



IMPLICATIONS FOR INSTITUTIONS/POLICY ISSUES

Social Determinants of (Un)Healthy Behaviors

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ABSTRACT *Medical education has historically relied on the rational choice model as a vehicle for promoting health behavior change, and has largely overlooked the powerful relationships between social class and health behaviors. The rational choice model, which assumes that people can choose to pursue behaviors that are needed for their health, has some clinical utility, especially in some circumstances, but it runs the risk of missing key sources of influence and of blaming the victim. The biopsychosocial model provides an alternative basis for teaching about health behavior change. Health behavior needs to be understood in a broad social context, in which social class is recognized as playing a large part in shaping many people's health behaviors through multiple pathways, including limited opportunities for self-fulfillment, financial constraints, health beliefs, self-efficacy, stress, and social support. In addition to highlighting the limitations of the rational choice model, we illustrate how to integrate the socio-cultural context into teaching about behavior change. Specific curricular suggestions include exercises for: (1) increasing students' awareness of their own biases regarding unhealthy behaviors and individual responsibility for change; (2) enhancing knowledge of social factors that impact health; (3) building advocacy skills; (4) learning from patients; and (5) practicing counseling skills through role-plays.*

KEYWORDS *Biopsychosocial model, behavior change, education, rational choice, poverty.*

In the closing decades of the 20th century, the public health communities in the US and other industrialized countries increasingly focused their attention on reducing individual behavioral risk factors, including smoking, high fat diet,

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inadequate physical activity, drug and alcohol abuse, and unsafe sexual behavior. These unhealthy behaviors are not randomly distributed throughout the population, but are strongly associated with lower social class. Improved health education is commonly assumed to be one of the key answers to unhealthy behaviors. However, many health education campaigns conducted in industrialized countries have been largely unsuccessful in changing behavior (Sorensen *et al.*, 1998).

We briefly review the evidence linking social class to health behaviors and show why an individualistic, rational choice model is incomplete. We propose a biopsychosocial model as a basis for a fuller understanding of risk behaviors. In this model societal factors are viewed as fundamental contributors that affect behavior through social, psychological, and ultimately biological pathways. We do not dismiss the contribution of personal choice, but are convinced of the need for far more attention to the social determinants of health. Certainly, those who are economically advantaged have a greater range of choices available than do those who are economically disadvantaged, but all people have some opportunities to make choices. Other papers in this special issue deal explicitly with the process of influencing personal choice. We don't dwell on it here. We conclude with curricular suggestions for the education of health providers.

Although our references and discussion focus on Western, industrialized countries, our main themes apply to populations in all parts of the world.

Social Class and Behavioral Risk Factors

If lifestyle and behavioral risk factors were not influenced by societal factors, then they should be randomly distributed throughout the population, without regard to social class. They are not. National surveys conducted in the US and Europe have demonstrated striking gradients in smoking, diet, and physical activity by social class (Marmot *et al.*, 1991; Uitenbroek *et al.*, 1996; Lynch *et al.*, 1997; Lantz *et al.*, 1998). For example, among a representative US sample, Lantz *et al.* (1998) reported statistically significantly higher rates of behavioral risk factors among those with less than a high school education than those with college education: smoking 42% vs. 20%, excessive alcohol intake 4.4% vs. 3.7%, physical inactivity 37% vs. 14%, and obesity 28% vs. 11%. Similarly, lower social class is associated with higher rates of drug dependence (Muntaner *et al.*, 1998), earlier age of first coitus (Bingham *et al.*, 1990), and nonuse of seat belts (Shinar, 1993). Little attention has been given to why lifestyle behaviors are clustered by social class. Instead, research and interventions have focused predominantly on changing individuals' behaviors.

Social Origins of the Rational Choice Approach

Some individual level interventions that attempted to change personal habits had

minimal effect as compared to broad social interventions such as cigarette taxes and bans on smoking in the workplace (Minkler, 1999). Why have most public health interventions focused more on individual behaviors rather than on the social context which influence these behaviors? This emphasis can be understood as a reflection of cultural values in the industrialized West. Anthropologist James Peacock (1994) identifies several core, organizing (Western) values that support an individual, behavioral-based analysis of health, including a belief in rationality, individualism, and self-sufficiency. Running in parallel to the cult of the individual is the erosion of the concept of community in popular imagination, in at least some cultures. With diminished sense of community, the influence of social conditions on individual behavior can become invisible. In this model, success or failure is seen as the property of the individual. Bellah and his colleagues (1996) believe that this approach is played out in class terms, with the rich being considered independent adults and the poor considered dependent children, each with themselves to thank or blame.

