delineation (1989) of a ‘critical realist’ perspective. I choose to use Bourdieu’s perspective as a starting point here because my aim is not a thorough review of thinking about integrating structure and construction, but rather some suggestions on how to elaborate the perspective, along with some empirical examples of how this might be done in research on culture, health, and healing.

References


Dressler, W., C. Borges, M. Balieiro and J. Santos, 2005. ‘Measuring cultural consonance: Exam-
Dressler, W., J. Santos and M. Balieiro, 1996