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Facing Defacement: Factors influencing indigenous patients in provider-patient communication in Baja Verapaz, Guatemala

Laura L. Burton

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**FACING DEFAACEMENT:
FACTORS INFLUENCING INDIGENOUS PATIENTS IN
PROVIDER-PATIENT COMMUNICATION IN
BAJA VERAPAZ, GUATEMALA**

BY

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**B.A. Theological Studies
Trinity Southwest University, 2001**

THESIS

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Master of Arts
Communication**

The University of New Mexico
Albuquerque, New Mexico

December, 2009

DEDICATION

This thesis is, above all, dedicated to my God and Savior who granted me the grace and strength to venture into this undertaking of travel and ethnographic research in Guatemala with the hopes of serving and helping the Achi people.

Secondly, I dedicate this thesis to my loving and supportive husband, Jerry, our two wonderful children, James and Elisabeth, and our parents. Without their love, patience, support, and picking up the slack, I would never have completed my studies and this research. Jerry, this accomplishment is the fruit of your encouragement and belief in me.

Finally, this thesis is dedicated to the Achi people and the volunteer workers, who sacrificially give of themselves to provide health, hope, and faith to the Achi people they serve.

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ABSTRACT

The purpose of this ethnographic research was to explain the factors influencing Achi patients in provider-patient interactions in Baja Verapaz, Guatemala. I explored the complex intercultural challenges influencing the interactions between biomedically-trained providers and indigenous patients. Data collection involved participant observation and twenty-four informal field interviews in Guatemala. I utilized thematic analysis to identify and understand the factors influencing Achi patients when interacting with health care providers.

Findings reveal that the Achi patients are influenced in provider-patient interactions by the reciprocal interaction among four major factors: environment, beliefs, emotional effect, and experiences. In addition, subthemes were identified for each of the

major factors. A central finding of this research was a new construct, defacement, which is purposeful communication that dehumanizes by destroying other-face. Four levels of defacement, each increasing in intensity and dehumanizing content, emerged from the data: disregarding, degrading, regañó-ing, and abusing.

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CHAPTER ONE

Introduction

This thesis examines the factors influencing provider-patient interactions in rural indigenous Guatemalan villages utilizing participant observations and field interviews. I identify the factors influencing patients in provider-patient interactions in this context through thematic analysis, propose a new construct, and some make some suggestions for health care workers. This chapter introduces the study by noting my experiences in Guatemala, assumptions, justifications, research questions, and definitions.

Experiences in Guatemala

My interest in addressing the provider-patient communication in rural indigenous contexts began last year when I entered the small hand-made mud-brick building that served as a clinic-for-the-day in a rural village in Guatemala. While with a health care team, I witnessed the health communication challenges between the health care providers and the Achi, an indigenous Maya people. These experiences were the motivation for this study.

The first patient visiting the health clinic illustrated the basic health care illnesses facing the indigenous people in the remote villages. To provide health care to the rural indigenous population, the health care team drove their trucks as far as possible. Then one of the village leaders and his son met us at the road. After sliding the heavy boxes of pharmaceuticals into net bags, they placed them on their backs with a strap across their foreheads. The team followed their steady and quick pace with unsteady trudging along slick, muddy paths up the mountain, through corn fields, and across a small river. After helping set up the pharmaceuticals in one of the two rooms, I joined the medical doctor

and his assistant in the adjoining room. A crowd gathered outside since word of the doctor's visit had spread to surrounding villages.

An Achi mother humbly entered the room with her lethargic ten-year old son and slowly sank into the hard wooden chair. Speaking in Achi, she quietly explained her son's lack of appetite and energy. She watched as the village leader's teenage son standing toward the back of the room translated her explanation into Spanish for the doctor. When the doctor asked what facilities they used for human waste, she dropped her head while faintly and briefly stating that they use the woods due to their lack of access to a latrine. When the doctor asked if she and her family wash their hands after going to the bathroom, she slumped lower and replied in a hushed tone, "Yes." After a brief examination of the boy's extended stomach, the doctor diagnosed an advanced case of worms. The doctor explained poor hygiene behaviors as the likely cause of the illness. As Achi women and children filed through the cool dirt-floored room, many were suffering from worms, diarrhea, scabies, skin infections, and similar illnesses that are preventable in the developed world.

The health care workers often try to persuade the patients to go to the hospital for surgery, comply with treatment directions, or change beliefs and behaviors. One fifteen-year-old young woman entered the clinic believing she was pregnant with her second child. In broken Spanish, she attempted to explain that although she was hopeful, things did not seem right. After an examination that appeared to be culturally awkward and embarrassing for her, the doctor diagnosed a tumor instead of pregnancy. He told her that surgery was critical. However, he knew a trip to the nearest hospital involved

significant logistical and financial challenges for her young family. If she went to the hospital, she would likely suffer both the embarrassment and discrimination common against indigenous people. Although the doctor insisted that the situation was critical and required surgery, I wondered whether her young husband would agree. As she left the room, I was distressed. Did she understand? Did she go to the hospital? These haunting questions motivated this study.

The health care workers often address misbeliefs that hinder the health of the indigenous people. For example, a woman diagnosed with gall stones held the common misbelief that laxatives would cure her. The doctor tried to correct her misbelief and persuade her of the necessity of surgery. The language barriers and her pre-existing beliefs appeared to hinder the persuasion. When she left, the doctor explained that he did not give her pain medicine because he believed the pain was likely the only thing that would persuade her to go to the hospital.

This thesis evolved from these and other experiences in Guatemala. Discussions with the volunteer health care providers working in this region revealed a constant struggle to address the intercultural communication challenges inherent in the context. The purpose of this thesis is to understand the factors influencing Achi patients in provider-patient interactions in rural Baja Verapaz, Guatemala.

Assumptions

The assumptions guiding this research include the role that sense making plays in communication outcomes. Humans are driven by the need to make sense of their experiences, self, others, and the world. This sense-making is filtered through their

existing knowledge and beliefs. Communication is a complex phenomenon involving the interplay between social construction and individual sense-making.

Giddens's (1984) duality of structure construct within structuration theory proposes that agency and constraint work as a duality in which "the structural properties of social systems are both medium and outcome of the practices they recursively organize" (p. 25). In other words, through communication people socially construct structures (boundaries, rules and essence) around a concept, for example, the choices, acceptable behaviors, and definitions regarding health, illness, and health care. This structure then constrains the communication and actions of the social actors (appropriate talk, behaviors, and choices regarding health and illness). Communication about health and illness structures and constrains the talk and behavior of the providers and patients. Through communication and individual culturally-bound sense-making, people create a cognitive structure through which they make sense of new information (Ausubel, 1963) Therefore, new information is understood in terms of what the individual already knows and believes. Because sense-making is grounded in culture, communication behaviors are often patterned in ways consistent within and at times across cultures.

Justification

Health care workers in rural Guatemalan villages encounter different provider-patient communication challenges than in the developed world. Understanding the factors influencing the Achi patients in communication with health care workers is a step toward improving the effectiveness of provider-patient interactions and ultimately the health of the patients.

Contextual factors influencing health. The contextual factors affecting health in Baja Verapaz, Guatemala, are unique. Guatemala has the highest infant mortality rate in Central America with forty-nine percent (49%) of children suffer from chronic malnutrition (USAID, 2009). According to the Pan American Health Organization (2001), approximately eighty percent of the physicians and over half of the professional nurses and nursing aides are located in metropolitan areas. This fact complicates health care in the rural areas where sixty-five percent of the population live and where health care services are sporadic or provided in large part by nursing aids, rural health technicians, midwives, and volunteer community health workers. Poverty exacerbates the health situation. Guatemala is the third worst country in the world in terms of income distribution with over half of the population, comprising mostly of rural indigenous Maya people, living in poverty.

The living conditions in many of the rural villages also create impediments to health. In Sabinillas, the vast majority of the villagers does not have latrines and live in small quarters with dirt floors. Because the doorways and windows are often open, disease carrying insects enter homes, crawl on cooking utensils, and sleeping areas. Village women and many in larger towns cook on open fires within their homes without proper ventilation. As a result, many women suffer from respiratory infections. The quality and accessibility of water varies among the towns and villages. If the community has a water distribution system, it typically distributes untreated river water at unpredictable intervals. The water is collected in concrete pilas typically left open and exposed to environmental elements.

The poverty and malnutrition of the rural Achi people was highlighted when a young mother entered the clinic carrying a small child in her arms while an older child was on her back in a sling made from a bed sheet. The child on her back was blind, very thin, non-responsive to the environment, and his limbs were not functional. She said that her four children all suffered from similar “illnesses.” After receiving prenatal vitamins and medication for her respiratory infection, she returned with the village leader who asked on her behalf if the doctor had forgotten to give medication to “fix” her children. Her despondency was apparent as I watched her walk away. Later, the doctor explained that the disabilities were most likely due to prenatal malnutrition.

Cultural factors influencing provider-patient interactions. Limited, if any, research has explored the cultural factors influencing the Achi patients in this context. Health care is provided to the Achi people by non-community, culturally-different health care workers, including Guatemalan Ladino providers and volunteer health care providers from the developed world. The volunteers receive limited intercultural communication sensitivity training prior to working in the field.

The health care workers and indigenous patients interact through culturally-developed frames of reference that function as interpretive lenses and guides for behavior (Ting-Toomey & Chung, 2005). The potential for misunderstandings, offenses, and misinterpretations is high when interactants rely on differing frames of reference, and often intercultural miscommunication goes unrecognized by both interactants (Cass et al., 2002). Identifying the cultural factors within the interplay between volunteer health

care providers and Achi patients can lead to greater understanding and improved health based on improved health communication.

Limited communication research in the developing world. Little scholarly work addresses provider-patient communication in the developing world. Few existing studies focus on public health (Conquergood, 1988; Graeff, Elder, & Mills Booth, 1993; Rodgers, 1995) and provider-patient interactions in Western medical facilities (du Pre, 2000). The intercultural training of doctors for clinical interactions often focuses on cultural sensitivity without providing practical intercultural skills that facilitate necessary changes in their patients (Carrillo, Green, & Betancourt, 1999). Existing studies fail to explicate and facilitate the provider-patient communication in indigenous contexts.

Provider-patient communication is critical to patient confidence in the doctor's explanation of the illness and compliance (Ito, 1999). This study enhances the understanding of the factors influencing provider-patient communication in the developing world and provides guidance for the health care workers to improve their interactions with indigenous patients.

Research Questions

Communication is a constructive and constraining process involving sense-making about symbol use among the interactants (Miller, 2006). As a process, communication produces and reproduces shared meaning which is simultaneously constructive and constraining. This process is a continuous, nonlinear, and complex transaction involving symbols and culturally-grounded sense-making.

My goal is to explain the factors influencing Achi patients in provider-patient interactions in Baja Verapaz, Guatemala. The following research questions guide my research:

RQ 1: What factors influence the provider-patient interaction for the Achi patients in Baja Verapaz, Guatemala?

RQ2: How do the cultural differences between provider and patient affect the communication interactions in the context of this study?

RQ3: How do biomedical and cultural knowledge about health and illness influence the provider-patient interactions in the population of this study?

Definitions

For clarification, the following terms are defined for this study: culture, indigenous, temporary health care context, and epistemology.

Culture. Culture is “a complex frame of reference that consists of patterns of traditions, beliefs, values, norms, meanings, and symbols that are shared to varying degrees by interacting members of a community” (Ting-Toomey & Chung, 2005, p. 37). People idiosyncratically make sense and adapt to changes in their environment, therefore, how people interpret and “take up” cultural elements vary considerably, even among people in the same culture. However, patterns still emerge among members of socially or ethnically distinct groups.

Indigenous. No universally agreed upon definition for the term “indigenous” exists. Typically, the term “indigenous” refers to a native people group in contrast to those living in a country as a result of immigration or colonialization. The descendents of

the Mayas in Guatemala, consisting of more than twenty different people groups, refer to themselves as indigenous. In this thesis, indigenous refers specifically to the Rabinal Achi in Baja Verapaz, Guatemala.

Temporary health care context. The inequitable distribution of health care workers is evident in a doctor to patient ratio of one to seven thousand in rural areas of Guatemala (Health System Profile, Pan American Health Organization, 2007). Rural villages often rely upon mission-driven religious groups and nonprofit organizations for basic health care services.

My study site includes a temporary clinic in a rural village established by a religious, nonprofit organization with a permanent base in Baja Verapaz. At intermittent intervals, the health care team sets up the clinic in a small two-room building with one room equipped with a wooden table and a few plastic chairs for examinations and one room serving as the pharmacy. The health care workers utilize a documentation system to record the patients' names, diagnoses, and treatments. They report collected health information to the government health agency.

Knowledge. Knowledge is socially-constructed and context-bound meaning making. Drawing upon their culturally-bound assumptions and perspectives about themselves and the world, people interpret and evaluate their experiences actively as they make meaning of their experiences (Baxter Magolda, 2004). As people encounter novel experiences, they may adapt by expanding or adapting their existing knowledge structures (Ausubel, 1963). Patients often encounter novel information and experiences for which they must actively make meaning.

Thesis Preview

My thesis research grew out of my experiences with provider-patient intercultural health communication among the Achi people in Baja Verapaz, Guatemala. Specifically, Chapter 2 reviews literature relevant to provider-patient communication in this context. Chapter 3 discusses the methodology utilized to collect and analyze data to address the research questions. Chapter 4 presents the analysis of the data of the study. Chapter 5 provides a summary of the key findings, limitations, suggestions for health care providers, and suggestions for future research.

CHAPTER TWO

Literature Review

The goal of this literature review is to identify relevant research for my study of the provider-patient interactions among the Achi people. This literature review draws upon scholarship from the fields of communication, learning theory, and medical anthropology. This review discusses provider-patient communication, intercultural communication, and health knowledge.

Provider-Patient Communication

Communication between health care providers and patients influences the well-being of patients. Provider-patient interaction is important because it impacts health outcomes, pain tolerance, stress, compliance with medical advice, and patient satisfaction (Blanquicett, Amsbary, Mills, & Powell, 2007; Brown, Stewart, & Ryan, 2003; du Pre, 2000; Willems, De Maesschalck, Deveugele, Derese, & Maeseneer, 2005). A common response to the complex and often less than optimal provider-patient interaction is to identify one interactant as responsible for the misunderstanding. However, applying a process view to provider-patient interactions recognizes that both interactants exert influence on the interaction (du Pre, 2000; Sharf & Vanderfold, 2003). Various factors likely influence health care encounters, including power, sociodemographic and culture differences between providers and patients.

Power differences. Cultures vary in the degree of acceptance of power differences in interactions (Hofstede, 1984; Ting-Toomey, 1988). The provider-patient interaction is typically asymmetrical with the provider possessing legitimate, reward,

coercive, and expert power (Beisecker, 1990; French & Raven, 1959). The provider has legitimate power when patients accept that the provider has authority and power to influence them. The reward power of the provider surfaces when the patients perceive the provider as having the power to “reward” the patient with medication or effective treatment. The provider has coercive power with the ability to “punish” the patient by withholding treatment or medication. Finally, the amount of expert power possessed by the provider depends upon the patient’s perceptions of the extent of the provider’s expertise.

The power difference between provider and patient affects medical interactions (Beisecker, 1990; du Pre, 2000; Roter & McNeilis, 2003). The power relations in medical visits are constructed and expressed through the establishment of goals and an agenda for the interaction, the degree to which the patients’ values influence the interaction, and the functional role assumed by the provider (Emanuel & Emanuel, 1992). Four provider-patient relational styles reflect the existent differences in power: paternalism, mutuality, consumerism, and default (Roter & McNeilis, 2003). Power differences and interactions with individuals from different socioeconomic status influence the provider-patient relational styles.

The most common style in medical interactions is paternalism (Roter & McNeilis, 2003), where the physician predominately makes the decisions for the patient and establishes the agenda and goals. In this style, the patient enacts a passive role demonstrated by not questioning, challenging, or expressing concerns. A mutuality relational style occurs when health decisions and the goals and agenda are mutually

determined. With the consumerism style, the patient enters the interaction with a marketplace mentality, shopping for the medical treatment desired and driving the goals and the agenda. In this style, the patient may unknowingly limit the physician's input and not fully benefit from the physician's knowledge. The default style often creates a dysfunctional standstill with unclear and contested goals and agenda often resulting both in noncompliance and ineffective communication (Roter & McNeilis, 2003).

The degree of acceptance and comfort with the provider-patient power difference varies by culture (Ting-Toomey & Chung, 2005). Individuals from small power distance cultures value equal power distributions, individual rights, and expect rewards and punishments based on performance. Large power distance cultures accept unequal power distributions, hierarchical rights, asymmetrical role relations, and expect rewards and punishments to vary based on rank, age, status, title and seniority (Ting-Toomey & Chung, 2005). Although cultures in Central America typically hold to a large power distance valuing, existing research assumes a small power distance valuing illustrated by criticism of the paternalistic relational style and emphasis on patient empowerment and patient-centered care (Beisecker, 1990; Lambert, et. al, 1997; Lepper, Martin, & DiMatteo, 1995). The asymmetrical power distance in the provider-patient interactions in rural Guatemalan villages has not yet been studied.

Sociodemographic differences. Patients of lower socioeconomic status receive different care than those in higher status (Blanquicett, Amsbary, Mills, & Powell, 2007; Fredricks, Odiel, Miller, & Fredricks, 2006; Willems, et al., 2005). Patients of higher social status (as measured by income, education, or other social class indices) receive

more communication from doctors, including more explanations, empathy messages, and information than lower status patients (Fiscella, Meredith, Goodwin, & Stange, 2002; Willems, et al., 2005).

Some of the differences observed among patients of different socioeconomic statuses can partially be explained by patients' communicative styles (Street, 1991; Waitzkin, Cabrera, Arroyo de Cabrera, Radlow, & Rodriguez, 1996). Studies conducted in western contexts reveal that patients with lower education and social status frequently engage in a relatively more passive communicative style, participating, questioning, and asserting themselves less than higher-status patients. The relative passive communication by patients, coupled with directive and paternalistic provider communication, result in patients receiving less information, being less involved in the treatment decisions, and experiencing lower health outcomes as compared to patients who engage in active communication (Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995; Willems, et al., 2005). Active communication, including asking questions, affective expressiveness, and engaging in decision making result in physicians reciprocating with additional information and involvement (Street, 1991). Greater cultural distance between lower socioeconomic patients and doctors may increase the communicative difficulties (Kaplan, et al., 1995) because providers often inaccurately assume that patients from lower social status are neither interested in learning about their health nor able to understand the information (Willems, et al., 2005). In the health clinic in Guatemala, the sociodemographic differences between the providers and patients are considerable.

Culture. Humans are obligatorily interdependent and profoundly social in nature (Brewer, 2007). Culture evolves as individuals group with similar others and develop shared patterns of thought, feeling, and behavior (Hogg & Reid, 2006). Culture is a multi-level construct consisting of four dimensions: surface level, intermediate level, deep level, and universal needs level (Ting-Toomey & Chung, 2005). The surface dimension is manifest in the popular culture consisting of the artifacts, processes, effects and meanings that have mass appeal in the culture. Because popular culture frequently does not correlate with the underlying values and norms of the culture, people often form incorrect beliefs about culturally different others when relying exclusively on popular culture for understanding.

The intermediate dimension of culture appears in the symbols, meanings, and norms of the community. Symbols are the signs, artifacts, word(s), and nonverbal behaviors that reflect social meanings. Cultural norms are the collective rules defining proper and improper behavior. The deep level dimension of culture is the traditions, beliefs, and values of the community. Community members share traditions including myths, legends, ceremonies and rituals. The shared beliefs refer to the assumptions people have about the world, other people, relationships, and their concept of time and space. The final dimension, universal human needs, is consistent across cultures. These four cultural dimensions produce active and fluid social constructions (Airhihenbuwa, 1995).

The interpersonal interactions between providers and patients are shaped by the broader social and cultural structures in society (Perloff, Bonder, Ray, Ray, & Siminoff,

2006; Waitzkin, 1991). The cultural beliefs, values, and social norms shape the meanings embedded in the cultural codes, symbols, and values that patients and doctors bring to the interaction (Airhihenbuwa, 1995; Lambert, Street, Cegala, Smith, Kurtz, & Schofield, 1997). Difficulties inherent within intercultural provider-patient interactions often contribute to misunderstandings and ineffective interactions (Berlin & Fowkes, 1983; Cooper-Patrick, et al., 1999; du Pre, 2000; O'Neil, 1989; Waitzkin, Cabrera, Arroyo de Cabrera, Redlow, & Rodriguez, 1996).

