Njeri Karanja, PhD, Kaiser Permanente Northwest, discusses providing care to African Americans

Cultural Competence in the Prevention and Treatment of Obesity: African Americans

By Njeri Karanja, PhD

I was a little surprised when I was asked to give this talk because I was trained in nutrition, not cultural sensitivity, and I'm from Africa, not the United States. However, the term 'African American' does have the word 'African' in it, so I agreed. I don't consider myself an expert in cultural competence, so I hope that those of you who work in this area can correct me if needed. However, I have had a chance to work with the African-American population, and, for obvious reasons, I'm passionate about the care that African Americans receive.

I'd like to talk a little about morbidity and mortality among African Americans to explain why we are focusing on this population. The three leading causes of death in the US are coronary heart disease, stroke, and cancer.[1] For each of these conditions, African-American men and women have a higher rate of death than do white men and women.[2] Data are more sketchily gathered for other racial groups, and we'll certainly have a better overall picture once the data are collected. For now, though, we have comprehensive data for whites and blacks.

The Problem of Obesity in the African-American Population

When you examine the risk factors for coronary heart disease, stroke, and cancer, namely overweight, obesity, and inactivity, you find that they are more common among African Americans, particularly women.[3,4] Although the prevalence of obesity is rising steeply for everyone,[4] prevalence of class II and class III obesity is significantly higher in black women.[4] In addition, some conditions appear earlier and in more severe forms in African Americans.[5,6] For instance, hypertension and prostate cancer occur earlier in life and in more severe or aggressive forms in black men than in white men.[5,6]

I reviewed some of the National Institutes of Health strategic plans for addressing disparity in health between diverse racial populations, plans that include studying variation in patterns and biology of disease attributable to race. We are beginning to believe that clinical guidelines and delivery of routine care may need to be adjusted for different racial populations. Dr Arline Geronimus advanced the 'weathering hypothesis'[7] for African-American women, which suggests the deterioration of health earlier than would be expected from chronological age. For example, Dr Camara Jones has shown that the population distribution of blood pressure in black women is different compared with that of white women; blood pressure in 40-year-old black women is the same as in 50-year-old white women.[8] If the weathering hypothesis holds true, it raises important questions about how we interpret data and create clinical guidelines for treatment and care.

Patterns of disease prognosis also differ between blacks and whites. For instance, *incidence* of breast cancer is lower in black women,[9] but *mortality* rate is higher in black women than in white women.[10] One explanation for this discrepancy is that black women seek care later,[10] which may be true. But if, for example, black women's bodies are aging earlier, would it make sense for them to start having mammograms at 30 as opposed to 40? If a black woman asks to have a mammogram at age 35, the response she receives may well be a mark of cultural competence on the part of the clinician, assuming that the weathering hypothesis may be in operation.

Sociodemographic and Philosophical Basis of African-American Culture

I'm not presenting diversity training in the traditional sense but am assuming that you understand the general principles and are ready to provide care to specific populations. One primary recommendation is that you learn the culture of the people coming to you for care. So I've put together some cultural, demographic, and social factors we need to understand to work with African Americans.

First, the African-American population in the US is growing faster than the white population but a little slower than Latino populations.[11] It will double in 50 years and is increasingly diverse due to immigration of people from the Caribbean and Africa.[11]

Although the economic status of African Americans has improved, the majority still live in poverty.[11] Only 33% of African-American households have an income above $35,000 compared with 70% of white households.[11] Unemployment is high. Many African Americans are first-generation middle class[11] and so lack the wealth that has been built by other Americans, primarily through home ownership. If an African-American grandfather couldn't purchase housing in 1909 because of discriminatory mortgage lending practices, enough time has not yet elapsed to develop family wealth. More African-American children than white children have both parents working.[11] Many poor families live in inner cities and are multigenerational, and, in some areas of the country, about 60% of African-American households are headed by women.[11]

African-American culture has African roots and has been shaped by the experience of

Njeri Karanja, PhD, is a senior investigator at the Kaiser Permanente Center for Health Research and a research associate professor of medicine at the Oregon Health Sciences University. Her primary area of research is nutrition and chronic disease prevention, with a special focus on minority populations. E-mail: njeri.karanja@kpchr.org.

slavery, which affects how African Americans relate to other cultures within the US. African-American culture is also influenced by European culture in outward ways, such as by language, clothing, and some cultural practices. However, in terms of inner values, many people who study culture think that African Americans have retained their African roots in three key ways.

… many cultural scholars now believe that the melting-pot theory is impractical and may not be desirable.