This contemporary, Western version of individualism operates in opposition to significant social, economic, and political trends that make individual success—even in maintaining one's health—difficult. Deindustrialization, for example, has reduced the number of well-paying manufacturing jobs in several countries, replacing them with low-paying service and retail employment, which seldom offers the fringe benefits sometimes associated with factory work. That is, there is no provision for health insurance, sick time, or death benefits (Newman, 1994). Policies that encourage the construction of subsidized housing in poor neighborhoods have isolated the poor in enclaves with few services and limited employment opportunities. People's abilities to make choices beneficial to their health are severely compromised by the decreasing number of opportunities available to them, as we explain below.

Rational Choice or Victim Blaming?

The rational choice model on which much public health education is based assumes that people are rational, aware, self-creating agents of their own health who can behave in the pursuit of self-interest (Boudon, 1998; Kaufman & Cooper, 1999; Mutaner & Lynch, 1999). The Theory of Reasoned Action (Ajzen & Fishbein, 1980), the Health Belief Model (Becker *et al.*, 1974), and the Stages of Change Model (Prochaska & DiClemente, 1986) are variations of psychological models of motivation and behavioral change (Glanz & Rime, 1995). In these approaches, which we refer to collectively as "the rational choice model," behavior is seen as a psychological property of individuals who are influenced by consciously chosen goals. For several reasons, we see this model as flawed. First, it places excessive responsibility for health on individuals, neglecting social factors, such as concentration of low-income families in geographically isolated areas, the overrepresentation of minorities among the poor, wage

discrimination against women, and income inequality (Wilkinson, 1996; Farmer, 1998; Adler *et al.*, 1999). The rational choice model doesn't usually ask why some people's choices are limited and others' are not. Choices about nutritious food, for example, are often limited in low-income neighborhoods. With few large grocery stores within walking distance, residents of poor communities typically rely on overpriced mini-marts that seldom stock fresh produce. (We acknowledge that some rational choice models, such as the Health Belief Model, seek to identify all barriers to change, including social barriers.)

Second, the rational choice model often overlooks the context of social relationships in which decisions about behavior are made. For example, poor women's exposure to HIV is not just a matter of too little education about the risks of unprotected sex (Farmer *et al.*, 1996; Zierler & Krieger, 1997). Poor women have limited options. For a woman to say "no" to unprotected sex is to risk losing her partner and with him her food, money, and housing. Poor women must give priority to the more immediate and pressing needs of food, shelter, and safety rather than the less tangible benefits of preventive health behaviors. Moreover, it is not just that the poor have fewer choices in maintaining their health. The well-off also have the power and prestige to avoid risks through better access to protective factors. Link *et al.* (1998) showed a consistent association between socioeconomic status and recent screening for cancer, with a smaller percentage of low-income women being screened for cervical and breast cancer as compared with middle- and upper-income women.

Third, the rational choice model may give more credence to the role of self-awareness or consciousness in human behavior than is warranted. Barch & Chartrand (1999) refer to the "myth of conscious intentional control of behavior," demonstrating the influence of the environment on acts of conscious choice. They argue that unconscious mental processes that are put into operation by environmental factors shape most everyday actions. Not only do many behaviors lie outside awareness, but automaticity (actions done without conscious thought) produces behaviors that sometimes are contrary to intentions. The combination of automaticity and the effects of environmental factors help account for the success of media campaigns in promoting unhealthy behaviors such as cigarette smoking. Far fewer resources are devoted to public health media campaigns endorsing healthy behaviors, and they rarely make such effective use of television, billboards, and magazines. For example, tobacco company Phillip Morris has invested about 40 million dollars in an ad campaign targeting women of color. The ad for Latina women urges, "Dance around naked with a rose between your teeth if you want. But do it like you mean it." The slogan for African American women advises, "Don't let the goody-two-shoes get you down." The ads cleverly appropriate cultural models of self-determination by invoking notions of women's empowerment and freedom to choose. Cigarette smoking in these ads becomes a symbol of women's liberation and independence.

Fourth, the rational choice model does not adequately address the impact of the workplace and economic hardship on individual and family psychology.

Workplace routinization and absence of control undermine an individual's sense of self-determination and cognitive flexibility (Kohn, 1969; Kohn & Schooler, 1969; Kohn & Schooler, 1978; Miller *et al.*, 1985; Ross & Mirowsky, 1992). These effects are not confined to working family members, but reverberate through the entire family. Economic and workplace hardship undermine family interactions and promote detrimental values and unhealthy behavior among affected children (Kohn & Schooler, 1982; Conger *et al.*, 1992; Conger *et al.*, 1994).

If the rational choice model is limited, why has it remained the dominant paradigm in so many industrialized countries? Lindbladh *et al.* (1998) suggest that the rational choice model represents the ideology espoused by—and the personal experience of—members of the dominant class. It provides a rationale for preserving current distributions of power and wealth. By propagating the cult of the individual, it exalts the “haves” for their successful lives while blaming “the have-nots” for their plight. By trumpeting individual responsibility, it focuses on changing individual behavior while ignoring social structures and contexts that promote unhealthy behavior. Thus, the government and society are relieved of responsibility for changing social institutions and public policies.