Historic beliefs and values are the foundation upon which an existing cultural system is built. However, culture is not a static, fossilized construct but rather is a fluid and dynamic construct as individuals adapt to deal with changing environments and experiences (Airhihenbuwa, 1995; Ibarra, 2001). An illustration of this adaptive aspect of culture appears in Capps's (1994) research of the Hmong community in Kansas City. As a result of exposure to a variety of new experiences, including exposure to biomedicine, war, migration, and Christian beliefs, the Hmong culture integrated traditional health beliefs with biomedical beliefs resulting in an eclectic medical pluralism.

In addition to this adaptive nature of culture, individuals attach different degrees of importance to different aspects of their culture based on individual experiences (Ting-Toomey & Chung, 2005). Culture has two aspects, the normative culture and subjective culture. The normative culture refers to the common patterns of the community. The individual attachment of varying degrees of importance to aspects of the normative culture creates the subjective culture.

The success of the Behrhorst Hospital in Guatemala illustrates the importance of providers adapting to cultural factors. In 1962, Behrhorst began providing health care to the Cakchikel people, an indigenous Maya people, in Guatemala. Some of the distinguishing features of his provider-patient communication were trusting patients to identify their needs, obtaining socially and culturally relevant information, and adapting his communication and health care to the patients' needs and beliefs (Barton, 1970). Suchman and Alksne (1961) discuss the importance of obtaining the patients' culturally-derived definitions of their illnesses and supporting the patients' method of handling their illness as long as it does not hinder healing. Further discussion of differences of health knowledge and beliefs appears in the health knowledge section of this literature review.

Intercultural Communication

A vast array of factors influences intercultural health interactions. This section explains intercultural communication, cultural patterns, and intercultural interaction theories.

Definition of intercultural communication. Intercultural communication is the “the symbolic exchange process whereby individuals from two (or more) different cultural communities negotiate shared meanings in an interactive situation” (Ting-Toomey & Chung, 2005, p. 39). Symbolic exchange is the use of verbal and nonverbal symbols to achieve shared meaning (Ting-Toomey & Chung, 2005). These behaviors (verbal and nonverbal) have no independent meaning, but rather only culturally interpreted meanings (Gudykunst, 1991). The extent to which communication is effective depends on the degree to which the interactants attach similar meanings to the

messages exchanged (Gudykunst, 1991). One of the challenges of intercultural communication is that culturally different others rely on different meaning systems for interpretation and are often unaware of the cultural frameworks guiding and driving their interpretation (Hall, 1976). In order to achieve shared meaning, the interactants must be mindful and strive to ascertain the intended meaning of the culturally different other (Gudykunst, 1991).

Studies examining the interactions in Australia between biomedical providers and aboriginal patients found that shared understanding is rarely achieved and the miscommunication is often unrecognized by the interactants (Cass, Lowell, Christie, Snelling, Flack, Marrnganyin & Brown, 2002). O’Neil (1989) explored the intercultural interactions between Canadian providers and Inuit patients. The Inuit community’s strong dissatisfaction was related to the health care providers’ misinterpretations of the social and cultural elements in the context. The interpreters struggled to bridge the divide of cultural meanings and were constantly having to make judgments about relevance and meanings embedded within both the providers’ and patients’ cultures. The patients’ dissatisfaction, noncompliance, and distrust grew out of the providers’ misinterpretations of social and cultural factors.

Cultural patterns. Researchers identify patterns in normative culture across communities in different areas of the world (Gudykunst, 1991; Hall, 1976; Hofstede, 1984; Ibarra, 2001; Ting-Toomey, 1988; Oetzel, 2009). Even though cultural patterns are frequently presented in binary categories, the constructs exist on a continuum with individuals’ subjective culture falling on various points along the continuum. Categories

of cultural patterns relevant to this study include high and low context, polychronic and monochronic, field sensitive and field independent, individualism and collectivism, high and low power distance, and high and low uncertainty avoidance.

High and low context. A culture's place along the high and low context continuum is determined by the degree to which the context, including the physical surrounds, nonverbal behaviors, status, and relationship between interactants, influences the meaning of behaviors. On the high context end of the continuum, interpretations are based on aspects of the context (Ibarra, 2001). Low context cultures rely heavily on the verbal messages for meaning with context exerting less influence on the meaning. Individuals from high context cultures typically communicate ambiguously and indirectly. Low context individuals often utilize explicit and direct messages (Ibarra, 2001; Oetzel, 2009). Research identifies German, Scandinavian, North American, Northern European, and Swiss cultures as existing on the low context end of the continuum. Chinese, Korean, Japanese, Arab, Middle Eastern countries, African, Mediterranean-based countries, and Latin American cultures typically reside on the high context end of the continuum (Hall, 1976; Ibarra, 2001). Because the Achi live within Latin America, it is likely that the Achi culture is high context.

Polychronic and monochronic. Cultures utilize and perceive time and space differently. Monochronic cultures emphasize schedules, segmentation, and promptness, where individuals are typically driven by schedules, formal or informal, pay attention to the clock, and prefer to tackle one task at a time (Hall, 1976; Ibarra, 2001; Ting-Toomey & Chung, 2005). Monochronic cultures use linear thinking and pragmatic action. In

polychronic cultures, time is flexible and people emphasize involvement with others so that relational time (interacting with others) trumps schedules or clock time. Polychronic cultures typically juggle multiple activities simultaneously and involve numerous individuals (Ibarra, 2001). Low context communities tend to manifest monochronic patterns. Polychronic cultures, like the Achi, typically exhibit high context patterns.

Field sensitive and field independent. Field sensitivity and independence constructs reveal the degree to which individuals depend on external cues to integrate, organize and classify their environment (Ramirez & Castaneda, 1974). Cultures that fall along the field sensitive end of the continuum perceive their environment in holistic ways while depending upon contextual and relational factors for meaning. Parts separate from the whole and messages isolated from context have little meaning for field sensitive individuals. Cultures that fall along the high context and polychronic end of the continuum tend to be field sensitive (Ibarra, 2001). Field independent cultures segment parts from the whole for analysis and understanding, organize the environment in terms of its parts, and depend on this part analysis for understanding the whole. Low context cultures are typically monochronic and field independent.

Individualism and collectivism. Another dimension on which cultures vary is the emphases placed on individual and group goals (Hofstede, 1984). Individualist cultures focus on individuals' realizing their individual potential and perceive individuals as having a unique set of skills, talents, and potential. Individual goals and needs hold more importance than those of the group (Gudykunst, 1991; Ting-Toomey, 1988). Collectivist cultures, in contrast, focus on group identity and emphasize the goals, needs, and views

of the group over those of the individual. Collectivist cultures value relational interdependence and ingroup harmony (Ibarra, 2001; Kim, et. al., 2000; Ting-Toomey & Chung, 2005).

Research shows that minority groups often develop multicontextuality (Ibarra, 2001), an adaptive strategy of those living in multicultural contexts that allows the individual to successfully function in more than one culture. The Latino graduate students studying in American universities demonstrate multicontextuality as they negotiate between their Latino culture and the Anglo university culture (Ibarra, 2001). Multiple cultures coexist in some communities in Guatemala. Some of the young Achi adults I met demonstrated multicontextuality as they negotiated between their indigenous and the dominant Ladino cultures.

Power distance. Power distance refers to the way a culture addresses social differences and hierarchies, including the extent to which people accept unequal power distributions in interactions (Hofstede, 1984; Ting-Toomey, 2005b). Cultures that align along the small power distance end of the continuum value equal rights, equal power distributions, and equitable distribution of rewards and punishments based on individual performance. Monochronic, low context, and individualistic cultures are typically small power distance. In large power distance cultures, individuals accept unequal power distributions, hierarchical rights, and expect rewards and punishments distributed based on age, rank, status, and seniority. Large power distance cultures emphasize respect for power hierarchies (Ting-Toomey & Chung, 2005). The power distance in provider-

patient interactions is typically large with providers holding more status and power than the patients.

Uncertainty avoidance. The extent to which cultural members accept or avoid conflict and uncertainty is a measure of the uncertainty avoidance dimension (Hofstede, 1984). Individuals from low uncertainty avoidance cultures are comfortable with new ideas and willing to question their beliefs and behavior (Gudykunst, 1991). Low uncertainty avoidance cultures encourage risk taking, welcome challenges, and view conflict as natural and potentially positive (Ting Toomey & Chung, 2005).

Communities with high uncertainty avoidance perceive conflict as a threat and have a low tolerance for ambiguity. High uncertainty avoidance cultural members value procedures and rules. They accept status differences and rarely question their beliefs or behaviors. Individuals from high uncertainty avoidance cultures typically avoid conflict. The high uncertainty avoidance of the Achi may result in avoidance and resistance to health behavior change messages.

Cultural patterns summary. Cultural patterns influence intercultural communication. People interpret the behavior and messages of others through their cultural framework. When the interactants are culturally different, shared meaning is difficult to achieve. Research identifies cultural patterns that vary on several dimensions: high and low context, polychronic and monochronic, field sensitive and field independent, individualism and collectivism, high and low power distance, and high and low uncertainty avoidance. Effective intercultural communication requires mindfulness of these dimensions.

I synthesize relevant aspects of Ibarra’s categorization and additional intercultural constructs into figure 1 below. The table represents the two extreme ends of the cultural continuum. Cultures vary in the placement along the continuum, and individuals within a culture idiosyncratically ascribe to various aspects of the continuum.

Figure 1

Polychronic	Monochronic
<u>High Context</u> <i>Information without context is meaningless</i>	<u>Low Context</u> <i>Information can be separated from context</i>
* <i>High use of nonverbal signals</i> <u>Focus</u> on multiple streams of information to determine meaning	* <i>Low use of nonverbal signals</i> <u>Focus</u> on explicit verbal messages to determine meaning
* <i>Communication is indirect</i> <u>Meaning</u> embedded in context. Embellish discussions and expect others to gather main ideas from context	* <i>Communication is direct</i> <u>Meaning</u> embedded in verbal messages. Spell things out exactly and value being specific getting to the main point quickly
* <i>Messages are implicit and restricted</i> <u>Context</u> is important; words are collapsed and shortened to create simple messages with deep meaning that flow freely.	* <i>Messages are explicit and elaborate</i> <u>Context</u> is less important, messages highly articulated with accurate distinctions, specific wording
* <i>Knowledge obtained by gestalt model</i> <u>Knowledge</u> holistic. Facts are perceived as complete units embedded in the context of situations or experiences <u>Reality</u> is seen in the whole. Elements not easily separated for analysis. Things are interconnected, synthesized and global	* <i>Knowledge obtained by logical reasoning</i> <u>Knowledge</u> dissected. Facts are perceived as independent parts. Information is gained by a rational scientific analysis <u>Reality</u> is elemental, fragmented, compartmentalized – easier to isolate for analysis
<u>Collectivism</u>	<u>Individualism</u>
* <i>Personal commitment to people is high</i> <u>Commitment</u> to people priority. People deeply involved with each other; relationships depend on trust, build up slowly and are stable <u>Orientation</u> is collectivist. Focus on group identity	* <i>Personal commitment to people is low</i> <u>Commitment</u> to career or goals. Relationship boundaries blurred, accustomed to short term relationships, often highly committed to career or job <u>Orientation</u> is individualistic. Focus on individual identity
* <i>Process orientation</i> <u>Accomplishing</u> tasks depend on relationships with others – positive interactions more important than completing task	* <i>Task orientation</i> <u>Accomplishing</u> tasks depend on people following policies and procedures and remaining focused on the goal. Focus on completing tasks –
* <i>Interactional space more communal</i> <u>Interactions</u> physically close. Comfortable interacting in close social distance with constant	* <i>Interactional space has boundaries</i> <u>Interactions</u> physically distant. Requires more social distance in interaction with little touching or

<p>nonintimate touching <u>Personal space</u> is shared and involvement with others is encouraged</p>	<p>contact <u>Personal space</u> is compartmentalized, individualized and private</p>
<p><u>Polychronic Time Orientation</u></p>	<p><u>Monochronic Time Orientation</u></p>
<p>* <i>Time is polychronic</i> <u>Emphasize</u> people and completion of transactions; multitask; change happens slowly because things are rooted in the past <u>Schedule</u> is fluid. Life has its own flow – reluctant to schedule time – Needs of people supersede schedule. Deadlines and schedules are general goals not controlling factors <u>Value</u> time with others and relationship investment, work is secondary. <u>Working</u> collegially is more important than achieving work goals</p>	<p>* <i>Time is monochronic</i> <u>Emphasize</u> schedules, compartmentalization, and promptness; equate time with money and status; change happens fast <u>Schedule</u> is rigid. Value schedules - work on a schedule; Intent is to do things quickly and see immediate results. Deadlines and schedules are taken seriously <u>Value</u> speed and efficiency in work. <u>Working</u> independently to accomplish individual goals more important than team or community goals</p>
<p><u>Large Power Distance</u> <u>Unequal social hierarchies accepted</u></p>	<p><u>Small Power Distance</u> <u>Equality valued</u></p>
<p>* <i>Large power distance</i> <u>Unequal power distance</u> is accepted and expected. Rewards and punishments distributed based on age, rank, status, and seniority. Interactions involve unequal power distributions.</p>	<p>* <i>Small power distance</i> <u>Equal power distance</u> is accepted and expected. Rewards and punishments distributed based on individual performance. Equal power distribution in interactions is valued.</p>
<p><u>High Uncertainty Avoidance</u></p>	<p><u>Low Uncertainty Avoidance</u></p>
<p>* <i>High uncertainty avoidance</i> <u>Tolerance</u> for ambiguity low. Uncomfortable with risk, new ideas. Beliefs and behavior are rarely questioned.</p>	<p>* <i>Low uncertainty avoidance</i> <u>Tolerance</u> for ambiguity high. Comfortable with risk, new ideas and willing to question beliefs and behavior.</p>
<p><u>Field Sensitive</u> <u>Dependent on external cues</u></p>	<p><u>Field Independent</u> <u>Dependent on internal cues</u></p>
<p>* <i>Field sensitive</i> <u>Orientation</u> - Rely on external cues for orientation <u>Conceptual learning</u> enhanced when concepts are humanized or in narrative format <u>Motivation</u> - Motivated in relation to achievement for others, group goals, benefit for others <u>Value</u> social rewards that strengthen relationships with important others <u>Interaction</u> - Tend to be informal and self-disclosing</p>	<p>* <i>Field Independent</i> <u>Orientation</u> - Rely on internal cues for orientation <u>Conceptual learning</u> enhanced with discovery or trial-and-error method <u>Motivation</u> – Motivated in relation to individual achievement, individual goals, and self benefit <u>Value</u> nonsocial rewards and individual recognition Motivated in relation to self advancement <u>Interaction</u> - Tend to be formal and private</p>
<p>* <i>Knowledge obtained by gestalt model</i> <u>Knowledge</u> holistic. Facts are perceived as complete units embedded in the context of situations or experiences <u>Reality</u> is seen in the whole. Elements not easily separated for analysis. Things are interconnected, synthesized and global</p>	<p>* <i>Knowledge obtained by logical reasoning</i> <u>Knowledge</u> dissected. Facts are perceived as independent parts. Information is gained by a rational scientific analysis <u>Reality</u> is elemental, fragmented, compartmentalized – easier to isolate for analysis</p>

* <i>Comprehensive thinking</i> <u>Reasoning</u> - Prefer deductive reasoning from general to specific	* <i>Analytical thinking</i> <u>Reasoning</u> - Prefer inductive reasoning from specific to general – focus on compiling details
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Intercultural interactional theories. This literature review discusses two theories relevant to the context of this study: coordinated management of meaning and face theories.

Coordinated management of meaning. The coordinated management of meaning theory focuses on interactants as processors of information and on the interpersonal and cultural rule systems that guide both action and interpretation (Pearce & Cronen, 1980). Pearce and Cronen define communication “as the process of creating and managing social reality” with a “reciprocal causal relationship between the actions people perform and the world view in which they define themselves as living” (pp. 233). In my study, the provider and patients are from different cultures and their actions and interpretations are dependent upon divergent cultural rule systems.

Pearce and Cronen (1980) use the metaphor of an undirected play to explain the coordination of meaning between culturally different interactants. The metaphor presents the image of a large randomly lit space with indistinct boundaries haphazardly arranged with clusters of theatrical props. While some sections of the area have coherent arrangements, others are empty or have senseless combinations. The actors know that they are to play an important part but do not know their role or whether they are to be cast, crew, or audience. The actors “differ considerably in the specific plays that they know, the number of scenes they can perform in each play, and their skill in determining what play is being produced” (p.120). If the response to an actor’s lines is from a

different play, confusion, frustration, and perceptions of incompetence may result. If, on the other hand, the actor is able to improvise his lines to adapt to the group, then communication and coordination of meaning can proceed.

This undirected play metaphor illustrates the roles that individual and culture play in the creation of meaning as well as the coordination of meaning through intercultural interaction. In the coordinated management of meaning theory, the meaning of an act varies according to the perspective from which it is interpreted (Cronen, Pearce, & Changsheng, 1989, p. 10). Individual rule systems direct the assignment of meaning to the actions of others in a sequence of levels. The number of levels, differentiation among levels, and consistency and coherence among levels vary with individuals. The original theory proposed six levels of meaning, content, speech acts, contracts, episodes, life-scripts, and archetypes.

Pearce eventually combines the six levels into four: culture, episode, self, and relationship (Pearce, 2005). Culture within this context refers to an individual's view of the world, right and wrong, honor and duty, and appropriate behaviors in situations. The cultural level also includes the institutions or organizations involved in the interaction, for example, government and charitable health clinics. This recent level of identification of culture appears to synthesize the previous levels of archetypes, speech acts, and content. The self (or life scripts), relationship and episode levels remain consistent with previous research.

The second element within coordinated management of meaning theory is logical force. The interactants' behavior is driven by the logical force created through the

interaction by the cultural rule systems and the meanings attributed to the others' behavior. This logical force constrains the behavior of the interactant informing how the interactant must, should, may, or must not respond (Pearce, 2005). In health care clinics in Guatemala, biomedically-trained health care workers and the indigenous Achi patient engage in a coordinated management of meaning through their interaction. As the undirected play of provider-patient interaction proceeds, the provider and patient interpret the other through their knowledge of the "script" and the logical force created as a result constrains and guides the interaction (play).

Face theories. Face negotiation theory argues that people in all cultures try to maintain and negotiate face in all communication situations (Ting-Toomey, 1988). The concept of face appears to have originated in China (Ho, 1976). However, Goffman (1959) introduced the concept into Western social theory. Through a theatrical metaphor, he proposes that individuals are constantly performing before others to maintain and manage multiple social identities through presenting a desired image of self to others. This desired image is face and is tied to the emotional significance and social worth of self and others. The salience of a particular identity depends on the context and goals of the individual and often individuals present and manage multiple faces and identities simultaneously (Ting-Toomey, 2005b). Communication serves a key role in establishing and maintaining face as part of social identities (Clark & Kashima, 2007).

Two prominent approaches to face include intercultural conflict (Oetzel, et al., 2001; Ting-Toomey, 1988; Ting-Toomey, 2005a) and politeness (Brown & Levinson, 1987). Research shows that individuals from different cultures manage face different in

conflict. In addition, the management of differing face concerns during conflict assists in reaching desired resolutions (Oetzel, et al., 2001; Ting-Toomey, 2005a) The politeness theory presents politeness as attempts to mitigate threats to the face of the other. Brown and Levinson (1987) identify positive and negative face. Positive face involves the human need to be approved of by others and negative face addresses the desire to not be imposed upon by others. Face needs are supported, threatened, or undermined in interactions with others (Ting-Toomey, 2005b). Face threats are verbal and nonverbal communications that conflict with an individual's face needs. Designing verbal and nonverbal messages to maintain, restore, or mitigate the threats to the recipient's face needs is referred to as facework (Lim & Bowers, 1991; Oetzel, et al., 2001; Ting-Toomey, 2005b). Lim and Bowers (1991) identify specific facework for each face want.

Lim and Bowers (1991) expand the construct of positive face by identifying two separate needs within positive face: fellowship and competence face. Fellowship face is the need to be approved of, included, and liked by others. The need to have one's abilities respected is competence face. For clarity, Lim and Bowers relabel the constructs involved in negative face as autonomy face. Issues of competence face include intelligence, appearance, general and specific knowledge and abilities. Autonomy face incorporates the concept of valuing and holding an individual's right to freedom of will and action, as well as the resistance of the imposition on that freedom by others.

Communication that supports an individual's fellowship face includes expressions of affection, approval, understanding and commonalities. A person's fellowship face is threatened through messages of disappointment, disapproval, and

negative emotions. Competence face is supported by official or formal praise, appreciation, and compliments. Criticism, disapproval, and messages that convey a lack of confidence in the other person's abilities threaten competence face. Messages that support autonomy face include providing options, being indirect, and politeness markers, such as "please." Autonomy face is threatened by direct orders, requests, and obligations. Providers' messages often involve face threats, including direction for behavior changes, disapproval, and instructions.