First, according to African metaphysics, human beings are part of the whole cycle of existence and do not dominate nature; they are part of nature. Second, a study of the African value system shows that Africans, including those in the diaspora, value relationships and human networks. That value was strengthened by the experience of slavery and is probably responsible for the resilience of African-American families. The third value is what philosophers call epistemology: the study of how knowledge is acquired and who possesses knowledge. In African epistemology, a supreme being is all-knowing. Ancestors, then elders, are next in this hierarchy, and the rest of us are at the bottom.[12,13] This hierarchy has implications for intercultural communications. A young doctor who is well educated may be valued differently than he or she expects; the person who is respected most within African-American culture may be an older woman because of her lived experience, which is considered more important than the formal technical training of the young doctor. Difficult relationships can result if you don't understand this cultural value.

Other aspects of African-American culture include a less rigid perception of time and a highly valued past;[14] you are who you are today because of where you've come from. That's very important and affects how African Americans experience the world. This is not to say that African Americans do not value the future but that they place greater emphasis on the past relative to cultures that originated in Europe.[14]

The legacy of slavery is foremost among African Americans, even though it's very uncomfortable to talk about slavery. It influences their day-to-day living in significant ways. They are the only racial group in America that did not immigrate here voluntarily, and, by their own accounts, they experience all forms of racism in small, continuous, and cumulative ways.[11]

African Americans are often stereotyped negatively as lazy, prone to violence, less intelligent, less patriotic, or dependent on white largesse. Consequently, some dehumanizing economic and noneconomic practices have been adopted within our society that greatly marginalize African Americans. During studies of obesity, we've been documenting presence of fast-food restaurants and liquor stores and lack of grocery stores around playgrounds and recreational areas in black neighborhoods. In my neighborhood, there are many corner stores with expensive, but nutrient-poor foods. Cigarette ads are placed three feet from the ground, and it's a question of who, other than children, is being targeted by these ads. One of the most important findings was in the Institute of Medicine report this year[15] stating that good-quality care is still denied minority populations. In this case, the prototypical minority population studied was African Americans.

Evolving Thinking for More Effective Treatment

My recommendations assume that you practice the general principles of culturally competent care. It's important to understand African-American demographics, psychosocial experience, and the legacy of slavery and to begin to structure ways of relating to African-American patients that they interpret as respectful.

First, accept differences; many cultural scholars now believe that the melting-pot theory is impractical and may not be desirable. Perhaps differences are not a bad thing. Second, we must build bridges among institutions and communities of color, including African-American communities; because of past experience, African Americans don't trust mainstream institutions, including health care institutions. Providing health education is one strategy for building those bridges. African-American focus groups report a knowledge gap about health; and health education is highly valued in these communities. Institutional contributions to community campaigns, such as those to reduce cigarette ads, can help. Inviting community members to serve on advisory boards is another strategy, but one has to keep in mind that although they have a rich knowledge base about their communities and their life experiences, community members may be people of limited material wealth. Offering them paid advisory positions may be a better approach.

I cannot overemphasize how important it is to understand the influence of racial prejudice on the collective psyche of African Americans. We must create an atmosphere that allows staff and clientele to correct inappropriate behavior.

We must also rethink the assumption that African Americans are overly sensitive. When the injuries of racism accumulate, someone may eventually protest, and sometimes protest may occur for a reason that others might consider a minor inconvenience. For an African American, however, the issue may be substantial or perhaps has been faced five times that day. We all make mistakes, but there are some things that are patently offensive. It's important to work with staff and whomever else you need to in order to find out what patients experience in your practice setting.

Another recommendation is to understand the deeper aspects of African-American life. Spiritual life is central and keeps African Americans connected to a highly valued social network. For instance, "I had to go to the funeral of a church member" is a very valid reason for missing an appointment. Understanding how social networks are organized also allows you to use them, because they can be a great source of support for your African-American clients.

My last recommendation is to cultivate authenticity. African Americans often talk about 'being real.' This is different from just going through the professional motions. A young white woman from Arkansas led a lifestyle change intervention group of older black clients for us, and they loved her because they could see how much she cared. She had a passion for changing the world, and they saw it. You gain credibility for trying to be real. ❖

After Dr Karanja's presentation, she and the panel responded to questions from the audience:

Our Kaiser Permanente (Panorama City) population is perhaps 40% Latino and perhaps 5 to 10% African American. There is an impression that Latinos and African Americans are somewhat resistant to losing weight for cultural reasons. Would you agree?

Dr Karanja: When you ask overweight African-American or Latina women whether they'd like to lose weight, they respond as all other women would. They know when it hurts to go up the stairs. However, they may be distracted by life events. I don't think it's that simple—that they like being overweight.

Dr Foreyt: As you go up the socioeconomic ladder, the pressures to lose weight might become stronger.

Dr Dietz: Let me add a comment on poverty's potential relationship to body size. A small but growing body of literature links increased rates of obesity with hunger. Excess weight may have a protective effect, operating as a buffer against food insecurity. We don't appreciate poverty's potential to influence food availability. That's probably not something we ask about when we take a weight or dietary intake history.