Integrating Socio-cultural Context into Health Care: Lessons for the Education of Health Professionals

We propose that a biopsychosocial approach to health care can help overcome the limitations of the ways the rational choice model has often been implemented by considering social contributions to the ill health of the poor. George Engel (1977) originally promoted the biopsychosocial model as a way of counteracting what he saw as an overemphasis in medical education and practice on bio-science, to the relative exclusion of the other relevant dimensions. His goal was to understand the human needs of patients within a concentric system of family, community and the environment. In our view, health professions education has too often interpreted the biopsychosocial model as focused on biological and psychological factors, with insufficient attention given to social context. When implemented, this educational approach has produced health providers with enhanced compassion toward individual patients, but insufficient awareness of social causes of disease. Such providers may overemphasize the role of patient's lifestyle choices. A focus on health behaviors can generate negative attitudes, not only about unhealthy behaviors but also about the people who practice them. These negative attitudes may contribute to conscious or unconscious biases about working with the poor, and can interfere with establishing trust and rapport between providers and low-income patients.

There is some evidence to suggest that bias, perhaps operating unconsciously, may contribute to adverse patterns of clinical decision-making based on race or

Table 1. Attitudes towards healthy behaviors and change: increasing learners' self-awareness

I. Increasing learners' self-awareness of attitudes and biases regarding health behaviors and change

Goal: to help learners reflect on their beliefs, values, feelings and biases that can influence their work with patients.

Process: facilitate a discussion of the following.

Step I. Cultural values in society and in medicine regarding health behaviors and providers' responsibilities to help patients change.

Step II. Learners' personal values, attitudes and biases regarding lifestyle behaviors and prevention activities.

Step III. The potential impact of learners' values and biases on their work with patients who engage in unhealthy behaviors that can be barriers or facilitators in patient care.

II. Exploring learners' past experiences with behavioral change counseling

Goal: to help learners reflect on their past experiences in counseling patients regarding behavior change and gain new insights from their successes or difficulties that can improve their work with patients from diverse communities.

Process: facilitate a discussion of the following.

A. Which health behaviors do you believe are most harmful to health of the patients you see?

B. What have been your experiences in helping people change health behaviors, both challenges and successes?

C. What is the social, cultural or economic background of the patients with whom you have had the least success?

D. Do you think your experiences helping patients change has altered (positively or negatively) your approach to patients who ... (smoke, drink, etc.?)

gender (Schulman *et al.*, 1999). In Table 1 we outline an approach designed to increase learners' self-awareness about personal biases around issues of health and personal responsibility. Since biases may lie outside of conscious awareness, a process that supports and guides learners through an examination of relevant beliefs and attitudes can help uncover hidden biases. Particular biases regarding health behaviors may or may not be sanctioned by the larger society and this may facilitate or inhibit their expression. Providers often have strongly held beliefs about the need for patients to adopt healthy lifestyles. In addition, "good" providers are considered those who successfully encourage adoption of these lifestyles by "good" patients.

Changing demographics of the US population (US Bureau of the Census, 1995), the disproportionate burden of illness experienced by low-income and racial/ethnic minority groups (USDHHS, 1991), and the increased competition for shrinking health care resources obligates providers to cultivate skills for working effectively with patients from diverse backgrounds (Like *et al.*, 1996). In March 1996, the US Federal Fifth Circuit Court of Appeals rendered a decision in Hopwood vs. the State of Texas prohibiting the use of race in any manner in higher education admissions and financial aid awards. This decision brought restrictions in the states of Texas, Louisiana and Mississippi. In

November 1996, California voters adopted Proposition 209 that dismantled “affirmative action” programs that colleges, universities, and medical schools had used to remedy past discrimination, and to increase ethnic and racial diversity among students (Cohen, 1997). The reduction in enrollment rates of underrepresented minority students to US medical schools since these events has undoubtedly slowed the progress toward diversifying the health professional workforce (Hawkins, 1997). This situation underscores the need for preparing all medical personnel for working with diverse populations. Well-meaning providers often believe that they can and do provide uniformly high quality care to all their patients regardless of their socio-cultural background (Fadiman, 1997). However, research shows that significant disparities in health and health care exist, and discrimination consciously or unconsciously affects clinical decisions and outcomes (Gemson *et al.*, 1988; Pierce *et al.*, 1995; O’Malley *et al.*, 1997).