Face needs and facework are culturally and individually conceived. In polychronic cultures, communication that is task focused and direct may threaten face since polychronic thinkers value relational interaction and perceive valuing others through embellished and extended indirect interaction. In monochronic cultures, embellished and relationally focused interaction that avoids the main points and task specifics may be perceived as face threatening to the monochronic.

In health care interactions, respecting the culture of the patient is linked to face concepts. Evidence of face threat is seen when patients are reluctant to discuss differing beliefs of illness or treatment due to fear of criticism or ridicule (Berlin & Fowkes, 1983). Afsana and Rashid (2001) found that rural women in Bangladesh were more trusting of health treatment, less anxious, and more likely to seek hospital care for childbirth when they felt their culture, dignity and privacy were respected by the health care workers. When patients do not feel that their culture is respected, they often reject the treatment and fail to comply with health messages. While studying the Canadian health care provided to the Inuit population, O'Neil (1989) found that health care workers tended to

trivialize aspects of the patient's culture and attribute unfamiliar behaviors to ignorance or lack of education, thereby threatening the patient's face. When patients' face needs are threatened, they often respond in ways that defend their face and seek to restore their public image within the culture. Face defense and restoration includes rejecting and refusing to comply with the health messages.

Face needs can be threatened by verbal messages, nonverbal communication, and situational factors. For Achi patients, the act of seeking health care from an outsider potentially threatens fellowship, competence and autonomy face. By coming for help, the patient tacitly admits that he or she is not competent to restore health or maintain health. Seeking help from a health care provider requires the patient to self-disclose a lack of competence and discuss often culturally and personally embarrassing body "malfunctions." Patients are often asked to disclose intimate details of their lives to a person they hardly know and with whom they only interact with in a medical setting (Lepper, Martin, & DiMatteo, 1995; O'Neil, 1989). Face needs and facework influence the health care interaction and outcomes desired both by the patient and provider.

The complexities of intercultural communication influence the Achi patients in provider-patient interactions in Guatemala. Coordinated management of meaning theory and face theories provide a useful groundwork for exploring the influence that intercultural communication has on the provider-patient communication in Guatemala.

Health Knowledge

Mindful intercultural provider-patient interactions require knowledge about the patient's health understandings and cultural perspectives. Patients make sense of their

symptoms and experiences prior to seeking medical help at the clinic. The process of making sense of new experiences and information as well as establishing new health behaviors can be seen as a form of learning. Learning theories and health explanatory models can illuminate this learning process of providers and patients. This part of the literature review discusses social cognitive theory, theory of meaningful learning, and health beliefs.

Social cognitive theory. Social cognitive theory proposes that what an individual knows and believes as well as how he or she behaves are determined by the reciprocal interplay of three factors: personal, behavioral, and environmental determinants (Bandura, 1986; Bandura, 2001). These determinants reciprocally influence the patient's and provider's behavior before, during, and following an interaction. The theory assumes human agency; that is, people are self-organizing, proactive, self-reflecting, and self-regulating. People are both the producers and products of social systems (Bandura, 2001).

Personal determinants include knowledge, goals, values, capabilities, self-efficacy, outcome expectancy, and outcome expectations. Determinants from the environment include the individual's social network, situational factors, social prompting, and social modeling by others. The behavioral determinants include the individual's behavioral capacity, reinforcement, and individual experiences. Patients and providers enter the health care interaction with knowledge, behaviors, and beliefs about health and illness shaped by the reciprocal interplay of personal, behavioral, and environmental determinants.

Outcome expectations are one of the personal determinants relevant to this study. The patient's outcome expectation, the belief that positive or negative outcomes will result from adopting the health behavior suggested by the provider, directly affects his or her compliance. Bandura (2001) suggests that people form expectations through four avenues: previous personal experience, vicarious experience, hearing about the outcome from social others, and messages that arouse emotional responses. People interpret personal experience based on existing individual and social belief structures. A patient may have attempted a specific health behavior and not adequately understood or complied with necessary instructions resulting in a negative outcome. The patient and social others are then likely to form a negative outcome expectation for that health behavior. The outcome expectation is subject to illogical, irrational thinking based upon misunderstood or misapplied behaviors. Similar to outcome expectation is outcome expectancy which is the value the patient places upon a health outcome expectation.

The behavioral determinant includes the individual's behavioral capacities (ability to perform the required health behavior) and the reinforcements received for the behavior, including those received from social others as well as physical reinforcements, for example, improvement in health and reduction of pain. Amann's (2003) somatic learning model extends the behavioral determinant construct. Somatic learning recognizes that the experiences of the body, whole person, are involved in the meaning making process (Hannaford, 1995). Somatic learning involves kinesthetic, sensory, and affective learning. Kinesthetic learning occurs through movement of the body (Matthews, 1998). The individual learns lessons through the movement process such as

discipline, diligence, dealing with stress, or solving problems (Amann, 2003). As a patient engages in a new health behavior, he or she learns not only the movements involved in mastering the behavior, but learns about the behavior's effectiveness and forms outcome expectations. Sensory learning involves information accumulated through the five senses. Individuals attach meaning and values to the sensory inputs.

Affective learning involves the individual's feelings and emotions. The lay person often refers to knowing something "in his gut." Emotions also influence the person's ability and motivation to reflect upon and learn health information. Often the rural indigenous patients delay seeking medical care from an outsider until an illness progresses to critical stages. As a result, the patient often experiences high levels of stress, anxiety, and fear. These emotions may impact the patient's motivation and ability to focus and learn the health information presented by the provider.

In the Achi villages, environmental determinants include social and physical limitations to health behaviors due to varying degrees of poverty. Economics and living conditions often constrain health and health choices. For example, a desired health behavior may require financial payments that are impossible for the individual to meet. The Achi patient's compliance with health messages is dependent on the idiosyncratic reciprocal interplay of personal, behavioral, and environmental determinants.

Theory of meaningful learning. The theory of meaningful learning illuminates the sense-making interpretations involved in provider-patient interactions. The theory proposes that the quality and usefulness of an individual's learning and sense-making depends upon the complexity, interrelatedness of his or her existing cognitive structure,

and how the individual relates new information to the existing structure (Ausubel, 1963; Novak, 1998).

Ausubel (1963) proposes that people's cognitive structure is hierarchically structured with general concepts serving as anchors for more specific concepts. Cognitive structures are idiosyncratically developed based upon the individual's abilities, experiences, and culture. An individual's existing cognitive structure, specifically the organization, stability, and clarity of knowledge in a subject-matter, is the major factor influencing learning, retention, and ability to apply knowledge to facilitate health. Patients' knowledge, understanding, and beliefs about health and illness are aspects of their cognitive structure. When a provider introduces a new health construct, such as the link between gastrointestinal problems and poor hygiene, the patient makes sense of the information through their existing cognitive structure.

When treating patients from different cultures, providers often encounter difficulties in communicating new health information because of the differences between the providers' and patients' cognitive structures. For example, Suchman (1961) cites a narrative from the Cornell-Navajo project, where providers attempted to educate the Navajos about the microbiological causation for tuberculosis. The Navajos' representational cognitive concepts attributed illness to spiritual causes. After seeing the tubercle bacillus under a microscope, a Navajo exclaimed "Ah, so you have found the demon that we knew all along caused the disease." In this example, the Navajos made sense of the new information utilizing their existing cognitive structure by subsuming the new information under existing categories and relating it to existing concepts. This is

consistent with John Smith's (1982) findings that individuals persist in beliefs even when faced with disconfirming information because they self-persuade; that is, they develop their own idiosyncratic meanings grounded in their existing cognitive structure.

In health interactions, patients are exposed to new experiences and information. The patient's compliance, application of the health information, and health outcomes are influenced by the manner in which the patient makes sense of the new information. Associating new information with existing cognitive structure in a meaningful way is critical to the ability to utilize the information to solve problems and guide behavior (Ausubel, 1963; Lawson & Chinnappan, 2000; Novak, 1998; Van Meter & Sperling, 2005). Lawson and Chinnappan (2000) found that students with unorganized, unstable, and unclear cognitive structures were less able to access existing knowledge in order to solve problems than students with organized cognitive structures. These students depended upon hints in order to know what knowledge to draw upon for the solution. This is relevant to health care encounters because the organization of a patient's health-related cognitive structure influences his or her ability to utilize the health information to guide their compliance with health treatments as well as provide a guide for action regarding future illnesses.

The key to meaningful learning is the development of propositions (relationships between concepts). "Meaningfully learned materials are related to existing concepts in cognitive structure in ways making possible the understanding of various kinds of significant (e.g. Derivative, qualifying, correlative) relationships" (Ausubel, 1963, p. 23). Meaningful health sense-making, therefore, requires relevant prior knowledge. If no

relevant prior knowledge exists, the learner will make sense of the new material rote (that is, with information stored in a disassociated, self-contained manner), fail to learn the material, or attempt to make sense of the new health information through existing knowledge which may result in invalid concepts and propositions.

Ausubel (1963) suggests that providing cognitive organizers in advance can assist in meaningful learning when no relevant existing knowledge exists. Advance organizers are more general and abstract organizing concepts that can serve as anchors for new concepts. It is widely accepted that the single most important factor influencing learning is what the learner already knows (Novak, 1998). If this existing information does not provide the structure for organizing new health information or fails to contain relevant knowledge, meaningful learning will not occur. Often when relevant prior knowledge anchors are absent from patients, health messages are ineffective.

Health beliefs. Health beliefs are an aspect of a person's socially-constructed and context-bound assumptions that guide individual sense making regarding health and illness (du Pre, 2001; Hallenbeck, Goldstein, & Mebane, 1996; Kleinman, Eisenberg, & Good, 1978; Payer, 1988). Beliefs about health, healing, and illness are cultural constructs profoundly affecting health communication and outcomes (Airhihenbuwa, 1995; du Pre, 2000; Suchman, 1961). This section discusses theories of illness and explanatory models related to my study.

Theories of illness. The World Health Organization (1948) defines health as more than the absence of infirmity and disease but also as a state of physical, mental and social well being. Kleinman, Eisenberg, and Good (1978) explicate the difference

between disease and illness, defining disease as abnormalities in the structure and function of body, organs, and systems. In contrast, patients suffer illnesses, that is, the experiences of devalued changes in states of being and in social function. In other words, illness is the human experience of sickness affecting a patient's daily life and reducing his or her ability to be satisfactorily socially engaged, to accomplish necessary life responsibilities, and to enjoy life. For example, in his study, MacDougall (2003) found that chronic sufferers of arthritis considered themselves healthy because with planning and effort they could engage in most daily physical and social activities.

Two conceptual approaches to health include a biomedical or a biopsychosocial perspective (du Pre, 2000). The biomedical approach is grounded in evidence-based medicine and primarily focuses on recognition, diagnosis, and treatment of disease (Kleinman, Eisenberg, & Good, 1978; Levin, 1998). The biomedical perspective conceives of illness as disease and health as the absence of disease. The dichotomous view of patients, with a person being either healthy or sick, fails to adequately recognize all aspects of the human experience with health and illness. The biomedical approach to disease is strongly mechanistic in nature, viewing the body as a machine, prone to malfunctions, requiring tune-ups or occasional part replacement (Hallenbeck, Goldstein, & Mebane, 1996; Kleinman, Eisenberg, & Good, 1978).

In the biopsychosocial perspective, health is not merely the absence of disease but is the harmony of various psychological, biological, and social factors. The influencing factors vary among cultures. For example, many cultures in Central America perceive illness as a result of an imbalance of hot and cold factors, assigning hot and cold values to

foods, energies, and treatments. Research shows improved outcomes when providers interact with patients in ways consistent with the patients' theories of illness (du Pre, 2000; Kleinman, Eisenberg, & Good, 1978).

The biomedical view is often considered the “correct” view based on scientific, empirical data; however, the reality is that the biomedical perspective is also a theory of illness with significant variations among different cultures in the developed world (Kleinman, Eisenberg, & Good, 1978; MacDougall, 2003; Payer, 1988, Pelto & Pelto, 1997). Payer (1988) found that interpretations of symptoms, diagnoses, and recommended treatments varied widely among providers in France, Germany, England, and the United States.

Cultural patterns of theories of illness are an important aspect of this study. Murdock, Wilson, and Frederick (1978) identified the world distribution of common theories of illness in their meta-analysis. Examining studies of 186 societies throughout the world, they found that although variations existed, prevalent theories of illness tended to remain constant among societies belonging to particular linguistic families.

Relevant to this study with its focus in Guatemala, the researchers grouped Central America with societies in South America. They found that the 22 societies in South America ranked highest in causal attributions of illness to spirit aggression and sorcery. Spirit aggression is defined as “the attribution of illness to the direct hostile, arbitrary, or punitive action of some malevolent or affronted supernatural being” (Murdock, Wilson, & Frederick, 1978, p. 455). Sorcery is defined as “ascription of the impairment of health to the aggressive use of magical techniques by a human being,

either independently or with the assistance of a specialized magician or shaman” (p. 455). Although these theories of illness do not necessarily represent the existing theories of illness among the Achi, they provide a starting point for research. During my initial visit with the Achi, I observed apparent pluralistic theories of illness similar to Capp’s (1994) findings in his study of the Hmong in Kansas City.

Explanatory models. The culturally guided and individually conceptualized understandings of illness, its causes, its consequences, and the best treatment comprise a patient’s explanatory model (Hallenbeck, Goldstein, & Mebane, 1996). Explanatory models reflect social class, cultural beliefs, education, occupation, religious affiliation, and past experiences with health and illness. How individuals perceive, experience, and cope with disease as well as how they communicate about health and illness, present their symptoms, decide when and to whom they go for care, and evaluate care emerges from the patients’ explanatory models (Kleinman, Eisenberg, & Good, 1978).

Patients enter health interactions with an idiosyncratic and culturally-grounded explanatory model (Carrillo, Green, & Betancourt, 1999). Biomedically trained providers often categorize theories of illness into beliefs and knowledge perceiving scientifically-based theories of illness as “knowledge” and biopsychosocially-oriented theories of illness as “beliefs” (Pelto & Pelto, 1997). In actuality, both are belief-based, culturally-grounded explanatory models. Although the explanatory models are guided by culture, individual explanatory models are shaped by individual roles and experiences in culture, such as socioeconomic status, social roles, individual experiences with illness, and the responses of significant cultural others (Carrillo, Green, & Betancourt, 1999;

Pelto & Pelto, 1997). The biomedically trained health care providers in Guatemala are likely to have different explanatory models than the Achi patients influencing provider-patient communication.

The explanatory models of both the health care worker and patient influence the interaction and outcomes. The prior knowledge through which the patient makes sense of health messages includes the explanatory model of the illness. The provider's diagnosis and treatment recommendations depend on his or her explanatory model. Therefore, provider-patient communication is a transaction between explanatory models. When the explanatory models of the provider and the patient are discordant, miscommunication, misunderstanding, mistrust, and failure to comply are likely outcomes (Kleinman, Eisenberg, & Good, 1978). Patient satisfaction is most likely when providers take into consideration patients' feelings and explanatory models (Callan, A., 1998; du Pre, 2001). When patients are satisfied and comfortable with the provider-patient interaction, they are more likely to trust and comply with the health advice they receive (Afsana & Rashid, 2001).

The provider and patient engage in sense-making activities throughout the interaction. The interpretations and behaviors occurring during the interaction result from and are guided by the reciprocal interplay among personal, behavioral, and environmental determinants (Bandura, 1986). The quality and usefulness of individuals' sense-making is influenced by the complexity, interrelatedness of their existing cognitive structure, and how new information is related to his existing conceptual structure (Ausubel, 1963; Novak, 1998). In health care interactions, the theories of illness and

explanatory models influence the provider and patient as well as the patients' after-interaction behaviors.

Summary

Provider-patient interactions. The differences in power, socioeconomic status, and culture between the providers and patients influence the provider-patient communication and the patients' health outcomes. An abundance of research exists on provider-patient communication; however, the majority of studies have been conducted in Western contexts. Few, if any, communication research explores the influence of these factors on provider-patient interactions in Guatemala with biomedically trained culturally-different providers interacting with Achi patients.

Intercultural communication. Provider-patient health interactions in Guatemala are intercultural social constructions. Research identifies cultural patterns in values, beliefs, and behaviors. I synthesized these patterns into a monochronic-polychronic continuum. This chapter discusses coordinated management of meaning theory and face theories. Although extensive research in intercultural communication exists, the applicability and usefulness of the theories and findings to elucidate the intercultural indigenous health care contexts has not been explored.

Health knowledge. This chapter also discusses the importance of health knowledge, including social cognitive theory, theory of meaningful learning, and health beliefs. Providers and patients in intercultural health care settings often enter the health interaction with different health knowledge and perspectives. The personal, environmental, and behaviors factors, the manner in which the patient makes sense of the

information, and patients' beliefs about health and the causation of illness influence the likelihood patients will accept and comply with the provider's health messages. Further, this thesis explores the impact of health knowledge and sense-making on provider-patient communication in the temporary health clinics in Guatemala.

CHAPTER THREE

Methods

The methodology used to accomplish the goal of this study involved participant observation, informal field interviews, and thematic analysis. This chapter discusses the role of the researcher, the characteristics and selection of the participants, the data collection process, and the method of analysis.

The following research questions guided my qualitative data analysis:

RQ 1: What factors influence the provider-patient interaction for the Achi patients in Baja Verapaz, Guatemala?

RQ2: How do the cultural differences between provider and patient affect the communication interactions in the context of this study?

RQ3: How do biomedical and cultural knowledge about health and illness influence the provider-patient interactions in the population of this study?

The goal of this study is to identify and explain the factors influencing the Achi in provider-patient interactions in Baja Verapaz, Guatemala. Qualitative research provided a method for identifying and understanding the complex forces influencing provider-patient communication at my study site and allowed me to uncover the richness, depth, nuance, multi-dimensionality, and complexities of real world interactions (Mason, 2002).

Role of the Researcher

As researcher, I recognize that my very presence and interaction in the field creates outcomes that otherwise would not have occurred. I limited my influence as much as possible, striving through active reflexivity to minimize my voice and maximize

the voice of the participants. I engaged in critical self-scrutiny to understand and stay aware of my influence on data collection process (Mason, 2002).

As part of the reporting and analysis process, the researcher selects the aspects of data to bring forward and the aspects that are left out, thereby influencing the understandings and outcomes of the research (Lindoff & Taylor, 2002). Being aware of this privileging process the field study, analysis, and reporting of results sensitized me, reduced the potential for researcher bias, and allowed the findings to emerge from the data.

My lens for viewing and understanding the world is grounded in my culture and experiences. My culturally-grounded values likely influenced my interpretations of the data. I am Caucasian and have always lived in Caucasian-dominated communities. Living as a member of a dominate group within a community shaped my perspectives of power and opportunities. As a woman born in the 1960s, I frequently heard messages of equality and color-blindness. I naively believed that people are to be judged by their behavior and character not their color, class, or status. As a young person, I was always surprised and disturbed by any overt discrimination. As an adult, I recognize that my position of privilege as a member of the dominate group blinded me to many of the struggles and lack of opportunities faced by people of nondominant groups.

My childhood experiences in a middle-class, Caucasian family of five children also shaped my cultural lens. My parents sacrificed to provide opportunities the family. Our middle-class economic status defined “sacrifice” to include giving up things, activities, and time. Sacrifice did not involve going without a meal, but did involve lower

quality meals than we desired. This modeling shaped my perspective of family and parenting including the value of children and parental responsibilities to put children's needs first. My values and definitions of motherhood are grounded in my mother's sacrificial dedication to my siblings and me. Because of her example, I value the time invested in home cooked meals from scratch and often feel like I am "cheating" when I use a convenience meal for my family. In my parenting, I have made sacrificial choices for my children including time commitments, giving up activities, accepting work that was below my training and skills, giving the children the best of the available food and accepting the smaller or less quality portions. Being raised in the Christian faith shaped my values including the value of the individual, charity, compassion, and sacrificial generosity.

I plotted my position on the polychronic and monochronic continuum and located myself in different places along the continuum. In leadership positions, I adopt the language of task, efficiency, and directness but I am naturally inclined to less direct communication. I recognize, however, that my definition of "less direct" communication, is bound by a monochronic perspective. For example, even though strong direct communication, especially in conflict, is something I "put on" as a second language, my frustration with "beating around the bush" type of communication exposes my monochronic tendencies.

In terms of time, task, knowledge gaining, power distance, analytical thinking, and individual learning, I place myself along the monochronic side of the continuum. I am strong in analytical thinking, more high-context than low-context, and become

frustrated when someone begins discussing details and parts prior to giving me the overall picture first. I position my commitment to people closer to the polychronic end of the continuum. However, my monochronic valuing is reflected when I interpret “valuing people” as not wasting their time and accomplishing tasks. I value people’s perspectives, culture, and their presence and enjoy discovering the lens through which others understand phenomena, enjoy spending time with others “just visiting,” and learning about the traditions and rituals of others from different cultures. Enjoying the presence of significant others without defining an agenda or task reveals a polychronic preference.

