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Cultural Relativism and Cultural Diversity: Implications for Nursing Practice

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Abstract

This article examines the doctrine of cultural relativism in nursing practice.To introduce the issue, an overview of the intellectual history of cultural relativism is presented. The academic themes of the debate surrounding cultural relativism are illustrated with an example of the social controversy in France involving cultural relativism as used to defend the practice of female genital excision among immigrant communities. The dilemma faced by nursing in making cross-cultural judgments is then examined in the light of the academic and social debates. The article concludes with a theoretical resolution of the issue of cultural relativism for nursing practice that is based on hermeneutic philosophy.

Key words: cultural sensitivity, cultural values, culture, female genital mutilation

Cultural relativism is an implicit principle underlying the conceptual approaches developed by nurses to guide cross-cultural caregiving. Borrowed from anthropology, cultural relativism refers to the perspective that the behaviors of individuals should be judged only from the context of their own cultural system. Its proponents argue that it buffers against parochialism, encourages openness to others, and results in flexibility when cultural differences are encountered. But critics have called cultural relativism a nihilistic doctrine that undermines any condemnation of the violation of human rights or of repression in cultures other than one's own. [1] Debates surrounding cultural relativism expose a dilemma that is particularly relevant to nurses as widespread international migration increases cultural diversity in societies throughout the world. A closer look at the issues involved in making cross-cultural nursing judgments is important in today's multicultural context, where the gap between a caregiver and a care recipient's frame of reference may be wide.

This article presents an overview of the intellectual history of cultural relativism to set the stage for a critical examination of the application of the principle in nursing practice situations. The themes of the academic debate will be

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illustrated with an example of a social controversy in France in which cultural relativism has been used to defend the practice of excising female genitalia by several communities of African immigrants in that country. This particular conflict revolves around a cultural practice that has significant consequences for health and is highly incompatible with the values of the contemporary nursing culture. The article examines the dilemma faced by nurses in making judgments in cross-cultural situations in the light of these academic and social disputes. Finally, a theoretical resolution of issues around culturally congruent nursing care is proposed based on hermeneutic philosophy.

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INTELLECTUAL HISTORY OF CULTURAL RELATIVISM

The idea that human judgments are culturally relative is not new. Montaigne, [2] the 16th century French writer, observed, for instance, that each man calls barbarism whatever is not his own practice. And much earlier, Herodotus, in ancient Greece, expressed essentially the same insight when he wrote, "If one were to offer men to choose out of all the customs in the world such as seemed to them the best, they would examine the whole number and end up by preferring their own; so convinced are they that their own usages far surpass those of all others." [3,4] (p57)

But the origins of cultural relativism in its modern form is associated with the American anthropologist Boas and his students Benedict, Herskovitz, and Mead. They developed the concept in the 1920s and 1930s as part of a reaction to the evolutionary theories of cultures that had been dominating their discipline. Evolutionary theorists ranked societies and their customs on the universal principle of technological complexity. In these schemes, the cultures of technologically simple societies were considered to be inferior to those of technologically complex ones. In contrast, Boas focused on identifying the particular traits of specific cultures, arguing that each culture had values of its own by which its progress could be measured. Furthermore, each culture, having focused on certain institutions rather than others, was complex in certain ways and simple in others.

Boas and his students enlisted the concept of cultural relativism to fight racism and racist notions, and "ethnocentricisms" was identified as its opposite. [4] This term referred to the use of one's own culture as the standard to judge other cultures and also to the assumption that one's own culture is superior to other cultures. Thus, underlying their relativism, one finds an implicit moral principle, that of tolerance and respect of the "other." Following the Second World War, this notion of infinite cultural tolerance became problematic. Some anthropologists saw cultural relativism as logically prohibiting any condemnation of the destructive regime in Nazi Germany. In addition, as colonialism declined, a non-Western elite argued that cultural relativism supported a conservative agenda against economic development and technological progress.