Educators need to provide learners with knowledge of the interrelationships between social inequalities, health behaviors, and illness (Muntaner, 1999). Students also need skills for gathering and utilizing socioeconomic information. A biopsychosocial approach that regards patients as experts on the socio-cultural factors influencing their health behaviors offers a way to integrate a socio-cultural context into patient care (Carrillo *et al.*, 1999). Table 2 suggests a framework for developing learners’ knowledge and skills in these areas. This integrative approach also reduces the likelihood that learners will inadvertently stereotype patients. Learners are encouraged to prioritize making a personal connection with patients, and exploring patients’ beliefs and perceptions about their illnesses and their expectations for health care (Kleinman *et al.*, 1978).

Using the framework outlined in Table 2, learners are guided through a series of educational experiences using facilitated small group discussions and role-plays to broaden their knowledge and skills regarding the impact of socio-cultural factors on the health of low-income populations. Advocacy skills are also taught to enable students to actively address social factors that impact the health of low-income patients. Learners are also provided with an overview of the principles and key concepts of motivational interviewing (Miller & Rollnick, 1991), and the stages of change model (Prochaska & DiClemente, 1986). Learners are introduced to approaches for building rapport, exploring the patient’s agenda and concerns, gathering information about the patient’s social context, and negotiating treatment plans. Students learn to gather socially and culturally relevant information from patients to enhance rapport and to tailor counseling messages to patients’ concerns. Students’ skills are reinforced through the use of role-play and feedback.

Conclusions

Given a general cultural orientation towards individualism with its contingent expectations of independence, self-sufficiency, and personal responsibility, it is

Table 2. Building knowledge and skills for integrating a socio-cultural context into patient care

I. *Enhancing knowledge of social context factors influencing health*
Process: students complete recommended readings and participate in a facilitated group discussion on the topics listed below.

- A. Social and political structures.
- B. Economic conditions influencing health.
- C. Cultural values regarding health and illness.
- D. Epidemiology of health behaviors.

II. *Building advocacy skills*

Process: students accomplish one of the tasks below and share their experiences with the group to reinforce their understandings of the social context factors impacting on patients' health.

- A. Assist a low-income resident in accessing available community resources.
- B. Work with a health care provider to identify resources that can improve the health outcomes of a low-income patient.
- C. Work with a community-based public health agency to identify and appropriately intervene in a social or environmental risk to the patient (e.g. lead contamination of the home, undernutrition, school problems).

III. *Implementing motivational strategies with patients from diverse backgrounds: learning from the patient*

Process Step I: provide a brief overview of key principles and approaches of motivational interviewing focusing on building rapport.

- A. General principles of motivational interviewing (Miller & Rollnick, 1991).
- B. Build rapport: get to know the patient as a person; the patient is the "expert" regarding his/her explanatory model and preferences for care. Learners are encouraged to incorporate appropriate questions about the patient's country of origin, beliefs about what caused the health problem, daily routine, or stresses in a role-play interview.

Process Step II: engage learners in an interactive discussion about strategies for gathering key information about the patient's readiness to change, key aspects of the history, and the patient's concerns about behavior change (Prochaska & DiClemente, 1986). Explore cognitive dissonance between the patient's values and current behavior.

Process Step III: build a provider-patient partnership by responding to the patient's expectations for care. Learners are encouraged to incorporate questions about past experiences with the health care system and/or the patient's preferences for treatment in a role-play interview.

IV. *Reinforcing counseling skills through role-plays*

Process: use role-plays that include social and cultural information that is relevant to the health behavior to be addressed in the counseling session.

- A. Create a brief role-play scenario to practice strategies borrowing from faculty or student clinical/life experiences. Essential components: patient's age, health history, social history, cultural beliefs/concerns, medical problems, reason for visit, and health behavior to be discussed.
 - B. Recruit volunteers; assign roles and tasks for the interviewer, patient and observers. Role-play the scenario for about 10–15 minutes.
 - C. Feedback. At the conclusion of the role-play, the participant in the role of interviewer complete a self-assessment of the interaction and their success in using the techniques. The interviewer receives feedback from the participant in the patient role and from the observers.
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not surprising that public health interventions and health professional education practices have stressed behavioral change approaches in addressing health promotion and disease prevention. Research into disease distribution across social classes has largely ignored the social–structural conditions in which lifestyle behavioral choices are made, reinforcing notions of healthy behaviors as the prime determinant of health outcomes. We argue that this individualistic focus on healthy behaviors in research, program design, and health professions education has had limited efficacy in changing health outcomes. Indeed, a large effect has been to blame the victims, most of whom are in low-income groups.

As an alternative, we propose an education approach that integrates socio-cultural factors into a patient-centered approach to health care, resulting in a true biopsychosocial model of care. This framework is designed for teaching students as well as seasoned practitioners. We believe that this integrative approach will encourage practitioners to make efforts to influence both individuals and the larger social context in which they function. Through advocacy and political action, as well as through work with individual patients, they can help improve health outcomes across social classes.

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