My cultural positioning supports the polychronic and monochronic concepts as a complex continuum where people are idiosyncratically located in various places along the continuum. Recognizing my own cultural positioning and my role as a researcher sensitized me to the lens through which I observed and analyzed the field data.

Characteristics and Selection of the Participants

Population. The population for this study is the Rabinal Achi people in Guatemala who are descendents of the Maya living in villages and towns throughout the Baja Verapaz department of Guatemala. A few of the towns have access to infrastructure and technologies, including intermittent electricity, cars or motorcycles, internet, and cell phones; but many villages are remote with access only by foot. Mountains and the Matanzas River dominate Baja Verapaz. Even though the Guatemalan government has made great strides in improving access to clean water, education, and health care for rural villages, a large portion of the indigenous population continue to lack access to clean water and adequate health care.

After the introduction of Roman Catholicism in the 1500's, Christianity eventually became the dominant religion in Guatemala. Many of the indigenous people groups merged Catholicism with their Mayan beliefs. Catholic and protestant missionaries have lived and worked among indigenous people groups in Guatemala for centuries providing humanitarian, educational, and religious assistance. Evangelical Protestantism is spreading among the Achi. Various denominational churches run by Achi pastors exist throughout most Achi communities. Christian missionaries provide access to health care to remote villages that have limited to no access to government health care.

Sampling. An organic sampling process utilized convenience and purposive sampling (Baxter & Babbie, 2004). The sampling process evolved as access to interviewees expanded through referrals. My entry into the community was facilitated by field informants, whom I met through my church contacts. My church has been a major financial supporter of a linguistic team translating the New Testament scriptures into the Achi language. The linguistic team has lived among the Achi for 30 years and is accepted and trusted as community members. After learning of my research, the linguistic team agreed to assist in my gaining entry and access to the community.

I engaged in participant observation at a temporary health care clinic where I utilized convenience sampling. The observation took place during one of the intermittent health care clinics in a remote village. This context allowed me to observe the provider-patient interactions and to talk with patients and health care providers during that day.

Using purposive sampling, I interviewed people in different communities gathering information about their experiences with health care interactions. During my initial visit to Guatemala, I made preliminary contacts and formed relationships with several informants in the field, including community members and workers living in the community. These informants provided the entry for informal interviews with community members. Additionally, I relied upon the informants' knowledge as community members regarding important community and cultural factors affecting the appropriateness of interviewee selection. This sampling method provided protection for the community members from my overlooking potentially culturally offensive factors. In line with Mason's advice (2002), the number in the sample for informal field interviews grew and developed throughout the research process in ways related to the emerging shape of the data.

Protections

I kept the participants' identities confidential by using pseudonyms for interview participants and towns (Appendix A) and referred only to the larger municipality to limit the possibility of identifying the participants. I obtained the consent of the health care team leader and the village leader prior to my participant observation data collection. If I perceived any discomfort or distress in the interviewees, I obtained advice from my field informants and altered my behavior, changed the wording of the questions, or ceased the distressing questions or actions. I relied upon my field informants to provide additional feedback regarding the comfort or distress levels present in the interviewees. Because the majority of participants in this study were illiterate, lacked formal education, and only

spoke Achi, I used the services of an Achi translator fluent in three languages: Achi, Spanish, and English.

The issues of informed consent during participant observational research are complex. The goal of participant observation is to develop sufficient rapport that participants become comfortable enough with me that they will share insights and information only insiders would know (DeWalt & DeWalt, 2002). The fundamental issue at the core of informed consent is to protect the participants' autonomy to choose whether to participate in the research. For my data collection in the health clinic, I gained the prior consent of the village leader and he was present throughout my data collection. I informed the village leader and health care team leader to inform me if at any time they believed that my presence and/or questions were inappropriate, offensive, or impeding the health care visits so I could change or cease the behaviors. The village leader's presence and my participation as a volunteer with the health care team provided me with supervision of my research and helped protect the participants from harm from my study.

I informed the patients that my presence and questions were related to a research study with a university and that I would not keep track of their names. In addition, I informed them of their right to request that I not be present during their health visit and that my presence or absence would not influence the care and medicine they received. I gained verbal informed consent from all those participating in interviews.

Data Collection Process

Qualitative research is best suited to explore the complexities and wide array of dimensions of the social world. Qualitative research holds an unrivaled capacity to

explore and explain “how things work in particular contexts” (Mason, 2002, p. 1). Participant observation and informal field interviews are appropriate qualitative methods to answer the research questions in this study. By observing and taking part in the daily activities, rituals, interactions, and events of a population as a participant observer, I learned the explicit (the aspect of culture that community members can articulate) and tacit (the aspects of culture outside of conscious awareness) aspects of the observed community or event (DeWalt & DeWalt, 2002). Participant observation is “both a data collection and an analytic tool” (Dewalt & DeWalt, 2002, p. 8). I used moderate participation, in which the participants in the study were aware of my role as a researcher and I occasionally interacted with the participants in the context of this study. My lack of fluency in Achi and Spanish limited my potential for full active participation. However, my volunteering with the health care team, interacting with the patients and the community, and teaming with an Achi translator allowed for the collection of a rich reservoir of data.

While in the field, I manually recorded extensive field notes, including details about the provider-patient interactions. I recorded informal field interviews on a digital voice recorder and took notes during the interviews. In addition, during appropriate interludes throughout the day and evening, I noted observations, impressions, and thematic ideas. The translator provided real time translations during observations and interviews. No transcription is a complete recording of the interaction nor is it an objective record (Mason, 2002). In light of this, the research questions guided the transcription process. I transcribed discussions and observations that identified factors

influencing the provider-patient interaction and revealed cultural and health knowledge differences influencing the provider-patient interaction.

Method of Analysis

The method of analysis for this study was an interpretive, qualitative four-step process (Boyatzis, 1998). As noted, I obtained data through writing extensive field notes during participant observations, digital recordings of participant observations and interviews, and discussions with field informants. The four step thematic analysis process involved identification of potential themes in the field, initial theme identification, thematic analysis rigor, and thematic interpretation.

Potential thematic identification. I started analysis in the field during the process of data collection and recording field notes. Each day, I reviewed the collected data, identified ideas about potential themes, and observed how events might relate to existing theory and to each other (DeWalt & DeWalt, 2002; Mason, 2002). While in the field, I benefitted from regular in-depth discussions with field informants about the data.

Initial theme identification. The second step in my thematic analysis was the identification of data-driven themes (Boyatzis, 1998). This involved transcriptions, immersion in the raw data, and thematic analysis rigor.

Upon returning from the field, I personally transcribed all the data. Through this process, I immersed myself in the flow of the conversations, inflections, and context of the data. The transcriptions consisted of over 74,000 words. I marked sections of the data for refined translation by a local fluent Spanish speaker, who listened to the selected sections of the recordings multiple times to provide a more complete translation than was

obtained through live translations in the field. Once all the data was transcribed, I read through the entire raw data set including field notes. The personal transcribing, re-translating, and reading through the entire raw data allowed for an immersion that provided a deep familiarity with the narratives and information within the data.

During a subsequent reading, I marked emergent themes in the margins of the text guided by the research question: What factors influence the provider-patient interaction for the Achi patients in Baja Verapaz, Guatemala (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006)? A list of emergent themes was created and subsequently evaluated during another reading of the entire raw data. This third reading resulted in a clustering and refining of themes. For example, the initial theme “language” was condensed with “finances” into a larger theme “environment.” Finally, I created a new refined list of themes and compared these themes to the raw data for further refinement and identification of subthemes to the major themes.

Thematic analysis rigor. The strength and power of the data-driven approach to thematic analysis is that it “uses, as much as possible, the way in which the themes appear in the raw information as the starting point in code development. The validation with the entire sample is a cross-check” (Boyatzis, 1998). My entire analysis process was grounded in the raw data rather than in summaries or samples from the data. This connection to and grounding in the raw data helped to protect the theme identification process from the potential error of projection. The error of projection occurs when the researcher attributes to the data a characteristic, value, or quality that is projected from the researcher rather than emergent from the data (Boyatzis, 1998). My analysis was

further protected from the error of projection by my extensive discussions with field informants which provided opportunities for correction and clarification.

This study was an ethnographic participant observation with purposive field interviews. Potential participants were identified and I was introduced by the field informants. The trust the interviewees held for the informants assisted in their feeling somewhat comfortable disclosing their experiences, thoughts, and feelings. This sampling process, as is common with ethnographic studies, limits the generalizability of the findings; however, the recurrence of themes throughout the data improves its rigor.

Thematic interpretation. Once the themes were identified and validated, I analyzed the themes identifying the interactions and relationships among the themes, comparing the findings to existing theory, and identifying the ways in which the data challenged or reinforced existing assumptions and theory. This process involved visually representing on a white board the themes and interactions in different ways and through the lens of different existing theories.

In summary, the data-driven qualitative thematic analysis used in this study consisted of four steps: identifying potential themes while in the field and discussed the data with informants; engaging in multiple readings of the raw data; and identifying, clustering, and refining emergent themes. The rigor of my thematic analysis was strengthened by comparing themes against additional readings of raw data and discussions with field informants. Finally, I interpreted the themes by identifying relationships and interactions among themes and by comparing the findings with existing theory.

Summary

Data was collected through participant observation and information interviews. The research questions were answered through qualitative, interpretive, and data-driven thematic analysis. This methods section discusses the role of the researcher, the characteristics and selection of the participants, the data collection process, and the method of analysis. I recognized my influence on the research environment and data “outcomes and limited my influence as much as possible through active reflexivity to minimize my voice and maximize the voices of the participants. Protections provided the participants include modified verbal informed consent, identification of the governmental municipality rather than the individual village, and the use of pseudonyms for names and communities.

CHAPTER FOUR

Findings and Analysis

The strength of qualitative research is its provision for challenging the researcher's assumptions and them to the emerging data. My initial exploratory trip to Baja Verapaz, Guatemala provided information upon which this study was founded. Unknowingly, I integrated the information from this initial trip with my personal perspectives into assumptions regarding health care in the field. The findings challenged these assumptions. The frequently recurring experiences of abuse, neglect, and disregard described by the Achi people participating in this study emerged as a dominant theme.

The first research question, "What factors influence provider-patient interactions for the Achi patients in the context of this study?" guided the analysis. The challenges to my assumptions and subsequent personal reassessments allowed for the emergence of the unexpected findings of a new construct, defacement, and a greater understanding of the interactions in provider-patient communication. Being granted the privilege of hearing emotional and dehumanizing personal stories from patients allowed me to give voice to the stories and to provide a framework for understanding. I discuss the findings related to prior assumptions, the factors impacting the provider-patient interactions, and the presentation of a new construct, defacement.

Exposed Assumptions

I entered the field assuming that economic and logistical factors were the main factors influencing in the Achi's health care choices. Throughout recent years the Guatemalan government has expanded access to health care to many indigenous

populations; however the expense and logistics involved in reaching the clinics frequently prohibit access for the poorest populations. Dr. Griego, a Guatemalan doctor volunteering his medical services in rural Achi villages, explained these challenges:

They have very few health services within the reach of the (rural) community.

When someone is sick in their family, it is a big problem. They have to think about leaving their other children or rest of the family in the community. On top of this, they have to invest a very large and burdensome amount of money to travel and sleep outside their own home. A lot of times if the sick patient is a child, the mother has to stay with him in the hospital. Furthermore, the father has to return to the home to take care of the other children *and* continue to work to provide support for the family.

The findings challenged my simplistic assumption regarding factors and revealed a complex interplay among four factors (environment, beliefs, affect, and experiences) that influence provider-patient interactions and drive the health care decisions of the Achi participants.

The use of the term “health care” by academics and lay people within the industrialized and developed world draws upon a schemata of assumptions. My health care schemata assumed provider-patient interactions center around the health and good of the patient, include a basic degree of care and concern for the patient as a suffering fellow human being, and include some degree of commitment to two key elements of the Hippocratic oath: do no harm and prescribe treatments for the good of the patient to the

best of the ability and judgment of the doctor. However, the recurring narratives of dehumanizing treatment shattered these assumptions.

Factors Impacting Provider-Patient Interactions

The data revealed that provider-patient interactions and the Achi people’s health decisions are shaped by the environment, beliefs, emotional effect, and experiences. I propose that the reciprocal interaction among these factors create the individual’s health reality. This health reality drives their health decisions that both shape the provider-patient interaction and serve as the lens of interpretation during interaction. Figure 2 outlines the four major emergent themes and subthemes discussed in this section.

ENVIRONMENT	BELIEFS	EMOTIONAL EFFECT	EXPERIENCES
Options available	Theories of illness	Confidence/trust	Behavior of doctors
Economics	Pharmaceuticals	Intimidation	Results of treatment/nontreatment
Language and Education	Unresolved belief conflict	Fear	Behavior of others
Health context (home/work)			

Figure 2

Environment. Environmental factors constrain health care decisions and provider-patient interactions for the Achi. The Achi have several options for health care, however, finances, education, and language limit the accessibility of options. Education level affects the people’s ability to interact with Ladino (non-indigenous or mixed-race Guatemalans) health care providers. The following subthemes related to environmental

constraints emerged from the data: options for health care, economics, language and education barriers, and health context.

Options for health care. The Achi people have seven choices for addressing illness: do nothing, attend government clinics and hospitals, access private doctors and facilities, use native healers, rely on pharmacies, visit charitable visiting health clinics, and utilize remedios (home remedies).

Do nothing. Occasionally people choose to do nothing when experiencing illness despite knowing it may result in death. Elizabeth, a health care provider working in temporary health clinics, explained the challenges that she faces trying to convince people in rural villages to go to the hospital for treatment.

We have had *very* difficult times on some occasions getting people to go to the hospital. People who *really* needed to. I just heard from Andres about a pregnant woman I saw in the clinic. I tried to get her to go to the hospital. I told her that the baby will probably die if she does not go. Well, he told me that she did not go and the baby died.

Elizabeth said she struggles emotionally with the reality of these choices. As a caring health provider, she gives her time and energies to improve the health of the rural Achi people. It is disheartening to her when they choose to do nothing.

Attend government clinics and hospitals. Government clinics (centro de salud or puesto de salud) and hospitals are free of charge for the indigenous population. Getting to these clinics requires a significant amount of planning and financial sacrifice for those living in rural villages. Typically, they have to walk several miles (with their sick family

member) to reach the location to catch a bus. The bus ride to the nearest town with a centro de salud usually takes hours and costs up to 10 quetzales each way. The average yearly wage for those working in towns is approximately 2,800 quetzales. However, many in the villages subsistence farmers and live on much less. Once at the clinic, they have to take a number and wait, often most of the day, to see a provider. The centro de salud usually opens around 8:00 a.m. and the line begins forming at 5:00 a.m. Occasionally after waiting all day, they are not seen and are told to come back the next day. If they are fortunate enough to see a provider, they often have to endure mistreatment, neglect, and abuse. People avoid the government health facilities if possible. Andres, a young man going to nursing school, explained, “Mainly just poor people go to the centro de salud. Anybody who has money would go to a private doctor in Villena.”

Government facilities struggle with limited funding. Alfonso works for the government health department. He explained, “Often they run out of medications and have to go a long time before they get more.” This becomes a problem for the patients suffering extreme poverty who cannot afford to purchase medications from pharmacies. Aleece, a young mother seeking care at the temporary health clinic, said that often when she and her peers go to a centro de salud, the health care providers say “no medicine” and send them away. Andres, the village leader, confirmed this, “This is a problem with the woman in our village. They do not want to go to the centro de salud because they are told ‘no medicine, leave.’ This is a big problem.” It is unclear whether the facilities do not have the medication or refuse to give it to the patients. In later discussions, my

translator clarified the women's perspective, "The feeling of the women is that the doctors do not want to give them the medicine."

Low wages and heavy workload are additional challenges facing the government health facilities. Alfonso said:

One of the problems in the health area is the salary for the all the workers is small.

One of the reasons the people in health area do not work well and do not do their best is because their salary is small.

Felicia, a retired nurse who worked in government health care facilities, added:

Another thing, we need to think about all the jobs (overwork), all the work they are doing because in the puesta de salud here, there are 23 programs. They have to work in all those programs because sometimes a supervisor will come and ask how are you doing about this program and what are you doing in this other program. They have so many, many jobs. In that time (when she worked) there were just 13 people in the health area in Altea. It is a lot of work for them.

The vast majority of the Achi's experiences at government health facilities in the data involve mistreatment. However a few positive stories emerged. Angelita, who had a young son who suffered with cancer and died at 7 years old, claimed:

In the specialty section (pediatric oncology) of the hospital in Guatemala City, they were very kind to my son. They would give him toys and explain what they were doing. They treated him with much kindness. I think because they know that they children don't have much time.

Andres shared this information about a good doctor:

There is one doctor who my sister has gone to that has been very friendly and really seems to care about the people. She asks questions about their lives, takes time with them. They feel comfortable with her. But this is *very* rare.

The experiences of mistreatment and abuse of the Achi people emerged as a dominate subtheme. Jose, a native healer explained, “In public hospitals, they *absolutely do not* give the attention that is required.” Benita, a young mother and daughter of Jorge, also stated, “To most people, the doctors in Villena do not receive them well. The ladies, they do not give them attention.” Felicia worked as a nurse in government clinics for 20 years and recently retired. She stated, “Discrimination of the indigenous people is a big problem. The doctors are rushed, don’t take time, and honestly don’t care.”

Access private doctors and facilities. If people have the money or can borrow the money, they choose to go to a private health facility. Diego, a young father and school teacher, explained his choice of going to a private doctor:

We realize that when we go to a private doctor, they receive you better. They ask “What have you taken?” and “What are your symptoms?” And when you go to the government doctor, they just ask you some questions then they write and write and write and send you out with a prescription to a certain medicine. That is all. I prefer to go to a private doctor because they take time and do more examining.

Patients prefer private doctors and facilities to the government facilities. “If anyone has enough money, they would go to a private doctor, even if it costs them the medicine and everything,” Andres explained. Jose further described the difference between government and private care:

A private health visit provides more attention. Because since you pay for everything, the doctors are not discriminating because they are getting paid. Any person who gets there, whether they are high class or low class, or even our race, they accept the patient and take care of them properly.

Although this option is expensive, Consuela, a teacher and mother in her early thirties, was adamant that the private doctor was worth it even if it requires sacrifice. As a teacher, she is eligible for separate government health care which is typically somewhat better than the general government care. She gives this reason for choosing to go to a private doctor:

Because I have been lucky and blessed, I can go to the private doctor first to find out what my daughters or I have. Then I take the note (prescription) that they give me and go to the government pharmacy. But with the private doctor, they examine me and give me tests and really find out what I have. It is worth it even if we have to sacrifice.

This sentiment was confirmed multiple times by many participants. “To go a private hospital is expensive so only the privileged can afford it,” Jose stated. Jorge, an elderly man, explained that when his wife had a stroke, he took her to a private hospital which was a great sacrifice for them financially. He said, “I never thought of going to the government hospital.”

Using native healers. In the Achi communities that I visited, healers varied from old women to young men, and they choose the vocation as a person in the developed world chooses a career. Their knowledge of diagnoses and treatments varied.

There are three types of healers consulted by the Achi: Aj q'ij (diviner), Aj cun (curandero), and Aj itz (hechiceros). Aj q'ij (q'ij means day or sun) use divining stones to foretell the future, communicate with the spirit world, and give advice such as identifying the most advantageous time to undertake an activity. Aj cun (cun means to cure in Achi) give medical advice and cures. The Achi people refer to aj cuns as curanderos when speaking in Spanish. This type of provider utilizes both herbal remedies and pharmaceuticals. Often they also enact ceremonies (both spiritual and custom) to facilitate healing. For example, some ceremonies include twirling around three times, passing an egg over a sore place, passing a duck over a sick child, and throwing salt over the shoulder. Midwives (comadronas) are seen as a type of aj cun and are consulted for health advice beyond pregnancy issues. They offer herbal or home remedy information. An Aj itz (itz means evil) may be called upon to perform functions of an aj q'ij or aj cun and has the power to put curses on people. The Achi people view Aj itz as the most powerful healer. The two curanderos (one female and one male) I interviewed claimed to spend time with their patients and expressed attitudes of care for their patients.

The Achi people expressed mixed attitudes and beliefs toward the healers. Some reject them entirely; some utilize both healers and doctors concurrently; and others see healers as a first course of action. When asked about the factors regarding the choice to go to a healer or western doctor Diego explained, "They go to healers because they do not trust the doctors too well and because of tradition. They will go to the healer before

going to the doctor.” Gracia, an elderly woman, explained, “Three aj cuns are members of the church. Some of them are good.”