Have studies looked at BMI by socioeconomic status across ethnic groups? My hypothesis is that you wouldn't see very much difference. Overweight is probably very prevalent in poor white populations as well. Is that true?

Dr Dietz: In white men, the curve is pretty flat across socioeconomic status. In white women, a reciprocal relationship exists between income and fatness. The curves are flatter in African-American and Latino groups.

It's easy to talk about a culture's liabilities, but culturally competent weight management works when we celebrate culture and its strengths. Successful food programs celebrate traditions, emphasizing the positives.

Dr Karanja: I agree. We can create environments that allow people to revisit their traditions. Instead of having mixed groups during behavioral intervention studies, we've had African-American groups. Sometimes slavery was an important focal point: members talked about how 'we ate that way when we worked in the fields and we can't continue now.' You can hardly discuss food in exactly this way in mixed groups.

Dr Foreyt: In schools, you could bring in elders and teach strategies in which tradition and culture make a big difference. I would always work with the youngest kids possible.

Returning to the clinical setting for a moment, what are the key competencies and skills for our health care professionals? If you had to pick two or three key principles or key activities for us to enhance within Kaiser Permanente, what would they be?

Dr Karanja: Cross-cultural communication would be the key one that I would emphasize. One that comes to mind is interpretation services. Providers speaking through an interpreter should speak directly to the client and not to the interpreter. Another principle is body language. Most non-European cultures are what we call 'high-context cultures,' so they may be listening to what you're saying but they are really watching your actions and behaviors and nonverbal cues a lot more.

Is there anything particular about body language for African Americans, for instance?

Dr Karanja: African Americans are a bit more complicated in that they've had 400 years of "studying" Western ways of communicating. They've had to learn how to listen and act on the basis of what they hear; however, their long-term perceptions about interacting with a given provider may still be shaped more by the actions and behaviors than by the words of the care provider. Communications with people from immigrant cultures benefit the most when you pay attention to body language. Newly integrated people tend not to know how to interpret the spoken word without attention to its context. ❖

References

1. Anderson RN. Deaths: leading causes for 2000. National Vital Statistics Reports 2002 Sep 16;50(16):1-85.
2. United States. National Center for Health Statistics. Health, United States, 2001 with urban and rural health chartbook. Hyattsville (MD); 2001. Tables 37, 39, 67 and 69. Available from: www.cdc.gov/nchs/data/hus/hus01.pdf (accessed April 1, 2003).
3. Schoenborn CA, Barnes PM. Leisure-time physical activity among adults: United States, 1977-1998. Advance Data from Vital and Health Statistics 2002 Apr 7;325:1-23. Available from: www.cdc.gov/nchs/data/ad/ad325.pdf (accessed April 1, 2003).
4. Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among US adults, 1999-2000. JAMA 2002 Oct 9;288(14):1723-7.
5. Flack JM, Ferdinand KC, Nasser SA. Epidemiology of hypertension and cardiovascular disease in African Americans. J Clin Hypertens (Greenwich) 2003 Jan-Feb;5 Suppl 1:5-11.
6. Stephenson RA, Stanford JL. Population-based prostate cancer trends in the United States: patterns of change in the era of prostate-specific antigen. World J Urol 1997;15:331-5.
7. Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. Ethn Dis 1992 Summer;2(3):207-21.
8. Weidenbach K. Violence aside, racism may be harmful to our health. Focus 1998 Feb 6. Available from: http://focus.hms.harvard.edu/1998/Feb6_1998/pubhealth1.html (accessed April 4, 2003).
9. US Cancer Statistics Working Group. United States cancer statistics, 1999 incidence. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control; 2002. Available from: www.cdc.gov/cancer/npcr/npcrpdfs/USCSreport.pdf (accessed April 2, 2003).
10. Li CI, Malone KE, Daling JR. Differences in breast cancer stage, treatment, and survival by race and ethnicity. Arch Intern Med 2003 Jan 13;163(1):49-56.
11. Williams JD, Tharp MC. African Americans: ethnic roots, cultural diversity. In: Tharp MC. Marketing and consumer identity in multicultural America. Thousand Oaks (CA): Sage Publications; 2001. p 165-211.
12. Tempels P. La philosophie Bantoue. Paris: Éditions africaines; 1949.
13. Onyewuenyi I. Is there an African philosophy? In: Serequeberhan T, editor. African philosophy: the essential readings. New York: Paragon House; 1991. p 29-46.
14. Ponterotto JG, Casas JM. Handbook of racial/ethnic minority counseling research. Springfield (IL): CC Thomas; 1991. p 55.
15. Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: confronting racial and ethnic disparities in health care. Washington (DC): Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; National Academies Press; 2003. Available from: www.nap.edu/books/030908265X/html/ (accessed March 18, 2003).