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Relativism and postmodernism

In the past two decades, postmodernism has created a contemporary resurgence of intellectual support for cultural relativism. This intellectual movement incorporates an epistemological relativism that argues that as everyone creates his or her own reality, there is no overriding viewpoint, no transcendent referent from which one can compare different knowledge traditions and judge one as being better than the other. All knowledge is embedded and contextual. [5]

The question is no longer simply about whether cultures can be evaluated, but about the incommensurability of knowledge traditions and the universality of human nature. The radical position derived from French postmodernists such as Derrida, Foucault, and Lyotard is that culture as the determinant of the human

psyche transcends nature. [5] Thus, there is an incommensurability of culture that entails an incommensurability of human psyches. Furthermore, as there are no culturally free frames of reference available to make cross-cultural comparisons, such efforts are deemed to be futile.

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Contemporary critiques of cultural relativism

Anthropological critiques of cultural relativism since the infusion of postmodern thought into the debate revolve around universalism and human nature. Spiro [6] argued that epistemological relativism rests on a wholesale form of cultural determinism and on the assumption that cultural diversity is unlimited. His position was that culture and nature are not mutually exclusive; that diversity, while dramatic, is not infinite; and that all human groups, no matter how diverse, comprise a common humanity constituted by universal biological and social characteristics. The construction and internalization of cultural propositions are often less arbitrary than relativists claim, as they are elaborated to satisfy emotional human needs.

Edgerton, [7] who also argued for a context-independent conception of human nature, evaluated the irrationality of cultural beliefs and practices by the criterion of maladaption. Maladaption is said to exist when a cultural belief or practice threatens survival or seriously impairs the health of its members. Defined in this way, Edgerton demonstrated that although anthropologists have assumed that practices that have existed for any length of time among a given group are adaptive, in fact maladaption is depressingly common throughout the world. In Western society, he pointed to the current cultural beliefs about female beauty that have resulted in anorexia nervosa and bulimia among increasing numbers of young women, threatening their fertility, their physical health, and even their very survival.

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Feminism and cultural relativism

Feminists have also addressed the themes of relativism, universalism, and difference in radical critiques of the epistemological foundation of Western thought. [8] Their position with respect to postmodernism is something of an anomaly. On one hand, in common with the postmodern movement, Linda Nicolson, a feminist scholar, has noted that "feminism has been quite explicit about the historical embeddedness of all theoretical perspectives." [9] (p93) In contrast, however, feminists situate intellectual perspectives in a very specific social context, that of the patriarchal order. Their focus, therefore, has been on the male domination of Western thought and the silencing of women. Again, in common with postmodernism, feminists have embraced the notion of difference. But as Susan Hekman, [8] a feminist who argued for a greater alliance with postmodernism, pointed out, this has been in pursuit of a universal principle, the essential nature of women. Furthermore, from the outset, feminist scholarship has been tied to an explicit political project to change the status quo of male privilege. For the most part, therefore, they have been critical of cultural relativism, seeing it as a politically bankrupt position that perpetuates the injustices of the existing system.

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CULTURAL RELATIVISM AND NURSING THEORY

In tracing cultural relativism in nursing, it is interesting to note that anthropologist Margaret Mead, who was associated with the concept's ascendancy in anthropology, was among the lecturers supported by the Russell Sage Foundation at the Cornell University School of Nursing to introduce psychosocial concepts to the discipline in the 1950s. [10] However, it is Leininger, [11,12] a nurse with doctoral training in anthropology, who is credited more than anyone else with pioneering cultural concepts in nursing. There is an implicit cultural relativism at

the heart of her theory of transcultural nursing that explicitly defines and applies the concepts of ethnocentricism and cultural imposition. These attitudes are identified as barriers to culturally congruent caregiving. Leininger exhorted nurses to recognize their own cultural biases, hold them in abeyance in cross-cultural encounters, seek out their client's cultural perspectives, and provide culturally congruent care.