Several people held negative attitudes toward the healers. “They dedicate themselves to be healers even though they don’t know anything just because they know there is money in it,” Jorge asserted. Benita, a young mother and daughter of Jorge, reinforced this point, “Some people have died from going to the healers. Because they gave too much stuff and they mix medicines and all that. People died.” She later commented about a time when she went to see an aj cun:

When my little girl was sick, I went to a curandera at 5:00 in the morning. She was very sick with fever. The curandera complained that she was being awakened. We talked through the door, “What is the matter with you?” I told her my little girl was sick. So she just told me what medicine to get. She never came out from her bed. I had to pay her 20 quetzales for that. Then later that day I took my daughter to the doctor.

Consuela, as well as others, was quick to make clear, “I have never gone to a healer. I don’t go to them.” Benita presented a mixed view, “Some of the healers, sometimes just depend on the pharmacy medicine. There are some curanderos that really know and some that just guess.” Jorge clearly stated his view of healers, “Actually, the curanderos don’t know anything.”

Rely on pharmacies. Pharmaceutical medications do not require a prescription in Guatemala. An individual can purchase one or 20 pills of amoxicillin or a steroid injection at a pharmacy and also at gas stations. The pharmacy workers do not have any

pharmaceutical training. However, people explain their symptoms and request advice on which medication to purchase. The people can avoid the long wait and mistreatment involved in the government health facilities and the expense of private doctors by using the pharmacies. “Often people will go to the pharmacy before they go to the doctor” explained Andres. People purchase pharmaceuticals based on recommendations from relatives or friends, past experience, or a recommendation from the pharmacist. For those in poverty, the pharmacy is often an easier and cheaper alternative than seeing a doctor. Rosita, a mother in her early thirties, explained, “I usually just go to the pharmacy and ask for medicine depending on the sickness: headache, stomachache, or other sickness.”

Visit charitable temporary health clinics. I joined Elizabeth and her team on a temporary health clinic in the rural village of Sabinillas. The patients said they were very pleased with their experience at the clinic. Aleece explained:

The difference here is that Elizabeth explains clearly and is easy to understand.

And in the centro de salud the people just don't tell you what is your problem.

They just say take this medicine or buy this medicine or no medicine. It is better here.

Rebeca, Aleece's sister, affirmed her statement, “It is good here because they pay attention. The people spend time with us and explain clearly. It is the reason we only come here.” Unfortunately, the clinics are held intermittently.

Utilize remedios. Remedios are the herbal and home remedies the people utilize to address illness at home. Two surprising findings were the lack of knowledge and use of helpful remedios and the contraindicative remedios. My initial findings seemed to

indicate that people did not know or use home remedies. Through discussions with informants, I refined my word choice to use “remedios.” With that refinement I gathered some information regarding home treatments for illness. Many people appeared to be dependent on healers, doctors, and pharmaceuticals rather than using remedios. Angelita explained, “Most of the people do not know (about which remedios or herbs to use). Most of the people go to someone who knows.”

Remedios can be anything from pharmaceuticals and herbs to aj cun-like ceremonial rituals. Rosita claimed, “Sometimes herb medicine is better than the pharmacy.” She also explained how she mixes “three kinds of medicine (pharmaceuticals or western medicine) and four kinds of herbs” to help a child with ojo (childhood diarrhea). Consuela described how she cooks chiltepe (a very hot pepper of Guatemala), smashes it with salt and lemon, and then drinks the juice as a treatment for gastritis. She later explained that she grilled skunk over coals for her husband to eat to treat his asthma. Benita said she makes a strong and bitter tea of herbs for a hurting stomach. Consuela told about when her family passed a duck over her sick child for seven days as part of a diarrhea treatment.

Many remedios are helpful or at least not apparently harmful to health. However, I learned of some remedios that are harmful. Marcos said that he knew of a woman in a nearby town that attempted to treat her child’s pink eye infection. She made a mixture of hot chili with lemon and put it into his eyes. This treatment burned his eyes and now the 15 year old boy is permanently blind. Susana stated that she has known neighbors who have taken a penicillin injection to cure a headache. Karen, a mother in her early

twenties, described how people attempt to cure warts by injecting them with insecticide or pesticide. She also explained that drinking some gasoline prior to getting into a car or bus is believed to be a treatment for motion sickness.

The people often learn remedios from older family members. Angelita's mother was a midwife; Consuela's grandfather was an aj cun; and Benita learned from her grandmother. Karen, on the other hand, does not have any family member connected to health care. When her baby was sick, Angelita suggested a remedio for her. For her job as a teacher, Consuela took a class taught by a curandero doctor in Novelda where she learned additional remedios.

Remedios and aj cun appear to be related in the Achi people's thinking. Those who reject aj cun healers also seem to reject or deny remedios. "I have never gone to a curandera," Consuela strongly asserted, but "I learned this from my grandfather and from the class." Gathering information on remedios was difficult because participants have experienced years of communication that devalues traditional beliefs and treatments.

The seven options for health care are available in a general sense; however, environmental factors constrain their options. For example, the villagers in Sabinillas are unlikely to see a private doctor due to their extreme poverty.

Economics. The participants often stated economics as one of the driving factors in their decision to seek care from one source rather than another. The government health facilities are free but the Achi face discrimination and mistreatment. The private health facilities and native healers provide acceptable care, but they are expensive even for people living and working in larger towns and typically out of reach for the poor in rural

villages. Pharmacies provide pharmaceutical medications with little or no wait and no mistreatment but with limited expertise. The temporary health clinics are free and available only on an intermittent basis.

Although the government facilities are free, Susana told me about her friend Sofia's experience with extortion. Sofia's father was told that he had facial skin cancer that required surgery. He had been a subsistence farmer all his life and was very poor. Family members made numerous trips to the hospital in Guatemala City (a minimum four hour drive) to accompany their elderly father to the city. Some hospital staff inquired about and discovered that some of his grandchildren were teachers. After this inquiry, the providers charged them a large sum for the surgery. After returning home from the hospital, they scrambled and pleaded with extended family and friends to collect the money. They brought the money to the hospital on the day of the surgery, but after the surgery they were charged even more. When they explained that they did not have any more money, the providers told them that they could not take their father home until they paid in full, saying, "He will just stay here and die unless you pay." I heard very few stories about extortion, but when other participants heard this story about extortion none were surprised.

People often choose to go into debt to see a private doctor. Teresa and Armando chose to go to a private hospital for her c-section delivery. The hospital charged them 7,000 quetzales, approximately two and a half years minimum wage salary. Because Armando knew some of the health care workers, they allowed him to take his wife home based on his promise to pay later. "We did not have that kind of money," he said. Out of

desperation, he took out a loan and was falling into extensive financial debt. Fortunately, he received financial help from a church in the United States. Taking out loans or borrowing from family appear to be very common ways to gain access to private health care

In another example, Elizabeth visited a family in the community, and the family told her that their thirteen-year-old son had to have emergency surgery for appendicitis. She explained that they took him to a private hospital in Villena, “It cost them 5,800 quetzales! Can you imagine? They had to borrow the funds to pay. It will take them forever to pay off that debt!”

Economics affects both the use of native healers and midwives. Aleece explained that her poor family in the rural village could not afford the native healers, “Herbal medicine from a healer is more expensive than medicine from the pharmacy. So my mother said we need to just pray and ask God for healing.” After deciding not to return to the hospital in Guatemala City for her son’s “head operation,” Rosita’s friends suggested she go to the “yoga guy” in town, “The yoga guy just listened to me and sold me three pills at 200 quetzales each. I do not want to take my son back to the yoga guy because he is so expensive and my son is not better.” Benita explained that in Blanes, the midwives are also expensive:

Most of the women go to the doctor now. They do not use the midwives anymore. Very few do. In the past the midwives used to wash the birth clothes from the ladies in the customary and traditional way in a place more far away. But they do not do this anymore and they charge more too.

Benita further explained how the midwives charge for their services:

It is expensive to go to the midwives. The house has to give a hen, chicken, to the midwife. And they charge more if the baby is a boy! If it is a girl, they charge 100 quetzales a day and it may be a week or so of services. So it could be 700 quetzales or more. But if it is a boy, they charge 200 quetzales a day!

Jimena, a Ladina curandera in another town, expressed concern for the plight of the Achi. “I don’t charge a lot of money because everyone is poor and everyone is a human being.”

The Achi believe that the degree of care and attention in provider-patient interactions is tied to economics. Jose asserted, “The doctors here in our country only worry about the children of people of class. They have to be of the same class and dress like them to get any attention.” With private health care, the Achi believe they can receive better care and more patient, kind, and caring provider-patient interactions when they pay the doctors. Benita explained, “The private doctor treats us nice because we pay him.”

Language and education barriers. Language differences are a challenging factor in provider-patient interactions. Health care facilities rarely, if ever, have people who speak the Achi language. Spanish is taught in the schools, but this is of little consequence to the many Achi adults with limited education and Spanish fluency. The majority of the Achi that do get some education do not go beyond the equivalent of sixth grade. Many in the rural villages have little or no formal education.

Dr. Griego, a Ladino doctor working with temporary health clinics, explained the language challenges involved in treating patients in rural villages:

A big problem is language. They speak a different language from Spanish. It would be ideal to have an Achi interpreter all the time. For example, it is difficult to explain medications. A common case would be treating lombrises (worms). We have to explain to the patient the treatment, say 1 teaspoon of the medicine, 2 times a day, for 3 days and then done. This is very difficult without an interpreter.

Elizabeth, the health provider at the clinics, also expressed frustration with the language barriers:

It is difficult. For example, I take a long time trying to explain carefully how to take the medicine. Then Anne explains it again when they come to the pharmacy. Sometimes, even then when they come back a week or two later, we find that they have not taken it properly. Because of the low literacy and education level, you can't write out the directions for them very easily. Even when you have taken time to explain it really well; many, many times they did not understand the explanation. I go out of my way to really try to very much simplify things, do an analogy, or something that would help them understand what I am trying to explain. It is difficult.

Elizabeth further summarized her experience with the language challenges and health:

When there is not someone to translate, it is very frustrating for both the patient and the health care worker. I have been in that position and it is not fun. And you want to do your best for the patient but you know that they do not understand

what you are saying to them and you do not understand what they are trying to express. So it is very frustrating.

During my observation in the clinic, Andres spent the entire day sitting in the clinic patiently translating for the village women. As Elizabeth stated, “He is sacrificing income, sacrificing time, and all that labor of carrying those heavy boxes and setting up. He probably gets up at 3:00 or 4:00 in the morning. He has an amazing heart for his community and people.” His presence and translating appeared to make the women more comfortable. Elizabeth stated, “His translating is invaluable. It makes it easier for the women to express their symptoms and concerns while also helping them more clearly understand the diagnosis and medical instructions.”

Typically, the government and private health care facilities do not have Achi translators. Occasionally, there are Achi nurses in the clinics. Unfortunately, they rarely will translate for the women. Felicia revealed:

Sometimes there are people working in the health area who can speak Achi, but we don't know because they are ashamed to talk in Achi. Sometimes they say, ‘I can't speak Achi.’ That is a problem when the Achi people don't want to talk in Achi.

Alfonso added, “Another problem is that the doctors often talk in technical language and the people do not understand.” In addition, Aleece and her sister explained, “No one in the centros de salud speak Achi. It is hard to explain our symptoms.” Felicia confirmed this point by describing her observations:

I have seen that sometimes the women (in the clinics) talk among themselves saying, ‘how do I explain my problem (symptoms) to the doctor? Because I can’t speak Spanish.’ Sometimes the women ask one another, ‘tell me how I can say this in Spanish to the doctor.’ And that is a problem. I can’t speak in Achi but I can understand some. So I will say, ‘speak to me in Achi.’ That makes the women feel much better and they say, ‘oh, thank you’ and they explain their symptoms.

The language factor goes beyond the simple challenges of translations to a deeper conceptual aspect of language. For example, Elizabeth shared a story of an El Salvadoran health care student assisting her in the clinics:

I was sitting with her and she was interviewing and talking with her patients. Spanish is her first language and she is asking all these questions and is getting certain answers. And I’m thinking, she is thinking something completely different than what the patient is thinking. Because I know how these people express themselves just simply because I have been here so long and have been doing this so long. She would call me over because she would get so frustrated because she did not understand the patient and the patient did not understand her. So, I would sit down and get exactly the information that she was looking for. She would sit there and laugh. I would say, ‘would you like me to translate for you from Spanish to Spanish?’ It became a joke.

Language difficulties include expressions and idioms. Even though Spanish was the health worker's first language, she struggled to understand the conceptual aspect of the Achi patients' Spanish.

Health contexts. The health contexts of home and work vary widely among Achi people. Jorge worked in the fields all his life. He explained how work affected his health:

Every January they turn up and burn the fields. I have never smoked but all those years of turning up the fields, I breathed so much smoke. Even once I had to run almost through the fire and smoke for a long way breathing all that smoke. I have emphysema from all those years of turning the fields.

Two months after this interview, Jorge died from emphysema.

Many communities lack access to clean water. Altea, an economically developed town, distribute river water throughout the town and has very poor water quality. Attempts to treat the water have been met with community resistance. In contrast, Sabinillas, a rural village, has a water system in the village drawn from a mountain spring which is relatively clean and safe for use. In addition to water quality, many behaviors surrounding food preparation and general hygiene inhibit peoples' health. Dr. Griego said he prefers to visit patients in their home villages:

When I go to the village, I can better observe their conditions of life, such as: if they have drinkable water, if they use or don't use latrines, if the house is clean, how many people sleep in a single room, how many people there are in the family, observe their way of life, etc. Also, do they thoroughly cook their food,

cover the food to protect it from flies and other insects, clean the dishes with clean water, and store the dishes and utensils away from insects and cockroaches, etc.

Family dynamics are another factor in the health context that affects provider-patient interactions. In the towns, I observed a number of strong, directive women, however, in the rural villages, the women are disempowered. Young married women typically move in with their husbands' family and become the lowest members in the family hierarchies serving their mothers-in-law and sisters-in-laws. Once a young couple grows weary of this, they often move in with her parents until they are able to reach economic independence and they move into their own place.

The young mothers are, therefore, disempowered in many ways. Elizabeth shared her experience treating the daughter of a young mother in Sabinillas:

The young mother brought her ten year old daughter into the clinic. A rock had fallen on the daughter's toes about ten days prior. She had sought medical attention from somewhere. They kind of washed it off and wrapped it in cotton. Can you imagine? Well, it was really infected. All I could see was black and oozy stuff. We soaked her foot to try to get the cotton off. It was *really* big time infected. Parts of her toes were going black; I think gangrene had set in. It was severe. I told the mom, 'you have *got* to take her to the hospital. They may need to amputate part of her toes to save her life.' If it was not already in her blood it soon would be and would kill her. I said that she really needs to go to the hospital like *now*. Well, the mother said, 'my husband is not here and he will get upset with me if I take her without his permission and he will not be back for two days.'

I don't know if she ever took her to the hospital, because she was from one of the surrounding villages.

Elizabeth struggles with the dynamics of the family, she said, "Many, many times if the husband is not there, the women don't dare to make a decision."

Beliefs. Beliefs are dynamic and fluid as people adapt to new information. My analysis revealed four subthemes: theories of illness, pharmaceuticals, unresolved belief conflicts, and perceptions of the other. My observations and interviews with medical professionals and the Achi patients indicate their perceptions and expectations influence their interactions.

Theories of illness. Three major causes for illness within the Achi people's theories of illness include ojo, mal aire, and hot/cold categories. Similar to other cultural values and beliefs, individuals idiosyncratically ascribe to these beliefs in varying degrees.

Ojo. Ojo is severe diarrhea with fever in children. A child gets ojo when he or she is "eyed" by someone. The illness is the unintentional result of an adult (in a certain state of being) looking at a child. Jose asserted, "There are a lot of children that have died from ojo because they can't handle the fever and diarrhea." The belief in ojo is commonly held among the Achi, although described treatments varied. Ojo is often mistranslated into English as evil eye. However, this community refers to it simply as ojo (eye). The "evil" or "bad" that is translated from "ojo mal" is the effect of ojo, that is, illness or death. Some mothers keep their children covered or do not wash their faces to reduce the chances of their child being "eyed." Rosita confirmed this, "That is one of

the reasons the ladies cover the faces of their babies. I do not do that, but other women do.”

Jimena described some of the adult states of being that can result in ojo: “Any drunken person that passes by on the street that looks at them (children), they can get the eye, and women that are having their period or pregnant because their blood is too strong.” Jose added, “A man who has been working in the field or long hours and is very tired or exhausted will cause ojo.”

Children who are considered weak are more susceptible to ojo. “If the child is strong, he can’t be eyed. It is just the weak ones. That is why it is important for women to take their vitamins when they are pregnant,” Jimena explained. Carmela shared this perspective about her children, “My older children had terrible problems with being eyed. But my youngest girl was better nourished. I took vitamins and stuff so the baby was born pretty fat and strong. She never had problems with ojo.”

Many Achi believe that ojo is treatable by curanderos or remedios but not by doctors. Jose stated, “They (the doctors) don’t accept it as true. But it *is* ojo; the doctors just don’t know it. The doctors do not accept that there is a disease called ojo and that it *does* exist.” Jimena’s cure for ojo involves seven herbs and making the sign of the cross on the child’s forehead with lemon juice. Rosita puts herbs in a bath when her baby has ojo. She also mixes three pharmaceutical medications (including aspirin and Alka-Seltzer) with four kinds of herbs for the child.

Consuela described an interesting treatment for ojo. Her daughter got very sick and her mother and aunt insisted it was ojo. Her family did a treatment and she also took

her to the doctor. The doctor said that she was anemic because she was not eating and had diarrhea. She explained:

I gave her the medicine from the doctor. My mother and aunt also came and they passed a duck over her body and said that the ojo would go away. For seven days we would pass a duck over her body. They would make a (sign of the) cross on the duck. Then they squeezed the tail of the duck and liquid stuff came out of the duck's tail. They put the stuff on the baby. It was a yellow liquid and was not throw up or feces. It came out of the duck's tail. They put in on the baby. It smelled so bad that it made the baby vomit.

Consuela said that when your child is sick, "You are willing to try anything to make her better." As an aj cun, Jose decided to experiment with ojo:

I have experimented with all that. When I was working very late in another town I would get home around 2:00 in the morning. I was very tired (described like hung over from tiredness). So, I experimented on my baby girl. When I would come home the baby was in my bed with my wife. If I went to bed with the baby in the bed, for the rest of the day she would cry and have diarrhea. Another time I told my wife to take her away from my bed because I am very tired and it is possible that I am making our daughter sick. And of course, when she took her away from me she would be better. Once I rested, I could see her and everything would be fine. So it is true. The ojo does exist and even if you give medicine they will get sick. The only thing you can do to prevent it is to remove your presence from them.

Diarrhea is common among children in Guatemala and the cause of many deaths. Many Achi attribute the cause to ojo. Susana explained that because ojo is caused unintentionally, an old tradition was for a pregnant or menstruating woman to send an article of clothing to a family with a young child to rub it on the child to negate any potential for ojo. Marcos described another interesting tradition that developed from the belief in ojo. He explained that in the past, it was a tradition for young children to bow before an adult and “offer their head.” The appropriate response from the adult was to touch the head and say, “May God bless you,” which would also negate ojo.

Mal aire. Another significant belief emerging from the data is the causal attribution of “diabolica,” that is, illnesses caused by evil spirits. These illnesses are referred to as “malignant illnesses” or “mal aire” (bad air) and are not curable with biomedicine. The participants were reluctant to discuss this belief in much depth because of past experiences with outsiders and doctors mocking their beliefs, however, Jose explained some aspects of this belief:

There are a lot of indigenous people that believe in evil spirits. They believe more in diabolical illnesses than natural illnesses. Doctors do not believe in this. But even though sometimes those who don’t believe say it is just talk or beliefs, it is true and it happens. And the illnesses really do exist.

He later discussed treatment for mal aire:

People often spend large sums of money to try to cure it but they need to understand that no amount of money will ever cure it or have good results. Only God can cure it.

Jose then gave an example:

I saw a case that was very critical of a person that came to see me. He went to go out to gather water and he got sick from mal aire. Even if they looked for the right medication and shots and strong antibiotics, there was nothing they could do against the force of the spirit. Only God can cure something that grave.

Rosita's son has a serious illness. She explains:

I took my son to the hospital in Villena. The doctor said they need to do an operation on his head. I was too scared for them to do that. So I brought him home. The doctor said that he had mal aire.

It is unclear whether the doctor gave the diagnosis of mal aire or it was how she made sense of the illness through her existing beliefs.

Hot and cold balance. Foods, behaviors, medicines, treatments, and states of being are classified as hot, cold or neutral. A widely held belief is that the interactions between hot and cold can cause illness or death and yet the descriptions at times seemed inconsistent.

