The Logics for Risk Behaviors and Nonadherence: Structural Vulnerability and Cultural Relativism

Philippe Bourgois
Professor of Anthropology and Director of the Center for Social Medicine, Department of Psychiatry, Semel Institute of Neurobiology, UCLA
Objectives of this Lecture

- Potential of cultural relativism and anthropological ethnographic methods

- Structural Vulnerability as a practical clinical tool for addressing health disparities and treating nonadherent patients effectively and ethically

- Case study of homeless heroin injectors, and alcoholic crack smokers
  - Recognizing contradictory priorities of War on Drugs and Public Health/Clinical Medicine
  - Harm Reduction in Public Health and clinical treatment—not just substance abuse

- Risk Environment and potential for upstream interventions
  - Strategy of structural vulnerability check list (see Academic Medicine article)
Cultural Relativism:
No culture good or bad, all have a logic

• Heuristic tool/attitude—not a theory and not a fact
  – Implies empathy and respect for other
  – Separate from personal ethics
  – Impossibility of cultural relativism but necessity for it

• Cultural competence = humility

• Centrality of power in cultural/class interactions

• Recognize structural forces shaping individual behavior (hence need for concept of “structural vulnerability”)
Risk Environment

• **Historical legacy and political economic forces**
  • Labor market (deindustrialization)
  • Migration history (genocide, slavery, economic refugees, political refugees)
  • Population loss

• **Ecological infrastructure (vacant buildings, wastelands)**
  • Open-air drug markets

• **Devastated socio-political public and private sector infrastructure**
  • Dysfunctional schools
  • Food deserts
  • Incompetent, brutal, corrupt police
  • Absence of functional parks, sanitation services, recreation centers, vocational training
  • Medical services deserts
  • Absence of healthy businesses

• **Political forces**
  • Zero-tolerance policing
  • Carceral management of poverty and drugs

• **Symbolic forces**
  • Racism
  • Stigma normativity
Structural Vulnerability

• Forces promoting risky behaviors and limiting individual ability/agency to make positive health choices
• Examples:
  • Addiction
  • Poverty: No insurance, no money for healthy food, no money for transportation, no safe housing
  • CLASS!—blind spot in the US—especially in laboratory and biological sciences
    • The particular pathologies caused by social inequality
  • Legal status
    • Contradictions between medical and security/repression priorities
• Marginal literacy
• Domestic violence
• Special needs/disability: Physical or cognitive
• Stigma due to non-normative identity: Race, sexual, alternative culture, tattoos, interactional style, dress, putative intelligence, appearance, accent, immigration, religion
Competing Cultural and Structural Conceptions of Risk

Public Health Culture:
- Sharing $\Rightarrow$ risk HIV, Hepatitis, abscesses
- Sharing $\Rightarrow$ ignorance, self-destruction, vice, individual incompetence

Versus

Street Culture:
- Sharing $\Rightarrow$ risk of opiate withdrawal symptoms, through social obligations and generosity
- Sharing $\Rightarrow$ moral responsibility, generous, smart self-interest
Moral Economy of Sharing

- Obligation of reciprocity
- Gift or favor
- Obligation of reciprocity
- Gift or favor
Harm Reduction (Risk Reduction)

- Meet patient more than halfway on patient’s terms
  - Avoid moral judgment
  - Lower threshold to access services
  - Respect/tolerance/recognition of alternative logic for patient’s (“abusive”) choices

- Goal: REDUCE SUFFERING
  - Not cure
  - Not necessarily perfect outcome
  - Management as chronic condition
  - Initiate a positive relationship with medical/public health services

- BUT ALSO may (without pressure or shaming judgment):
  - Motivate patient to take less drugs
  - Motivate patient to abuse body less
  - Render treatment an appealing option
Examples of Harm Reduction

• Needle exchange
• Safe injection rooms
• Mobile methadone and buprenorphine clinics
• Outreach vans and visiting nurses serving homeless encampments
• Opiate prescription programs
• Housing first (tolerance for substance use)
• Specialized surgical outpatient clinics for abscesses
• Vein care clinics and vein management messages
• Public showers and bathrooms
• Foot clinic
Injection room saves 30 lives

PS
April 4, 2013 - 10:44

Deputy mayor wants more drug-taking facilities across the city but opposition party Konservative is still against legal injection rooms

Staff at Copenhagen's first legal drug injection room have saved 30 lives since it opened last autumn, according to metroXpress newspaper.