Other cultural assessment frameworks have been developed by nurses such as Giger and Davidhizar [13] that, like Leininger's, also imply a culturally relative stance. [14,15] These frameworks provide categories for nurses to identify clients' cultural beliefs, norms, and values. Their purpose is to assist nurses in avoiding ethnocentric assessments so that they can provide care that is responsive to the recipient's cultural perspective. In addition, nursing scholars have emphasized the concepts of cultural sensitivity and cultural competence. An expert panel of the American Academy of Nursing [16] defined cultural sensitivity as the awareness, and use of knowledge related to ethnicity, culture, gender, or sexual orientation in explaining and understanding the situation and the responses of clients and their environments. Culturally competent nursing care is based on this knowledge. Thus, Campinha-Bacote's [17] model described cultural competence as embodying the following attributes: awareness of one's own biases and prejudices toward other cultures, knowledge about culture in general, ability to conduct accurate cultural assessments, and interpersonal skills in cross-cultural encounters.

Nurses then have developed conceptual frameworks to enable the profession to provide care that conforms to clients' cultural perceptions of what care should be. The values of tolerance and respect of the "other" underlie this work as they did the earlier anthropological doctrine of cultural relativism. As these models provide universal categories to shed light on particular cultural differences, relativism and universalism are not opposed to one another. Nevertheless, the emphasis is on the former. Leininger noted, for instance, "The informants' emic knowledge and experiences are far more important for grounded data than the researcher's etic a priori viewpoints. These emic care constructs are invaluable to explain, develop and guide nursing actions." [12] (p158) Interestingly, in light of the debate surrounding postmodern relativism, Tripp-Reimer and Fox [18] invoked the universalism of a shared humanity that transcends diversity to criticize an overemphasis on cultural differences in nursing conceptualizations of transcultural care. They argued that there has been a focus on categories of differences that fails to address what is essentially human, independent of form.

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THE CASE OF EXCISION

These abstract issues can be illuminated with a very real situation involving the cultural practice of excising female genitalia among immigrant communities in France. The public debates in this particular instance are especially relevant because they have been laced with the themes of relativism, tolerance, universalism, and difference. Furthermore, the cultural custom at stake affects health, is being imported to societies throughout the Western world, is highly incongruent with nursing culture, and often prompts a visceral, highly charged, negative reaction among Western women.

The excision of female genitalia has been part of traditional culture in communities of such countries as Nigeria, Ghana, Mali, Senegal, the Ivory Coast, Gambia, Sudan, Egypt, Kenya, Djibouti, Liberia, Sierra Leone, Togo, Ethiopia, and Eritrea. [19] Linked to values about female purity and family honor, this custom varies in extent among the groups who practice it; in some communities the tradition involves clitoridectomy alone, whereas in others it involves clitoridectomy, excision of both labia, and suturing of the wound to leave only a small opening for the passage of urine and menstrual blood. The age when the excision is done also varies among communities from infancy to puberty and even to young womanhood. A vigorous international campaign is being waged to abolish the practice throughout the world. Women's groups have worked to raise consciousness about the custom, have pressured international organizations such as

UNICEF and the World Health Organization to condemn it, and have fought for legislation against it. As immigrant communities import the practice to the West, the battlegrounds are increasing as feminist groups in Europe and North America oppose it within their own nations as well as on the international stage. The conflict in France is but one of these internal battles.

The immigrant communities who brought the custom to France are mostly from areas in West Africa. The persistence of the practice appears to be widespread in the new homeland. For instance, in 1984 a feminist group estimated that approximately 23,000 girls in France were at risk to have their genitalia excised, and numbers were believed to have increased considerably by 1994. [19] Despite the lack of French legislation outlawing the custom, cases have been tried in French courts, including one that resulted in the death of the child involved. The law invoked in these cases prohibits a range of violent acts against minors. The trials received a great deal of media attention and public debate. Winter, [19] who reviewed them, reported that the defense used cultural relativism to argue that the practice is culturally determined, is not a threat to the French republican order (the public sphere), and should therefore be a matter for families (private choice) to decide for themselves. Raymond Verdier, director of the research center Droit et Cultures at the Universite de Paris and an academic who provided intellectual ammunition for this position, maintained, "One can measure the extent of the danger of a national penal law which incautiously tries to penetrate the intimacy of families and uncompromisingly impose our ways of thinking and of living on foreigners who do not necessarily share them." [20] (p1) People on this side of the argument equated the practice with circumcision. Verdier said, for instance, "like circumcision-which internationally, it (clitoridectomy) is on a par . . . it is the sign of the complementarity of the sexes-excision is an act of social incorporation into the group of women." [21] (p3)