Jimena explained, "Every illness is classified as a hot or cold illness." Benita further explained, "A person who has an infection, which is a hot illness. If they are given a hot remedy it will kill them." However, she also said, "When you take a hot medicine you are not supposed to take a cold bath or drink cold water because the medicine is hot. But if the medicine is neutral you can do anything." Rosita, on the other hand, stated, "All pharmacy medicines are cold medicines." When asked how a person knows if the medicine is hot or cold, Benita explained, "Some people know. The

curanderos know.” Jimena described injections, “All vaccines or injections are hot because they give fever. You should not bathe for two days after, and then you can bathe.” People often mentioned the dangers of bathing after taking medicine. Javier disclosed an experience from a year ago that illustrates the influence of hot and cold beliefs:

I was sick but I don’t remember what was wrong with me. And the mother of my friend noticed and said, ‘Are you sick?’ I said, ‘Yes, I’m a little sick.’ She then said ‘I give you something to drink to make you better.’ When I asked what it was she said, ‘Don’t ask about that, just take it and drink it. But it is hot so do not take a shower with cold water or take anything cold.’ But I don’t believe in that. Also when I was little, when we had injections the person would say to my mother, ‘Take care of your kids: do not have them take a shower for two days.’

Benita recalled that after getting a complex B injection some friends told her, “Now you can’t take showers in cold water.” She had to take ten shots, one per day. She did not believe it so she showered anyway.

When taking medicine, the hot and cold categories of diet are also important.

Jimena listed some hot and cold food categories:

These are the hot things: beans, cheese, herbs, plants, corn, milk, cow meat, oranges, and hen meat (which may actually be turkey). Cold are the macuy plant, cream, pork, lemon, chicken, and ducks. Vegetables are neutral foods. You cannot mix hot and cold foods.

Jimena explained:

It depends on the illness. Some illnesses require that you give them cold foods and some require hot foods. It really depends on what the illness is. For a sick person, it is always better to just give them vegetables because they are neutral foods so that they don't get worse.

Pregnancy and childbirth are an especially important time to be mindful of hot and cold foods. Jimena said,

When a woman gives birth, she needs to eat just hot foods. She should eat beef soup. But make sure there is no duck in the soup because that is cold and their stomach will swell. They need to keep a diet for forty days otherwise we are back to square one and the stomach will swell like they are pregnant again.

The influence of hot and cold beliefs on provider-patient interactions is exemplified in this example from my observations during the temporary health clinic: Elizabeth was explaining to a young pregnant mother that she needed to be eating more beans and eggs for the protein. The mother exclaimed, "No, they are hot." Later Elizabeth interpreted these situations:

Often people will ask me, "Can I drink coffee while I'm taking this medicine?" or "Can I have this and such?" I finally realized that what they are really asking in the back of their mind is, "Is this medicine hot or cold? So, can I mix it or not with these other items, like coffee?" So what they are *really* asking is "will drinking coffee or eating something else make me sick?" because of the hot and cold thing.

Pharmaceuticals. Many Achi hold unfounded beliefs about the power or effectiveness of western medicines. Elizabeth explained:

People always want medicine to cure their problem. And the fact is there are a lot of times where it would be a waste of funds to give them medicine, for example, the antibiotic that they want. They may have a viral infection and it (the medicine) is not going to hit it. Sometimes even though they are sick, they don't need medicine or they don't need the medicine that is available. People want a pill to cure their problem. Some things are not curable with a pill. There is medicine to relieve it but not cure it. It is hard to explain that symptoms from allergies are not curable.

Andres discussed how the Achi people often buy just one pill of antibiotic. "When they start feeling better they think they are cured. And so why buy more? The medication is expensive so they don't buy more."

Additionally, people often engage in concurrent treatments. While Consuela's family used the duck treatment for ojo, she also gave her daughter pharmaceutical medicine prescribed by the doctor. After eight days of treatment, she took her daughter back to the doctor who said that she was recuperating well. Benita revealed the concurrent treatment used by curanderas, "they use a mixture of medicine from the pharmacy and herbs."

Unresolved belief conflict. Several decades of exposure to western biomedicine, Ladino culture, mockery by outsiders and doctors, and increased education has created an unresolved belief conflict for some Achi. This unresolved conflict is evidenced when

participants quickly deny utilizing certain treatments or believing in native health beliefs such as hot and cold, mal aire, or ojo. After a quick denial, some refer to an aspect of hot and cold or a treatment that they tried. After Consuela explained the concurrent treatment involving the duck and pharmaceuticals, she expressed this conflict, “Which one helped her? (duck or medicine) We don’t know.” Diego, her husband, stated, “Ojo has not really been proven or even tested. No one really knows what causes it or if it really even is.”

Emotional effects. The emotional responses and experiences of the Achi in health care contexts influence their health decisions and provider-patient interactions based on confidence and trust, intimidation, fear.

Confidence and trust. Confidence and trust, or lack thereof, in a doctor, curandero, or treatment were frequently mentioned in discussions about health care. People initially have confidence or trust in a provider based on a referral from family or friends. Andres asserted, “People would prefer to have their trusted person tell them (what medicine to try or doctor to see).” Aleece came to the temporary clinic for the first time based on a referral, “My sister comes here sometimes and told me ‘go to the clinic because they are good and will give you medicine.’” Rosita went to see the yoga guy because friends told her “the man is good and helps people.” She said, “I trust in him because that is what the people say.” That trust and confidence in the yoga guy quickly evaporated, however, she explained, “He did not examine my son. He just listened to me and told me to buy the three pills. But my son took the medicine and he is not better. The yoga guy is not good.”

The behavior of the health care providers during health visits affects the trust and confidence of the patient. After Benita went to the curandera at 5:00 a.m. and the curandera did not get out of bed, she took her daughter to see a doctor. Because the curandera did not take the time and appeared unconcerned, Benita lacked confidence in her recommendation for treatment. In contrast, Consuela experienced a caring doctor who listened and gave clear advice. “Because of that, I had confidence in the doctor.” Felicia elaborated on the confidence and trust of the Achi patients in this way:

They (the Achi patients) tell us (indigenous nurses) more things and they trust us. They are even more confident in the medicine that they are given when they feel like they have had a good visit. When they feel like they were paid attention to and given good attention and care.

Felicia also shared an experience with a patient who expressed confidence because of the care:

When a patient came one time, I did very simple things: took her temperature, pulse, respiration. Later the lady found me at my house and told me, “Thanks to you I feel more comfortable now because you did more than the doctor. I will get better now because of you.”

Felicia concluded, “It gives the patients confidence when you are nice to them and do simple things like check their vital signs.”

Confidence influences compliance with health messages. Noncompliance due to lack of trust or confidence was evidenced in Andres’s experience:

Last year I was working way up in the mountains. I had a terrible headache, raging fever, sore throat and was not breathing well. I finally got to see the doctor but the doctor sent me back because no one had taken my vital signs. I had to wait and find someone to do it. After all that, he said, ‘You have laryngitis and take Tylenol and this antibiotic.’ I did not trust his diagnosis because I believe I was much sicker than that. He listened to my lungs but I’m not convinced. So I went home and looked up my symptoms in my books (Andres is studying to be a nurse). Then I went to the pharmacy and bought a different medicine than what the doctor told me.

Andres claimed, “I did not believe or have confidence in the diagnosis because it did not match my symptoms.” He then explained, “That is why people choose to go to a private doctor. They have more confidence that they will get the particular medicine that they *really* need.”

Intimidation. Intimidation is to be frightened into submission, compliance, or acquiescence, and can result from verbal and nonverbal communication. It is closely linked to perceptions of power, abuse of power, and powerlessness. The target of fear is loss: loss of social standing (face), loss of dignity, loss of physical well being (abuse, financial standing, and denial of medicine or treatment). The Achi patients reported experiences of abusive communication from many government health providers resulting from intimidation. The power and socioeconomic differences between the Ladino and Achi populations contribute to feelings of intimidation by the Achi. For example, at the clinic, Aleece, pregnant and experiencing very bad headaches, stated to Elizabeth, “I am

intimidated to go to the doctor.” Although few people directly claimed to feel intimidated, it appears in their stories. Intimidation surfaced in their reluctance to question the doctors or ask for clarification. Andres disagreed with the doctor’s diagnosis “but I did not argue with him.” Angelita also revealed feelings of intimidation while recounting her abusive treatment by government health providers. She said, “I was too young to protest my treatment.”

Fear. People experience the emotional effect of fear when they face an impending threat of harm while perceiving themselves as powerless to prevent or reduce the potential harm. The findings indicate that the Achi patients experience feelings of fear toward illness, medical treatment, or the abusive communication from health care providers. Such fears appeared evident among the poor and less educated population. Rosita cried as she expressed her fear regarding her son’s illness:

I took my son many times to the hospital. In the hospital in the city, the doctors said he needed an operation. I said no because I am too afraid. So I brought him home.

The fear experienced by Aleece affected her physically, “I get so nervous and scared to go to the doctor that the pain in my head gets worse.”

The Achi’s emotions evolving from their experiences affect their health decisions and provider-patient interactions. Confidence and trust influence if and where the Achi patients seek health care. In addition, distrust and a lack of confidence often appear to be a consequence of negative communication and perceptions of lack of effort or care. Noncompliance with medical treatments appears associated with a lack of confidence and

distrust. Feelings of intimidation result in the reluctance to ask questions, seek clarity, or disagree with the health providers. The findings indicate that the Achi patients often avoid seeking necessary health care because of feelings of intimidation and fear.

Experiences. The theme of experiences builds upon the behavioral category in Bandura's (1986) social cognitive theory. The experiences of the Achi patients influence future decisions regarding health and provider-patient interactions and include: experiences with doctors' behavior, experiences with others' behavior, and experiences resulting from treatment or nontreatment.

Experiences with doctors' behavior. The experiences with doctors are dependent upon the chosen health care option. The experiences with private doctors and private health care facilities are typically more pleasant and satisfying than those at public government facilities. The contrast between positive and negative experiences forms stereotypes and expectations among the Achi patients. These expectations influence whether and where they seek health care. For example, Angelita chose not to take her mother-in-law back to the doctor in Guatemala City because she anticipated both verbal abuse and poor care. These expectations also influence the Achi's communication, for example, the Achi consistently do not ask questions of the doctors or seek clarification.

These expectations of poor and abusive behavior by government doctors resulted in many other people choosing to go into substantial debt rather than get care at a government health facility. Positive experiences with government doctors are a source of surprise. For example, Jose stated, "It is rare to find a doctor who actually takes care of

his patients.” In contrast, Elizabeth and Dr. Griego both have earned a reputation among the people for providing caring, patient, and good health care.

Experiences with others’ behavior. Recommendations and referrals by significant others influence health decisions and provider-patient interactions. Andres explained that when people are sick, “First before going to the pharmacy, they would ask their friends and relatives. “What do you do when you have such and such symptoms?” and they get the advice of their friends and relatives. Then they go to the pharmacy and ask for that medicine.” He added, “If the friend or relative does not have any ideas, they will ask the pharmacists. But they would prefer to have their trusted person tell them.” Aleece came to the temporary health clinic because her sister referred her to the clinic. Also, Rosita went to the yoga guy because friends or relatives told her that he was good. In another example, Angelita recommended a remedio to Karen for her baby who was sick.

Experiences resulting from treatment or nontreatment. Finally, the Achi make judgments about health care providers based on the results. Rosita, for example, changed her opinion of the yoga guy after the results of his treatment, “I trusted in him because the people say the man is good help for the people. But when my son took the medicine there were no results. He is not good.” Andres explained, “Friends say, “Oh so and so is a good doctor. He cured me.” Then they believe that this doctor will help and cure them.” When the Achi patients experience improved health, they typically attribute the improvement to the health care provider. These experiences influence subsequent health care choices and provider-patient interactions.

The four major themes with underlying subthemes emerged from the data, Environment, beliefs, emotional effect, and experiences, affect both health care choices and provider-patient interactions. The four factors reciprocally interact among each other in ways that I, as an outsider, do not fully understand. However, identifying the factors is the first step toward understanding.

Defacement

The central theme of defacement surfaced as dominant because of its frequency and intensity in participants' discussions of health care. Defacement is purposeful communication that dehumanizes by destroying the other's face. This section discusses the concept of face within Achi culture, the inadequacies of the existing face theories, and the themes of defacement.

Face in Achi culture. The concept of face is embedded in the Achi culture and language. Having or losing face is usually expressed in Achi with idiomatic phrases that use "day/sun." Kanyak uq'ij is literally "I raise his day." It means to praise. Kank'aq b'i uq'ij is literally "I throw down his day," a phrase that means to demean someone (a verbal put-down). K'o uwach is "There is his face/He has face," that is, he is important, powerful, and influential. Jinta uwach means "There isn't his face/He has no face," meaning he is not important or he is a nobody. The following phrase combines both words: "mas nim uwach uq'ij chikiwa konoje" and is literally translated, "More great the face of his day than anyone else or all others." This describes someone who is exalted, has glory and fame.

The Achi are attentive and sensitive to issues of face within their community. Offenses are experienced within broad social networks, so that offending a person's face has ramifications for the entire extended family. Susana shared a story of a young western European woman ("Michelle") working in the village who developed a relationship with an Achi woman of similar age. When Michelle sensed tension in their relationship, she went to her Achi friend and asked what was wrong. The Achi woman ran off crying. Later that day Michelle was told by the girl's father that she was no longer welcome within the extended family. As a monochronic outsider, I do not fully understand the aspects of the situation that caused, what seemed to me, to be a strong reaction. Based on my research, I surmise that the monochronic directness of the communication was interpreted by the polychronic Achi woman as offensive. In addition, the message may have been interpreted as a correction, which is strongly insulting in the Achi culture.

Susana explained, "One of the worst things that can happen to you in this culture is to lose face." However, Achi suffer various degrees of face loss in government health care settings. The Achi people often choose to face defacement in health care settings because all other options for receiving treatment for an illness are expended or out of reach.

The Ladino people hold the majority of the power positions in most sectors of society throughout Guatemala. I observed very limited interactions between the Ladinos and indigenous people. The government makes efforts through education to emphasize the equal status and value of the indigenous people. However, the discriminatory

attitudes toward indigenous people are deeply ingrained and persistent. Elizabeth explained:

Especially the older Ladinos, I think many of them have such ingrained prejudices toward the indigenous population. The younger generation does not have as much prejudice because of the emphasis on equality and the value of the indigenous population by the government. The younger generation would just not as likely say it out loud. But I have friends in the city that have said at least two or three times in my hearing comments like, “Oh, indigenous, they are dogs. They have sex in the open and whatever.” And I’m thinking, you have no idea because you have never really had a relationship with, had a friend, or known anybody who was indigenous. You have never gotten to know them or their culture. But the thing is, it is so deeply ingrained that it is a belief that they heard and were taught by parents and grandparents, great grandparents. It is very *deeply* ingrained.

This common Ladino attitude and perception toward the indigenous people is manifest in the defacement communication of many Ladino doctors toward the Achi patients.

The literature on face is unable to explain the experiences of the Achi patients in government health facilities, and a new construct of face is needed to explain practices of defacement. Many studies of face come from researchers and populations in the developed world, but no studies deal with the concept of face within Achi culture or the impact of face and defacement on the provider-patient interactions in this context.

Inadequacies of the existent face literature. Face theories explain that people are expected to attend to, show regard for, and limit loss of the other's face when engaged in a social interaction (Brown & Levinson, 1987, Goffman, 1959, Ho, 1976, Lim & Bowers, 1991). Ho (1976) explained this assumption:

Face is distinctively human. Anyone who does not wish to declare his social bankruptcy must show a regard for face: he must claim for himself, and must extend to others, some degree of compliance, respect, and deference in order to maintain a minimum level of effective social functioning. (p. 881)

Face negotiation theory proposes that three face needs emerge within a social interaction, self-face, other-face, and mutual face (Ting-Toomey, 1988). Focusing on conflict, face negotiation theory assumes that self face and other face are important during conflict as interactants negotiate a resolution to the situation (Oetzel, et al, 2001). Face theories argue that in communication situations, people in all cultures try to maintain and negotiate face.

The results from my study challenge the existing literature in two areas. First, the data challenges three of the foundational assumptions within the face literature: interactants possess a concern for the face of the other interactant; interactants make some efforts to mitigate the threats to other-face; and when self-face is threatened or directly offended, face protection behaviors will be undertaken to counter the face threat. Secondly, purposeful de-facing of the other is largely absent in the literature. My data revealed that some providers show no concern for other-face and patients often do not engage in defensive facework.

No concern for other-face. The government doctors often display little to no regard or concern for the Achi patients' face. Contrary to concern or regard, the doctors often purposefully and with hostility denigrate the face of the Achi. This purposeful destruction of other-face is defacement. Concern for other-face is grounded in the avoidance of social bankruptcy (Ho, 1976). However, there is no risk of social bankruptcy in failing to regard face and purposefully defacing the Achi patients because the health care workers view the Achi with disgust and perceive them as less than human. Therefore, the health care workers risk no social sanctions for defacing the Achi patients.

No defensive facework. Secondly, contrary to the assumptions in the face literature, Achi patients do not appear to defend face nor outwardly resist defacement by health care workers. Many expend great effort and expense to avoid subjecting themselves to it, however, some Achi, who are without the means to afford or borrow the money to go to a private provider, willingly subject themselves to defacement in the hope of receiving adequate medical treatment or medicine. The Achi patients anticipate the abusive and hostile defacement from the government doctors, and some choose to endure it, while others choose to do nothing knowing the result may be death. Although the Achi people recognize that the communication they endure to receive health care is immoral, but feel powerless. Aleece dejectedly said, "The doctor at centro de salud spoke badly to me (she refused to describe the "bad communication"), but I do not respond. I just take it."

Absence of purposeful defacement. The literature assumes interactants have vested social interests in attending to the face of others. Much of the face literature

focuses on strategies individuals use to mitigate face threats to others. Communication that is purposefully destructive to other-face is absent from the face scholarship. Although studies discuss aggressive and dominating facework, the interactants still negotiate within a social network with the goal of resolving or winning the conflict (Oetzel, et al., 2001). It is recognized that some situations require the purposeful threatening of a person's face (requests, corrections, commands in emergencies); yet even these actions still show some concern or respect for the other's face (Brown & Levinson, 1987).

The Achi patients in this study repeatedly report that government health care providers use communication that is aggressive and devaluing. Far from regarding the face of the patients, the communication dehumanizes them. This kind of communication expresses contempt, disgust, and disregard for the Achi patients. Defacement extends beyond the failure to mitigate threats to other-face to the purposeful and hostile destruction of other-face.

Themes of defacement. Defacement devalues the humanity and dignity of a person. This form of dehumanizing communication places people "outside the normative universe of moral protection" (Hagan & Rymond-Richmond, 2008). Through defacement, an interactant (in this case, a health care provider) frames another as something less than human, depriving him or her of basic human qualities and value (Harris & Fiske, 2006). Therefore, the defacer does not experience the psychological dissonance from mistreating, abusing, and neglecting another human being.

Four types of defacement emerged from the data, and involve both verbal and nonverbal communication. Each type increases in intensity and dehumanizing communicative content (figure 2): disregarding, degrading, regaño-ing, and abusing.

Disregarding	Degrading	Regaño-ing	Abusing
Ignoring	Mocking	Verbal flogging	Physical abuse
Lack of effort	Name-calling		Neglect
Dismissing			

Figure 2

Disregarding. Disregarding is the first degree of intensity that includes both nonverbal and verbal communication. Disregarding includes ignoring the patient, exerting a minimal amount of effort, dismissing the patient and/or symptoms. Many Achi stories included experiences with disregarding defacement from government health care providers.

The first subtheme of disregarding is ignoring. By ignoring the Achi patient, health care workers reduce the patient’s value and dignity as a human being. This level of defacement comes largely from nonverbal communication. Since face is an outcome of social interaction, failure to acknowledge a patient denies them the needed social interaction and is purposefully de-facing.

For example, Angelita explained how health care workers engage in the disregarding defacement through ignoring, “When we get there (centro de salud), they make us wait outside. They tell us to wait until they *feel* like treating us.” Angelita shared her story of labor and delivery:

I was at the hospital in labor. After the doctor examined me, he never came back. He left and I was never examined again. The whole day passed and I just kept walking around because nobody came back. And the pain was so severe; this was the only thing I knew to do. No one came back to examine me. They just left me there.

The second subtheme of disregarding is a lack of effort. The Achi recalled their experiences with doctors who failed to exert a minimal effort to listen, examine, and explain their diagnosis or treatment. When providers exert little or no effort, they communicate their perspective of the worthlessness and lack of human value of the patient.

Felicia explained, “From what I have observed as a nurse, the doctors begin writing a prescription before the patient has even finished talking. So it seems they are not fully attentive or listening.” Jose confirmed this saying, “The people tell me that the doctors do not listen to their problems and symptoms.”