Since heroin users were invited to take their drugs under the supervision of trained health workers – two nurses are always present during opening hours – the facility in the Vesterbro district of Copenhagen has been used over 34,000 times.

“We are able to step in when a user has an overdose,” the injection room’s manager, Rasmus Koberg Christiansen, told metroXpress. “We have the same antidote that ambulances have so there is no longer the same need to call for one when someone has an overdose.”
# Chart 1
**Structural Vulnerability Assessment Tool**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sample screening questions and assessment probes</th>
</tr>
</thead>
</table>
| Financial security | Do you have enough money to live comfortably—pay rent, get food, pay utilities, telephone?  
  - How do you make money? Do you have a hard time doing this work?  
  - Do you run out of money at the end of the month/week?  
  - Do you receive any forms of government assistance?  
  - Are there other ways you make money?  
  - Do you depend on anyone else for income?  
  - Have you ever been unable to pay for medical care or for medicines at the pharmacy?  |
| Residence        | Do you have a safe, stable place to sleep and store your possessions?  
  - How long have you lived/stayed there?  
  - Is the place where you live/stay clean/private/quiet/protected by a lease?  |
| Risk environments | Do the places where you spend your time each day feel safe and healthy?  
  - Are you worried about being injured while working/trying to earn money?  
  - Are you exposed to any toxins or chemicals in your day-to-day environment?  
  - Are you exposed to violence? Are you exposed regularly to drug use and criminal activity?  
  - Are you scared to walk around your neighborhood at night/day?  
  - Have you been attacked/mugged/beaten/chased?  |
| Food access      | Do you have adequate nutrition and access to healthy food?  
  - What do you eat on most days?  
  - What did you eat yesterday?  
  - What are your favorite foods?  
  - Do you have cooking facilities?  |
| Social network   | Do you have friends, family, or other people who help you when you need it?  
  - Who are the members of your social network, family and friends? Do you feel this network is helpful or unhelpful to you? In what ways?  
  - Is anyone trying to hurt you?  
  - Do you have a primary care provider/other health professionals?  |
| Legal status     | Do you have any legal problems?  
  - Are you scared of getting in trouble because of your legal status?  
  - Are you scared the police might find you?  
  - Are you eligible for public services? Do you need help accessing these services?  
  - Have you ever been arrested and/or incarcerated?  |
| Education        | Can you read?  
  - In what language(s)? What level of education have you reached?  
  - Do you understand the documents and papers you must read and submit to obtain the services and resources you need?  |
**Discrimination**

*Ask the patient* Have you experienced discrimination?
- Have you experienced discrimination based on your skin color, your accent, or where you are from?
- Have you experienced discrimination based on your gender or sexual orientation?
- Have you experienced discrimination for any other reason?

*Ask yourself silently* May some service providers (including me) find it difficult to work with this patient?
- Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments?
- Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care?
- Is this patient likely to elicit distrust because of his/her behavior or appearance?
- May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?

---

*a* This tool should be utilized along with common questions regarding intimate partner violence, alcohol/substance use, diet, and exercise.

*b* The questions in bold function as initial screens that could potentially be quantified. They are followed by assessment probes to elicit more detail and context.

Bourgois et. al. 2016, Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care
Academic Medicine DOI 10.1097/ACM.0000000000001294
ACKNOWLEDGEMENTS

Jeff Schonberg ‘s photographs copyrighted.

National Institutes of Health for the research funding for R01 grants:
DA010164
DA027204
DA027689
AA020331
righteous dopefiend

PHILIPPE BOURGOIS | JEFF SCHONBERG

University of California Press 2009