Women's organizations in France campaigning against the custom refer to it as genital mutilation, not circumcision, and equate it instead with removal of the penis. They assert that the custom is built on a male-dominated belief system that has been elaborated by men to control women's sexuality for their benefit. Several of these groups, such as SOS Femmes Alternatives, attack the legality of the practice in an effort to end it through the court system. They have lobbied to have cases brought to trial and defend this position under the principle of universal human rights. Winter quoted from an interview with an activist protrial feminist who explained her stance with the following comment: "The result, when the clitoris is removed, is the same. Whether it is the clitoris of a little black girl or a little white girl, whether it is a pair of scissors, a razor blade, or a knife, the result is identical. And we should not hand down different judgments whether it is a French woman or an African woman. The result is there has been a crime whoever has committed it." [19] (p966) And in the "whoever" lies the rub for antitrial feminist groups. The "keepers of the tradition" are often women. Mothers may arrange for and be present at their daughters' excision; women known as exciseuse perform it; and women are being tried for it. Thus, although organizations such as GAMS (Groupe pour l'Abolition des Mutilations Sexuelles) reject the cultural relativist argument, they reject as well the application of a universalist abstract principle developed by what they consider to be a culturally homogeneous patriarchal society to a culturally different community of women whose lives (and perspectives) they believe are being controlled by an internalized ideology of another patriarchal order. They focus instead on providing education and support to immigrant women to change the custom from within the community.

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CULTURAL RELATIVISM IN NURSING PRACTICE

What are the implications of these positions for nursing practice? In a seminal anthropological paper, Geertz [1] argued that cultural relativists and antirelativists offer a choice of worries. The relativists' fear is that "our perceptions will be dulled, our intellects constricted, and our sympathies narrowed by the over-learned and overvalued acceptance of our own society." [1] (p265) On the other hand, antirelativists worry about "a kind of spiritual entropy, a heat death of the

mind in which everything is as significant as everything else, thus as insignificant. Everything goes." [1] (p265) For Geertz the first is by far the more significant, and he dismisses the second as overstated. The problem for nursing as a practice rather than an academic discipline is that both worries are very real.

As far as the first worry is concerned, evidence abounds that health care professionals have compromised clients' health and well-being by riding roughshod over cultural values, beliefs, and norms. Furthermore, when providing care in cross-cultural situations, nurses often belong to a dominant or mainstream cultural group and their client to a minority group, which enhances a tendency for them to be culturally blind, deaf, or intolerant. However, because constructs about what health is and how it is to be attained or maintained are clearly cultural, from the relativistic perspective, then, no cultural belief about health can be assumed to be superior or inferior to any other. Health behaviors, therefore, can only be judged within the frame of the person's cultural reality. Although nurses' writings on cross-cultural caregiving indicate that they do, in fact, place limits on relativism, consistency with the principle means that nurses must respect any culturally validated behavior regardless of the health implications identified from the standpoint of their knowledgebase.

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TOWARD A RESOLUTION OF THE DEBATE

What are we to make of this? How should we respond when working with an immigrant woman from the Ivory Coast, for instance, who requests help in planning a trip to her country of origin to have her daughter's genitalia excised, or to a Somalian refugee who expresses her wish to be reinfibulated following childbirth? Do we root out and put aside our ethnocentric values, avoid cultural impositions, and provide culturally congruent responses in all situations or only in some? And if only in some, how will we decide when to be ethnocentric and when not? Or instead should we opt out of the dilemma altogether and restrict our interventions to people whose culture we share because our health judgments can only be conducted through the prism of cultural knowledge? Insights from the field of hermeneutics may offer a way out of this impasse.