The doctors often do not exert the effort to physically examine the Achi patients. Whether their failure to examine is an example of ignoring or related to emotions of disgust toward the patient, or an overt desire to avoid touching or being near the Achi is not clear from my study. Stories of government doctors failing to examine patients appeared frequently in the narratives. For example, when the other women waiting at the temporary health clinic overheard Marta say that the doctors did not examine her, they all simultaneously expressed similar experiences. Consuela also confirmed this experience:

When we go to the government health clinics all they do is ask questions, then they write and write, and send you out with a prescription for a certain medicine. And that is that. No examination. In the government clinics they just prescribe, they don't do any examining.

Andres had a similar experience:

I went to the centro de salud. I was very sick with high fever, sore throat, and not breathing well. First, I went to see the doctor. Then he sent me back because no one had taken my vital signs. I had to wait and find a nurse willing to do it. Then I returned and the doctor looked in my throat and said, 'You have laryngitis, take Tylenol and this antibiotic.' But I did not believe him because he did not take any time to really examine me. He was not interested in digging any deeper than a superficial first impression of the illness. Listen, look, and give a prescription and (clap) you are out of there.

Felicia told of a pregnant woman who came to the clinic because she was bleeding:

The doctor just said, without examining her, that it was just part of her rhythm (menstrual cycle). The woman was complaining because he had not examined her but just gave her some medication. After that, I examined her and gave her a proper examination. I told her she needed some bed rest and should be ok. She (the patient) said, 'Thank you. All I needed was someone to give me a proper examination.'

In addition to failing to exert minimal effort to examine patients, the doctors often fail to explain their diagnosis or instructions for taking the prescribed medication. Aleece

described this defacement when explaining how the temporary health clinic was better than going to centro de salud:

The difference here is that Elizabeth explained to me clearly and easily. And in the centro de salud, the people don't tell you what your problem (diagnosis) is. They just say, take this medicine or buy this medicine, or no medicine. They do not explain.

Rebeca at the temporary clinic confirmed Aleece's account, "In centro de salud, the doctors ask about symptoms but do not tell us what our problem is." Angelita's recollection of her labor and delivery illustrates this as well:

When I began in labor pains I went to the hospital. They sent me home because they said it was not my time to give birth. But they did not examine me. I went back the next day because I was in a lot of pain and again they sent me home with no examination. I then went back the next day and the same thing happened. That night I went back again and they left me outside until I couldn't stand the pain. All this time they did not examine me. The next morning they finally examined me and admitted me.

The final subtheme of disregarding is dismissing, which includes a lack of empathy, dismissing symptoms, and sending the patient away. This type of disregarding often involves both nonverbal and verbal communication. Through the dismissive, nonempathetic social interaction, health care providers devalue the patients' human experience of suffering and show a lack of value for the patients' humanity and well

being. This communicative behavior defaces the Achi patient. Jose explained the dismissing of symptoms with a lack of empathy:

Sometimes the people tell me that the nurses tell them that the children do not have anything wrong. They only check the face of the child and think that they do not feel hot, but when I check with a thermometer they do have a fever. The nurses tell them go and take the child home because there is nothing wrong with him. To bring the child back only if they start crying again tomorrow or the next day.

This dismissive defacement is illustrated in Angelita's recounting of bringing her sick son to centro de salud:

One afternoon I took my son to centro de salud because he was very ill with fever. They told me 'No. The times we are open are from 7am until noon and today it is too late.' But it was only 11:50 and they said 'No. Come back tomorrow.'

Angelita's labor and delivery story also included examples of providers dismissing her pain with a lack of empathy. She noted, "I kept telling the nurses that I was in a lot of pain and they would say, 'That's fine. Just shut up. Why do you come here to cry?'"

Sending the patient away involves a dismissive shooing, "get gone" connotation. The women in Sabinillas used the Achi word "jat" to describe the dismissive sending away they experienced from government health care providers. In Achi, jat involves an insult. Susana explained,

In an activity we did with some Achi people, we gave them a situation to enact and had them make up their own dialogue. This one dialogue developed by the

Achi included *jat*. The situation enacted was a man came to ask a rich man for work. The rich man insults him, saying, ‘Why would I want a sickly, lazy looking worker like you? Get out of here (*jat!*).’

The women’s use of the Achi word “*jat*” in their description of the health care workers’ sending them away is an example of disregarding defacement. Rosita shared this story of her sister-in-law who was three months pregnant:

She went to the public hospital because she had a horrible headache, felt like she was choking, and was panting from the extreme pain. The nurses told her, ‘*Jat* (leave, get out of here). There is nothing wrong with you.’ They did not even examine her.

Aleece shared a similar experience of dismissive defacement:

I took my son to *centro de salud*. I said to the doctor, ‘My son is bad. He has fever and is bleeding from the nose.’ But the doctor just said, ‘No medicine’. He did not sit down with me. He did not examine my son or listen. He just said, ‘No medicine’ and ‘*jat*.’

Andres confirmed, “That is a problem. Usually the families from this village don’t want to go to *centro de salud*. The doctors say only “no medicine” and “*jat*.” Jose also confirmed this experience, “But with our race, when someone goes to the doctor and asks for help, they (the doctors) just tell them everything is fine (nothing is wrong with you) and to just leave (*jat*).”

Degrading. Degrading is the second level of intensity of defacement and includes mocking and name-calling. Whenever the women shared the degrading messages, their

emotion and cowering body language communicated how hurtful these messages were to them. Aleece refused to tell me what the doctors said to her. All she would say is, “They speak badly to me.”

Beliefs and culture are an integrated aspect of face and identity, therefore, through mocking the beliefs and their way of life, the health care providers deface the Achi. Diego’s words provide a sense of the affect of this degrading communication, noting that, “Telling us to change our way of life produces an enormous shock. That is why I say it is like a punch to the stomach. It is a shock.”

Direct mocking is even more powerful defacement. Consuela said, “The way they (Achi patients) tell the doctors things, the doctors just laugh at them.” Felicia shared a similar perspective, “Sometimes if you say something like that (sharing a specific health related belief), the doctor says, ‘You are crazy’ because the doctors usually do not know our culture.” Susana confirmed that, “In the past, whenever they (the Achi) would go to a western-trained doctor, they (doctor) would make fun of *everything* the person believed about health and everything they did.”

Another method of defacement through degrading is name-calling. Name-calling is dehumanizing because through name-calling, the communicator (health care provider) denies qualities and values of humanity to the targeted group or individual (the patient) (Hagan & Rymond-Richmond, 2008). Harris and Fisk’s (2006) study demonstrated through neuroimaging that study participants perceived members of severe prejudiced out-groups in ways that were functionally and cognitively equivalent to objects. Framing the Achi patients as an object diminishes the moral and practical

constraints on the providers thereby allowing the provider to mistreat the patient without moral repercussions (Hagan & Rymond-Richmond, 2008).

After many unsuccessful attempts at getting the women in the temporary clinic to elaborate on the “bad talk” they received from government doctors, Marta quietly told me off to the side, “The doctors do not understand our culture. When I go to centro de salud, they say bad words to me. They say ‘you are like a dog’ and that is not good.” Elizabeth confirmed the name-calling when she stated that some of her Ladino friends have referred to indigenous people as dogs. Felicia told me that while working as a nurse, the doctor said, “I hate her (Felicia) because she is indigenous. He would say to me, ‘You are a pig.’ The words of the doctor were not good and they hurt my heart.”

Using words that frame a person as an animal can be dehumanizing regardless of the cultural setting, however, in Achi it is especially insulting. Susana explained:

To be called an animal in Achi culture is very, very insulting. There are not any real comparisons in English. We say, ‘Swift as a deer,’ and such. There are positive ones in English. But not in Achi. To call an Achi person *chikop* just kind of means animal or beast and is very insulting because it is like a beast instead of a human.

She continued:

A dog would be even worse than *chikop*. A dog is worse. A dog has two connotative meanings in the culture. One is having litters indiscriminately and the other is sexually promiscuous (mostly used for males). Like dogs copulate without any morals.

Name-calling may also be implicit within the message of health providers. Angelita shared her experiences during labor:

At 5:00 in the afternoon, I again told the nurse that I could not take it anymore. She told me to shut up. ‘Having a baby is like a chicken laying an egg and you are making a big ol’ scene for no reason.’ And I would cry and cry because I could not take the pain any longer.

Degrading communication dehumanizes the other, does not show regard or concern for other-face, and purposefully defaces the other. The dehumanizing effect of degrading is a reduction or elimination of the moral constraint to treat the other as a fellow human being. Dehumanizing also makes it easier for ordinary people to permit and participate in immoral and hurtful behaviors against the other (Hagan & Rymond-Richmond, 2008). Degrading communication from providers not only hurts the Achi patients through defacement, but also lays the groundwork for further abuse and inadequate medical care and treatment.

Regaño-ing. I label this theme *regaño-ing* because there is not a good English equivalent translation. The Spanish word “*regañar*” and its corresponding Achi words surfaced frequently in the descriptions of government provider-patient interactions. Simplistic translations of *regañar* into English include scold, rebuke, and bawl out. However, these English translations fail to account for the emotional and insulting nature of *regañar* in the health care context of this study. The word includes perceived insult, anger, disgust, irritation, and a tone of voice that is demeaning and contemptuous.

“Verbal flogging” or “tongue lashing” are English metaphoric terms that convey some of the concept of regañar in this context.

The Achi language provides more distinction among insulting words. My informant explained that regañar is the common Spanish translation for three different Achi words for insult. However, the three Achi words vary in their insulting and offensive nature. The first word, with the root “yaj” includes concepts of disapproval or complaint. In Achi culture, yaj includes face loss and insult. A similar but stronger word has the root “yoq” and carries elements of anger and often includes offensive language. It is so strong that it is rarely used and is avoided. The final insult is “Kuk’aq b’i uq’ij,” which includes the elements of yaj and yoq’ but is more dehumanizing and denigrating. The literal translation is “to throw down someone’s day, reputation, or face” and implies that the person is of little value, not important, or worthless. When discussing their experiences in Achi, the people used all three Achi words to describe the government health care providers’ communication.

The Achi frequently experience regañar-ing by government health care providers. Aleece summarized, “The doctors spoke badly to me (regañar and kuk’aq b’i uq’ij). We (Achi women from the villages) do not answer them. We don’t answer, we just hear. (just take it). This happens very often.” Angelita explained:

The people that come into the centro de salud that cannot speak Spanish they get regañar-ed more. They (doctors) tell them (instructions) one time. If we (Achi) do not understand them the first time about the medicines, they tell us, ‘Then why do you even bother us and come here if you are not going to be able to take the

medicine?’ They say, ‘Why should we bother to give you (Achi people) medicine if you are not going to be able to do it?’

Marta at the temporary clinic provided this example:

When I was pregnant with my baby, I went to Toledo to the doctor. The doctor regañó-ed me and only said, ‘Take contraceptives.’ I was scared. I will not go back to centro de salud. Women from this village, we have many children. The doctors do not understand and they regañó a woman when she goes to centro de salud. The doctors say bad things, they call us dogs.

Numerous regañó stories included information about provider-patient interactions with women in pain. Benita spoke of a lady who was at the hospital the same time as she was, “I saw a lady who needed an operation after her miscarriage. They just regañó-ed her and she was in a lot of pain. They did not treat her well.” Angelita’s labor and delivery story teemed with regañó experiences. For example: “I was complaining and complaining because of the pain and the nurses would just regañó me. The worst part was that it was the indigenous women nurses who kept regañó-ing me.” After facing regañó all day during labor and having an emergency c-section that evening, her disturbing experience continued:

After the operation, they took me to another room. They (the nurses) had to pass me to the other bed with a lot of care because I had just had an operation and a baby. They asked me to help them move me over to the other bed. But I could not because I had just had an operation. The nurses began to regañó me. They were very mad at me and kept regañó-ing me.

Elizabeth told me of a situation of a father's experience with being regaño-ed by a doctor:

There was a case I remember, a child with a deformity of the heart. The father delayed getting help because he did not understand or was not told that the child would need surgery within a few months of birth. When the father took the baby to the doctor, he was regaño-ed and yelled at for not bringing her in for surgery sooner. The doctor said, 'You deserve this because you did not bring her in sooner.'

Regaño refers to a dehumanized state of being of the other and far from regarding and attending to other-face, regaño purposefully de-faces the other. When it is within their ability, the Achi avoid government health clinics to avoid experiences of regaño. For example, Angelita is assigned the responsibility of caring for her elderly mother-in-law who has dementia and violent tendencies (she is the youngest and most recent family member). She missed an appointment in Guatemala City for her mother-in-law because of her studies. Even though her mother-in-law clearly needed a prescription adjustment, she said, "I can't face going back to ask for a new appointment because I know that they will regaño me a lot." Dr. Griego confirmed the regaño-ing of Achi patients:

The case is that the personnel assume that the indigenous people are careless or indifferent to their health problems or that in the end they will not want to change.

This is why they are treated severely or indifferently and regaño-ed.

Abusing. The final and most intense form of defacement in my study is neglect and physical abuse. Dehumanizing and defacing communication frees the interactant to behave toward the other in inhumane ways. In most of the stories of defacement,

multiple types of defacement coincide with abuse. This is not surprising since research concludes that dehumanizing communication is often integrated with and facilitates abusive behavior, including genocide (Hagan & Rymond-Richmond, 2008).

Occasionally, the defacement faced by the Achi culminates into physical neglect and abuse. This story of neglect came from Sophia regarding her granddaughter:

Isabel was reluctant to take her son to the public hospital in Guatemala City because her first child died at age four in her arms while at the hospital. Isabel took her little girl to the hospital for a periodic check-up because she had been sick. While she was sitting in the waiting area, the child's breathing got worse and worse. She saw that her little girl could not breathe and ran up to the doctor and pleaded for help. He pushed her aside and told her to sit down and wait her turn. Finally, it became obvious to some of the nurses that the little girl was in trouble. They ran to get help, but it was too late.

Marcos also described a story that began with disregarding and ended in neglect:

About 6 years ago, I drove an Achi woman to the hospital because she was in labor. When we arrived it was evening. We were not allowed into the waiting room because she was "not far enough along" (without an examination). The health care workers locked the doors and left the women outside on the street. There were three other women there in labor left outside on the street at night. There were concrete stairs up from the street to the hospital doors. A woman was on the stairs in labor halfway up to the doors. A doctor was looking out the window the whole time. She began to deliver her baby right there on the stairs

and they did not unlock the doors or come out to help her. I ran up to the doors and was banging and banging, I was yelling at them to come out and help her. They let her deliver her baby alone on the stairs. Because she was on the stairs, the baby fell down a couple of stairs and received quite a gash on its head and was banged up. The whole time the doctor was watching out the window! They finally came and brought the lady and the baby into the hospital. Later another lady had her baby on the grass next to the stairs.

When the health providers engage in defacement and perceive the Achi patients as less than human, it frees them from the moral constraints that impel them to provide humane medical treatment (Hagan & Rymond-Richmond, 2008; Harris & Fiske, 2006).

Benita observed physical abuse while she was in the hospital to deliver her baby:

The female doctor was ready to leave because it was the end of her shift. There was a young lady, she was only 16 years old, crying in the corner. She said, 'Oh, thank God that doctor is leaving!' She was crying and screaming in pain from labor. That doctor did not care and went over to her and hit her so she would shut up and stop crying. The girl was indigenous and the doctor did hit her. The doctor kept asking her, 'Why are you crying? Everything you are experiencing is normal and you should stop screaming.' That is when she hit her. And yes, she was a woman doctor.

Angelita's recollection of her labor and delivery experience includes neglect, physical abuse and the other defacement types. After her c-section, she recalled disregarding defacement leading to neglect and abuse:

The doctor said that the baby was dying and he had to operate. He regañó-ed the nurses for not attending me. I only remember that the doctor told me that my baby was already purple and that the heartbeat was very weak. It took a long time for the baby to cry.

She continued to describe her defacing experience after the c-section as equally dehumanizing. After the nurses regañó-ed her continually for not being able to assist them in getting to the other bed:

Then finally just one nurse got my arms and the other grabbed my legs. They just threw me into the other bed. I only felt when I hit the bed and I was screaming in pain. What I was yelling about was that my stomach was going to open from the operation. It was very traumatic because they just threw me into a bed and I was screaming in pain.

Through defacing communication, the government health care providers dehumanize the Achi patients, framing them as less than human, and thereby releasing them from morally obligated humane treatment. The experiences of the Achi with government health facilities abound with defacement. The four types of defacement (1) disregarding, (2) degrading, (3) regañó-ing, and (4) abusing permeated the responses of the Achi patients.

Summary

This analysis discusses how my assumptions were challenged by the data, identifies the factors influencing provider-patient interactions, and elaborates on a new construct labeled defacement. This study exposed and contested major assumptions in

the face literature and illustrated the complexity of the driving forces influencing the Achi people's health care.

My schema about what constitutes health care prior to this study assumed that health care providers' interactions center around the good of the patient, include a basic degree of care and concern for the patient as a fellow human being, and involve some degree of commitment to two key elements of the Hippocratic oath: do no harm and prescribe treatments for the good of the patient to the best of the providers knowledge and ability. After this study, my schema for health care recognizes that some providers engage in defacing communication and lack a regard for the suffering or health of the patient.

The factors (environment, beliefs, affect, and experiences) reciprocally interact in a complex interplay that drive the Achi people's health care decisions and influence provider-patient interactions. A central finding of this study was the defacing communication practices of government health providers, including disregarding, degrading, regañó-ing, and abusing.

CHAPTER FIVE

Conclusion

This ethnographic study using participant observations and qualitative field interviews explored the factors influencing provider-patient interactions in Baja Verapaz, Guatemala. The findings of this study expand and contribute to existing literature. This chapter presents key findings, limitations, and directions for future research.

Key Findings

Factors influencing provider-patient interactions. The first research question I sought to answer with this study was: What factors influence Achi patients in provider-patient communications? The following model (figure 3) illustrates the four major factors influencing the provider-patient interactions in rural Guatemala. Extrapolating from Bandura's (1986) social cognitive theory, the model presents the four factors reciprocally constructing and being constrained by each other.

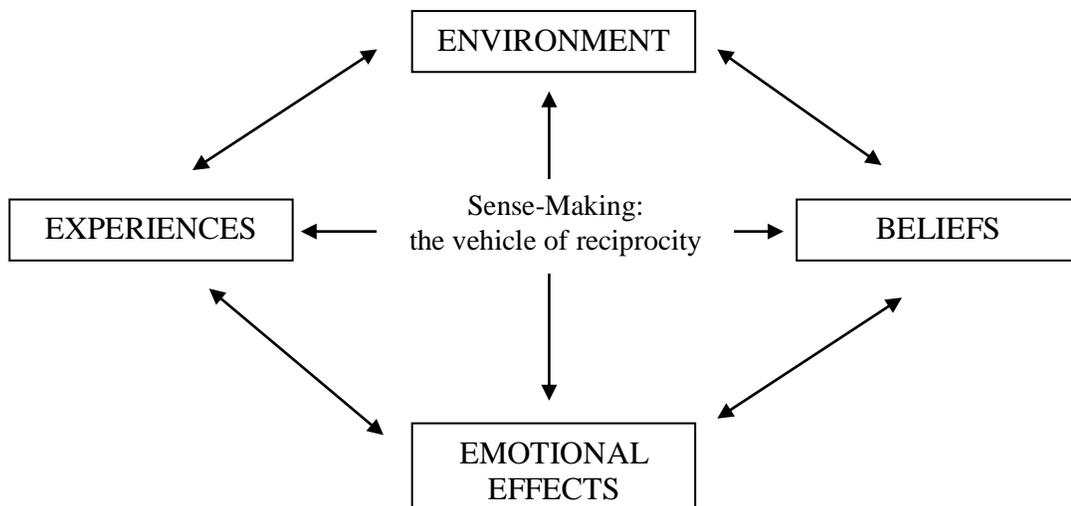


Figure 3

Each of these major factors contains subthemes. Environment consists of the health care options available, economics, language and education, and the health context. Beliefs include theories of illness, pharmaceuticals, and unresolved health belief conflict. The subthemes of emotional effect include confidence and trust, intimidation, and fear. The final factor, experiences, contains the subthemes about the behaviors of doctors, results of treatment or no treatment, and the behaviors of others.

The Achi people's health care decisions are affected by a complex reciprocal interaction among these factors that also influence provider-patient interactions. For example, Rosita experienced defacing communication (experiences) by a government doctor. The doctor's behavior (experiences) influenced her emotionally (emotional effects). As she made sense of his messages, it created feelings of fear and intimidation (emotional effects). Further sense-making of the doctor's behavior resulted in her lacking trust and confidence (emotional effects) in his diagnosis and the prescribed medication. She determined that the medication was not worth the sacrificial investment required to obtain it (beliefs and environment). Her friends told her (experience) that her child had ojo (beliefs). Recommendations from friends (experiences) influenced her to consider seeing a native healer (environment) to treat her child. Through further sense making, she determined that the financial investment (environment) required to consult with a native healer was not within reach (environment). Her environment constrained her options for health care (environment). She chose to try some remedios (environment) for treatment of her child. Each of the factors reciprocally influences the others. At first, Rosita's health care decision appeared to be driven by economics; however, deeper

exploration exposes a complex reciprocal interaction among the factors that construct her health reality (reciprocal health reality) and affect her health care decisions.