The hermeneutic tradition in postmodern thought espouses a relativism that avoids nihilism. Inspired by the work of Martin Heidegger, it deals with interpretation and is essentially a philosophy of understanding that elucidates how one person comes to understand the actions, words, or any other meaningful product of another. [5] Hermeneutic philosophers treat social interaction as analogous to a text that is "read" or interpreted to discover its meaning. In concert with other postmodern thought, the notion of metanarratives that explain the world from some objective, disinterested standpoint is rejected, and all understandings are considered to be culturally shaped. Indeed, Gadamer, [22] a student of Heidegger and central Figure incontemporary hermeneutics, argues that prejudice (the preunderstandings one derives from one's cultural tradition) are the condition for human understanding. This does not mean, however, that all prejudices or traditions are as good as any other, a key point for the issues being examined here. Furthermore, hermeneuticists argue that dialogical interaction may build up better or truer understandings because one must reposition oneself as one goes about understanding the other. [5]

At the heart of the hermeneutic perspective, then, is constructive communication across cultural traditions. Gadamer [22] argued that to understand a cultural "other," one must adopt a fundamentally open stance and listen to the other's claims. In seeking avenues for interpreting these claims, one exposes oneself to errors created by one's own preconceptions. Thus, Gadamer [22] saw in such dialogue the possibility for a fusion of horizons, in which there is a meeting of the contextual understandings that transforms and enriches the perspectives of both participants. The object in reading difficult texts or making sense of behavior, according to Gadamer, [23] is not to sanction every prejudice around, nor to put our own prejudices to a critical test, but rather to encourage the most fruitful prejudices to develop.

In cross-cultural encounters between a nurse and client, both are at the center of a hermeneutic circle. The nurse reads and interprets the client through the prejudices of one tradition, and the client reads and interprets the nurse through the prejudices of another. However, the possibility of understanding through dialogue exists. As Renato Rosaldo, [24] a hermeneutic anthropologist, point out, in a position reminiscent of Tripp-Reimer and Fox's [18] argument about a common humanity discussed earlier, everything outside one's group is not alien. Although one must avoid a reckless attribution of one's own categories and experiences to members of another culture, not only are there striking differences, but there are also striking similarities in human psyches across cultures. Additionally, no interpretation is ever final or definitive, and either or both parties may reposition themeselves with respect to their prior "prejudices" as a result of the ensuing dialogue. Thus, cultural beliefs, values, and customs are never frozen, and any cultural encounter may result in a new fabric of shared meanings.

How does this perspective influence a practice situation where culturally congruent care violates the values and beliefs the nurse has brought to the encounter? It shifts the focus from a dichotomous choice between tolerance or intolerance, acceptance or rejection, to one of dialogue, understanding, and change. All negative judgments of other cultural practices will not necessarily be abandoned as a result of this, nor will the care necessarily support the original cultural belief of the client. This approach does entail, however, an openness to making sense of other "prejudices" by trying to understand the horizon informing them and a willingness to examine one's own preunderstandings critically. This was precisely what appeared to be missing in the public debate around excision in France, where different groups put forward competing interpretations based on Western intellectual "traditions" without seeking out the immigrant women's perspectives on the issue. In searching for authentic understanding of clients' interpretations of customs that are an affront to fundamental values and beliefs, nurses' horizons are broadened and enriched. They may well continue to reject the custom following such a dialogue and respond in a manner that is not congruent with the client's culture. But this response will be based on "truer" knowledge. Additionally, such dialogue across traditions may also result in a constructive reworking by a client of an earlier prejudice involved in the custom and, thus, to a "truer" understanding of its consequences.

Nurses need to recognize that their interpretations about health, illness, and behavior are contextual and provisional, but they must also recognize that the interpretations of their clients are also contextual and provisional. As such, the perspectives of either or both are subject to change. In any cross-cultural encounter, then, nurses need to seek understanding of the cultural interpretations of their client, engage in a critical examination of their own cultural interpretations and the presuppositions informing them, and, following this, base their practice on judgments that represent their own best possible provisional interpretation at that moment in time.

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