Rebeca's narrative about her visit to the temporary rural health clinic illustrates how the reciprocal interaction influences provider-patient communication. Rebeca visited the clinic because she was pregnant. Her previous experience with defacing communication by government doctors (experiences) resulted in her feeling intimidated (emotional effects) with doctors. She could not afford (environment: economics) a private doctor (environment: options) and she refused to go back to a government clinic. She waited for the temporary health clinic to arrive (environment). During the provider-patient interaction, she was afraid to express her concerns or ask for clarification (emotional effects) because of her past experiences. After an examination, the doctor explained that she needed to be eating more eggs and beans (experiences, environment). Rebeca quickly stated, "No, those are hot" (beliefs). Rebeca's beliefs of hot and cold and the environmental economic constraints limited her compliance with the diet recommendations and influenced the provider-patient communication.

Extrapolating from coordinated management of meaning theory (Pearce & Cronen, 1980), the patient's reciprocal health reality becomes both part of the lens for interpreting and a guide for action during the provider-patient interaction. The provider-patient interaction is influenced by the reciprocal interplay of the four factors as both the patient and provider engage in sense-making about interaction.

People make sense of new information and experiences by relating it to their existing cognitive structure developed through a lifetime of sense-making (Ausubel,

1963, Novak, 1998). For example, when Rebeca told the doctor that she could not eat eggs and beans while pregnant because they are hot, she subsumed the doctor's messages into her existing cognitive categories, resulting in her noncompliance with the diet messages. Another example of people subsuming new information into existing categories was when patients attributed hot and cold characteristics to pharmaceutical medications. Because sense-making involves the interrelation of novel information with existing prior knowledge, dramatic changes in cognitive structure are uncommon.

The findings show that power and sociodemographic differences influence the provider-patient interactions. The doctors in Baja Verapaz, Guatemala, hold the power to "reward" the indigenous patients with medicine, thereby possessing reward power (Beisecker, 1990). The indigenous patients also perceive the doctors as having coercive power to "punish" by refusing medicine as evidenced in the often stated experience of the government doctors saying, "No medicine" and "Jat." The paternalistic power relationship between the doctor and indigenous patient revealed in the findings show an abuse of power resulting from providers' neglect, abuse, and dehumanization of the Achi patients (Roter & McNeilis, 2003). Abuse of power in provider-patient interactions, although absent from the current literature, is evident in my field study's findings that expose a frequent and disturbing abuse of power by many government health care workers.

Consistent with the research on sociodemographic differences, the lower status Achi people receive inferior care in comparison to higher status Ladinos (Fiscella, Meredith, Goodwin, & Stange, 2002; Willems, et al., 2005). Felicia explained, "The

Achi people experience discrimination when they go to *puestas de salud*. They do not get attention and are told, ‘Wait, wait, wait.’ But when a Ladino arrives, they attend to him or her immediately.”

Willems, et al., (2005) show that doctors often inaccurately assume that lower status patients are not interested in learning about their health and not able to understand the information. Dr. Griego confirmed this, “Doctors here assume that the indigenous people are careless or indifferent to their health problems or that in the end they will not want to change.” The power and sociodemographic differences combined with assumptions of the government doctors often result in experiences of neglect and abuse of the Achi patients when they submit to the abusive power of the health providers.

Cultural differences impacting provider-patient interactions. The second research question is: How do the cultural differences between the provider and patient impact the communication process? The findings reveal three cultural differences that impact the provider-patient communication: correction in Achi culture, ethnocentrism, and pluralistic culture.

Correction in Achi culture. Face is embedded in the language and behaviors of the Achi. As Susana explained, “One of the worst things that can happen to you in this culture is to lose face.” Brown and Levinson’s (1987) politeness theory acknowledges that correction is inherently face threatening and politeness mitigates threats within inherently face threatening messages. In Achi culture, corrective messages cannot be easily mitigated, if at all. Therefore, a provider’s correction of health behaviors often results in face loss for the Achi patient and is interpreted as an insult.

Face in Achi culture creates a challenge for health care workers who seek to improve the health of the Achi people by suggesting changes to their health behaviors. My findings reveal the Achi frequently perceive messages from doctors as insulting, although some health providers' messages are well-meaning while other messages are purposefully dehumanizing. Felicia explained that sometimes the Achi perceive well-meaning messages as insulting:

Sometimes the Achi people think that doctor is rebuking and insulting (regaña-ing) them. But it is not that really. The doctor may be saying to do something because it will help them to live better. But the person says, 'No, they regaña me.' That is a problem.

The differences between monochronic and polychronic cultures illuminate this challenge. My findings indicate that the Achi demonstrate some polychronic characteristics, including indirect communication, valuing the amount of time spent in the health visit, and depending on context clues for meaning. The health care providers demonstrate monochronic values, including utilizing direct communication and valuing efficiency. These differences influence the provider-patient interactions and often result in the Achi patients perceiving the doctor's messages as insulting and offensive.

My findings identify a challenge facing health care providers working with the Achi population. Provider health messages often need to include suggestions or instructions for changes in behavior. Providers need to recognize that the Achi patients may interpret their well-meaning health messages as offensive face-loss because all correction results in face-loss in the Achi culture.

Ethnocentrism. The government doctors often mock the beliefs and behaviors of the Achi patients. Consuela brought the ethnocentrism of the government doctors to light when she said, “The way they (Achi patients) tell the doctors things, the doctors just laugh at them.” In addition, Felicia explained, “Sometimes if you say something like that (sharing a specific health related belief), the doctor says, ‘You are crazy’ because the doctors usually do not know our culture.”

The effects of provider ethnocentrism and defacing communication are illustrated by the Achi patients’ reluctance to ask questions, seek clarification, or reveal their beliefs. For example, at a temporary health clinic, Elizabeth carefully and thoroughly explained the instructions for taking the medication and Andres translated her statements into Achi. After completing the visit, Aleece received the instructions again when the other volunteer distributed the medication to her. Later, I observed Aleece approaching Andres outside asking for clarification of the medical instructions. The ethnocentrism of the government doctors also takes the form of degrading communication, including mocking statements which exposes the contemptuous and devaluing attitudes the providers hold toward the Achi people making the Achi people even more reluctant to ask questions, seek clarification, or disagree.

Pluralistic culture. The Achi have incorporated biomedical treatments into their existing cognitive structure as predicted by Ausubel’s (1963) theory of meaningful learning. For example, Rosita incorporates pharmaceuticals into her remedios for ojo, mixing three pharmaceuticals with four types of herbs; curanderos use a mixture of

pharmaceutical, herbal, and ceremonial treatments, and many Achi categorize illnesses and medicines into hot, cold and neutral.

This pluralistic blending of biomedical and traditional beliefs results in some people having unresolved belief conflicts. Many patients quickly and firmly denied ascribing to traditional beliefs of hot and cold or to visiting a curandero; however, they later described engaging in concurrent treatments. For example, when Consuela's daughter was sick, she took her to a biomedical doctor and began the pharmaceutical treatment while concurrently treating her with traditional remedios. The treatment involved passing a duck over the sick girl for seven days. On the seventh day, a smelly, yellow substance was extracted from the duck's tail and rubbed on the girl. Consuela's comment revealed her unresolved conflict, "We took her back to the doctor and he said she was recuperating well. Which one helped her? (duck or medicine) We don't know." Many Achi utilize both biomedical and traditional medicine concurrently because they are not sure which is effective.

Cultural knowledge about health and illness. My final research question was: How do biomedical and cultural knowledge about health and illness influence the provider-patient interactions in the population of this study? Three major illness attributions among the Achi that influence the provider-patient interactions are: ojo, hot and cold balance, and mal aire.

Ojo is a form of diarrheal illness in children. A child gets ojo when an adult looks at the child while the adult is in a certain state of being. It appears to be related to hot and cold balance. The states of being include pregnant women, menstruating women, men

who have been working in the field all day, and a drunken person, which are all hot states of being. When an adult in these states of being looks at a child, they unintentionally cause ojo by causing the child to become too hot. Treatments are different for organic diarrhea and ojo. Ojo beliefs also affect provider-patient communication. For example, if a doctor diagnoses organic diarrhea and the patient believes the diarrhea is from ojo, the mother may not comply with the biomedical treatment.

This study identified the belief in the importance of maintaining a balance between hot and cold for preserving health. The Achi classify illness, medications, treatments, foods, and states of being as hot, cold or neutral. This classification also directs the appropriate treatment. The wrong balance of hot and cold can cause illness or death. A number of examples include: a person is advised not to shower for a number of days following an injection of medication; a pregnant woman is advised to avoid hot food; a person with a hot illness must avoid hot food as too much heat can result in death. The women are expected to manage the balance of hot and cold foods in meals to maintain the health of her family. When taking a hot medicine the person must avoid taking a cold bath; and mixing hot and cold foods will cause illness.

The final patient causal attribution prominent in the culture is mal aire, an illness with a spiritual cause, often referred to as a “diabolica” illness that is not curable with biomedicine. Few people acknowledged belief in mal aire, but they attributed the belief to “many indigenous people.” Jose explained, “I saw a case that was very critical. This person went to go out to gather water and he got sick from mal aire.” It appears that a malevolent spirit randomly selected this man and caused him to get sick. Mal aire can

also be caused by a curse from an aj itz (that is, a native healer with the power to put curses on people).

Existing research asserts that both individuals' conceptualizations of their illness (explanatory model) and descriptions of their symptoms are grounded in their culture and theories of illness (Carrillo, Green, & Betancourt, 1999; du Pre, 2000; Hallenbeck, Goldstein, & Mebane, 1996; Kleinman, Eisenberg, & Good, 1978; Murdock, Wilson, & Frederick, 1978). When providers' and patients' explanatory models are dissimilar, miscommunication and noncompliance often results (Kleinman, Eisenberg, & Good, 1978). Consistent with the research, the findings revealed that the Achi's descriptions of symptoms are grounded in their idiosyncratic, culturally-grounded explanatory models. Elizabeth explained the influence symptom descriptions have on provider-patient communication:

Even for people who speak fluent Spanish, it is difficult. The Achi have different ways of explaining their symptoms than what you might get from the Ladino population or other places. It is hard for people that have not been in Guatemala a long time to really understand what people are talking about.

She elaborated:

For example, people will say, 'My lungs hurt.' Well, they are not really talking about their lungs. They are talking about their muscles on their back and shoulders. Another example is they say, 'I have a pain in my heart.' When I ask where the pain is, they point to their middle abdomen. If you don't know this, you will be lost.

Jose, a curandero, described two additional symptom descriptions: “the snake grabbed my leg” for a muscle spasm; and “there is a snake to me” for rheumatism.

The differences in conceptualizations and symptom descriptions between providers and patients make reaching shared meaning difficult. The providers struggle to understand the symptoms for diagnosis and treatments and the patients struggle to make sense of the providers’ messages in light of their pre-existing health and illness conceptualizations.

Defacement. Defacement is a dominant theme in the Achi participants’ discussions about their health care experiences in government facilities. Defacement is purposeful dehumanizing communication through destroying the other’s face. The findings challenged three foundational assumptions in the face theory: (1) interactants possess a concern for the face of the other, (2) interactants make some efforts to mitigate the threats to other-face, and (3) when self-face is threatened, self protective measures will be undertaken to counter the face threat. Achi patients said that the government doctors often display little or no regard for their face. In fact, contrary to regard, the doctors often denigrate the face of the Achi patients. Rather than enacting face-saving behaviors, Achi patients frequently choose to face defacement when other options for illness treatment are out of reach or deemed ineffective.

Through defacing communication the doctors devalue the humanity and dignity of the Achi. This form of dehumanization places the Achi outside the “normative universe of moral protection” (Hagan & Rymond & Richmond, 2008). In this way, the defacer experiences no psychological dissonance from mistreating, neglecting, and abusing the

Achi patients. Four types of defacement emerged from the data: disregarding, degrading, regañó-ing, and abusing.

Disregarding. Disregarding is the least intense and includes both verbal and nonverbal communication, including: ignoring, lack of effort, and dismissing as subthemes of disregarding.

Ignoring another human is purposeful defacement. When Angelita was left in the hospital alone and ignored while she was in labor, she suffered severe pain, yet throughout the entire day, no one checked on her, examined her, or offered her any assistance. Many stories from the Achi included experiences with government doctors who exerted little or no effort to listen, examine or explain the diagnosis or treatment. Aleece stated, “When we go to the centros de salud, they do not examine us.” Similar to ignoring, lack of effort fails to regard the dignity of the patient and results in defacement. Dismissing, the final subtheme of disregarding, was illustrated when government providers told the Achi patients, “There is nothing wrong with you, get out of here” or “No medicine, leave.” Andres confirmed this, “That is a problem. Usually the families from this village don’t want to go to centro de salud. The doctors say only “No medicine” and “Jat.”

Degrading. Degrading is the second level of defacement and is more intense involving more direct communication than disregarding. Two kinds of degrading emerged in the data: mocking and name-calling. Consuela said, “The way they (Achi patients) tell the doctors things, the doctors just laugh at them.” Felicia also expressed a

similar perspective, “If you say something like that (hot and cold belief) the doctors says, ‘You are crazy’ because the doctors usually do not know our culture.”

Name-calling is another form of degrading. It frames the other as something other than a fellow human being, thereby diminishing the moral constraints for behavior of participants and bystanders (Hagan & Rymond-Richmond, 2008). The Achi patients recounted experiences about when government doctors called them dogs and pigs. Angelita said that when she would cry because of the labor pain, the health providers told her, “Deal with it. Having a baby is like a chicken laying an egg and you are making a big ‘ol scene for nothing.”

Regaño-ing. The third level of defacement, *regaño-ing*, lacks a good English equivalent. The Spanish word “*regañar*” and its corresponding Achi words appeared frequently in the Achi patients’ narratives about their experiences at the government health facilities. Simple English translations include scold, rebuke, and bawl out. However, these words fail to capture the patients’ strong emotions and feelings of insult from the providers’ communication. *Regaño-ing* involves insult, anger, contempt, and disgust. English metaphoric translations with similar meanings are “verbal flogging” or “tongue lashing.”

The Achi frequently experience of being “*regaño-ed* by government health care providers. Angelita explained, “If we (Achi) do not understand them (the doctors) the first time about medicines, they tell us, ‘Then why do you even bother us and come here if you are not going to be able to take the medicine? Why should we bother to give you medicine?’” Later she explained that after missing a doctor’s appointment for her mother-

in-law, “I can’t face going back to ask for a new appointment because I know that they will regaño me a lot.” Elizabeth shared the following story that provided another example of regaño. A father delayed getting help for his baby with a deformed heart because he did not understand or was not told that the child would need surgery within a few months of birth. When he took the baby to the doctor, “He was regaño-ed and yelled at for not bringing her in for surgery sooner. The doctor said, ‘You deserve this because you did not bring her in sooner.’”

Abusing. The final level of defacement is verbal and physical neglect and abuse. Dehumanizing and defacing communication allows the health provider to behave in inhumane ways toward the Achi patients. Isabel’s four year old child died in her arms in the waiting room of a public hospital. When the child’s breathing continued to get worse, she ran up to a doctor pleading for help. She recounted, “He pushed me aside and told me to sit down and wait my turn.” When it finally became obvious to the nurses that the little girl was in trouble, they ran for help but it was too late.

Research has revealed that dehumanizing communication is the groundwork for physical abuse and even genocide (Hagan & Rymond-Richmond, 2008). Angelita’s appalling labor and delivery experience culminated with physical abuse. After an emergency c-section caused by the nurses’ neglect, the nurses persistently regaño-ed her for not being able to assist them in getting off the operating gurney into a bed. She recounts:

Finally, just one nurse got my arms and other grabbed my legs. They just threw me into the other bed. I was screaming in pain. I felt like my stomach was going to open from the operation. It was very traumatic.

Through dehumanizing communication, defacement frames the other as less than human and thereby releases the provider from morally obligated humane treatment. My study identified four types of defacement: disregarding, degrading, regañó-ing, and abusing.

In summary, four major factors influenced provider-patient interactions: environment, beliefs, emotional effects, and experiences. Additionally, the study identified three areas influencing health care interactions: correction in Achi culture, ethnocentrism with government doctors, and the pluralistic beliefs of the Achi. Several sources of cultural knowledge about health and illness influence the provider-patient interactions: ojo, hot and cold balance, and mal aire. Finally, a complex construct of defacement emerged as a new theory.

Limitations

The limitations of field research and my limited time in the field limit my findings. My participant observation included one temporary health clinic and I interviewed twenty-four people. As is consistent with ethnographic studies, some field interviews were brief and casual while others were lengthy. Also consistent with qualitative research and similar to a snowball sampling method, the results are limited in their applicability to other populations. Therefore, the results of my study illuminate the experiences and observations of the participants. The intensity and frequency of the

themes suggest the findings potentially provide a useful lens for further studies with the Achi and other indigenous populations.

Despite my efforts to limit the impact of my bias, the interpretations of the data necessarily involve my cultural and idiosyncratic lens. Frequent discussions with informants in the field provided helpful clarifications and cultural checks, as well as, protections from the error of projection. Through this validation process, I improved the usefulness of my findings to elucidate the health care experiences of the Achi.

Recalled narratives have both strengths and weaknesses. As time passes, individuals make sense of their experiences. The sense-making process brings aspects of the experience into prominence while minimizing other aspects. In addition, patients' sense-making of their experiences depend on their cognitive schemata grounded in their culture. Participants' narrative recall may lack "accuracy;" however, all interactants within a communication situation interpret and make meaning through their idiosyncratic lens. Therefore "accuracy" of an interaction is an elusive, if not, nonexistent quality. The strength of the participants' narratives is that they provide an "accurate" account of what was meaningful to them. The hurts, humiliations, defacements, and joys are "accurate" to their personal meaning making. This study considers this reflexivity of the participants' sense-making a strength. However, as in the case of all ethnographic research, the findings are not always generalizable to the larger Achi population or other indigenous populations.

Directions for Future Research

This study provides a useful starting point for further studies in the area of intercultural health communication among indigenous populations. The qualitative analysis of ethnographic data introduces a new construct, defacement, into intercultural health communication. The theorizing around this construct provides a direction for future research, opening up multiple lines of inquiry that could contribute to our understandings of abusive and dehumanizing communication in many different contexts. Future research could further explore the impact of defacement communication in terms of power positions, conflict, and in the continuation of discriminatory attitudes. In particular, some interesting questions include: In what ways does the use of defacement communication perpetuate the repression of certain groups? In what ways do victims of defacement resist the effects of the dehumanizing? Are the four levels of defacement emergent in this study existent in other contexts?

The findings revealed that the differences between the doctors' and the Achi's theories of illness and beliefs significantly affected the provider-patient interactions. Beliefs are a deep-level aspect of culture, and I was fortunate to have informants willing to discuss their beliefs and provide connections to other participants who provided further understanding. However, many aspects of the Achi's beliefs regarding health and illness remain elusive. Future studies exploring and unpacking the beliefs and the influence of those beliefs on health communication could provide useful information for health care providers in similar contexts in the United States and other parts of the world. Building

on the findings of this study, future research could explore the impact of health and illness conceptualizations on persuasion attempts.

In the future, I plan to develop lay training materials based on the findings of this study to assist health care providers working among the Achi and other indigenous populations. In addition, I would like develop brief educational material that could be utilized by the health department in Guatemala to educate the government health care providers working with indigenous patients.

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Appendix A

Description	Pseudonym
Ladino doctor working with temporary health clinics	Dr. Griego
1 st Achi Woman at temporary health clinic	Aleece
Young Achi woman in her twenties	Angelita
Physician's Assistant working with temporary health clinics	Elizabeth
Village leader in community with temporary health clinic	Andres
Young Achi man in nursing school	Carlos
Young Achi mother in her late twenties	Benita
Curandero	Jose
Young Achi teacher and mother in her early thirties	Consuela
Achi mother in her thirties	Rosita
Indigenous man in his forties who works for the government health care system	Alfonso
Retired nurse who worked in government health clinics in her forties	Felicia
Achi father and teacher in his early thirties	Diego
Elderly Achi man	Jorge
Elderly Achi woman	Gracia
Curandera	Jimena
Young Achi pregnant woman visiting temporary health clinic	Marta
Young Achi woman visiting temporary health clinic and sister to Aleece	Rebeca
Field informant	Susana
Achi woman in her forties	Sofia
Achi couple in their thirties	Teresa and Amando
Niece of Curandera	Carmela
Young Achi man and translator	Javier
Informant	Marcos
Young Achi woman in her twenties	Isabel