
How Personal Factors, Including Culture And Ethnicity, Affect The Choices And Selection Of Food We Make

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Abstract

Most major cities in the world are made up of diverse societies, consisting of a wide range of individuals from different ethnic and cultural backgrounds. Ethnicity refers to a social group, which shares certain distinctive features, such as language, culture, physical appearance, religion, values and customs. Culture on the other hand refers to how we do and view things in our group. For example a shared set of values, assumptions, perceptions and conventions based on a shared history and language can make a certain group. In order for society to function efficiently and smoothly these individuals must learn to integrate and coexist together. This will involve among other things, accepting and sampling different types of foods and even adjusting their diets. This is due to the large impact culture and ethnicity has on diet, which results in changes in health. As a result the choices and selections of food that people make, in the classes of foods they eat, will vary widely.

Different cultures may encourage or frown upon consumption of different foods by individuals who belong to their groups. Also the consumption of different foods at different stages of life may be actively encouraged or discouraged. This is due to the benefits and dangers of consuming these foods at certain times of life and in certain conditions. For example most cultures will not approve of the consumption of alcohol during pregnancy or lactation. This is due to the adverse affects produced by this drink. Foods and nutrition may also be affected by culture, with respect to different beliefs within the culture.

Religion plays one of the most influential roles in the choices and subsequent selection of foods consumed in certain societies. For example, in the Hindu and Buddhist religions the consumption of both pork and beef is frowned upon. This is because it is considered to not be clean meat. Also ancient Hindu scriptures prohibit the eating of these meats. As a result of this the large majority of Hindus and Buddhists (roughly 90%) have taken this rule to the extreme. They refuse to eat any meat at all and are strict vegetarians, despite being allowed to eat chicken and lamb. Conversely only the consumption of pork and not beef is prohibited for the same reasons in the Islamic religion and Judaism. However all other meats consumed in these religions must be halal and kosher respectively. This means that special prayers are performed in order to make the eating of these animals acceptable. In stark contrast Christianity and the

Catholic religion allow the consumption of any types of meat without the need for any kind of repentance to God in the form of prayer. Also at the other extreme to these religions the Jain religion does not allow the eating of any meat and any vegetables grown beneath the soil. During my community placement the first patient I interviewed had her diet largely influenced by her religious beliefs. For example she was a strict Hindu who was also a vegetarian. She did not even eat any dairy products. Her diet largely consisted of boiled rice and a wide selection of vegetables, and for dessert some fresh fruit. My second and third patients were both Christians and their diets were not as strict and were more varied and balanced. As a result I would not consider these patients to have their food choices largely affected by their religion.

Within certain religious groups there are different levels of acculturation. This means there is a large diversity with respect to the extent certain individuals follow the teachings of their religion. In some cases this diversity may result from the patients own interpretation of their particular religion. For example some individuals may be devoutly religious and follow their religion strictly according to the teachings. Also some individuals may not be as religious to such a degree and will tend to follow their religion more loosely. In the case of the patients I interviewed, only the first patient was very religious. This resulted in her food choices being greatly influenced by religion. However the next two

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patients were not as religious by their own admission, which resulted in them having more freedom with respect to their choices in the foods they eat.

We may decide certain personal factors that affect choices and selection of foods. This is because we have an input into these factors, which can influence their outcome. Among these factors are our patterns of eating, which include for whom the food is being made. For example in traditional eastern cultures foods tend to be prepared for a large number of people at regular times of the day. The opposite is true in western cultures, where food is prepared less frequently during the day and often the same meal is eaten more than once during the day. My first patient followed a typical eastern diet and made food for her husband and children at regular intervals during the day. However my other two patients tended to follow typical western diets and ate food at less regular times during the day. They also tend to cook different meals or even buy pre-prepared foods for their children rather than the whole family eating the same meal.

Another personal factor, which affects food choices, is the occupation of the patient. This factor directly influences the people's social class. In certain professions such as manual labour and driving, which are associated with low socio-economic status, food choices are often limited. My second patient was a builder, who did not get regular work. As a result his family tended to only buy essential foods, such as bread and milk, only once a week from local shops and markets. In his family's case, a wide range of different foods is not essential as his main priority is providing the essential foods for his family. This is because he does not earn a large salary so cannot afford to spend his limited income on unnecessary luxurious food products. In contrast to this my first patient was the wife of a businessman who would be included in the upper bracket of a social hierarchy. As a result she tended to go shopping at least twice a week and bought her foods from large more costly supermarkets. My third patients were an elderly couple, who were both former athletes from their respective countries. However they are now both farmers. However due to their sporting past, they have both become accustomed to a nutritious well balanced diet and both still follow a healthy lifestyle.

The mood and individual personality of the patient may influence the choices of foods we select. My second patient ate a less well-balanced diet and ate more fast foods for main meals and snacks between meals than my other two patients. This may be due to the financial constraints on him and his

family, which results in him enjoying life to a lesser extent. As a result he tends to eat more sweet foods and snack more. As my other two patients seemed to enjoy life more, they only ate at regular meal times and did not eat between meals.

Geographical factors such as where people live and the range of shops situated near them may influence their choice of foods. These factors are usually enforced upon these individuals. For example, some low-income families may live far away from certain shops. These families may not be able to afford a car or to pay regularly for public transport to travel to where more shops are situated. As a result, their food choices will be limited only to local shops, which may have a poor selection of certain foods and even lack other foods. Both my first and second patients live near to large supermarkets and smaller groceries and markets. As a result they have the chance to pick and choose which shops to buy certain foods from. However my third patients, who are farmers, live a long way away from any shops so have to travel into town where there are more shops in order to have a wider variety of foods available to them. They can buy fresh perishable goods once a week here when they drive into town to a supermarket. However even here the choice of foods is limited. As a result any foods they want which is not available to them here they must grow or produce themselves. This is largely season dependent, so their food choices are greatly influenced by these factors.

There are many other factors, which affect the choices and selection of food we eat. Among these is the age of the individual choosing the food. Children will usually choose to eat foods such as fish fingers, chicken nuggets and jelly, which are principally foods developed for younger people than older people. Children will also refrain from drinking alcohol, tea and coffee, which are seen as adult drinks and are not consumed in large quantities or frequently by most children. Young people will on the whole have less regard for their general health and state of their bodies. This is in some cases because they do not fully understand what effect different foods have on their bodies. However in the majority of cases most young people understand these adverse effects but choose not to follow any advice given about refraining from eating foods which harm their bodies. Therefore they will usually eat more oily fast foods such as burgers and chips. They will also not cook or eat home made meals as often as older people. Also some younger people will have role models from television or certain industries, who they idolise to a certain degree. This may result in them

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usually wanting to lose weight, which will affect their food choices. At the other extreme the older generation may have experienced a life event such as a stroke or heart attack. This will result in them changing their attitudes towards more healthy food choices and a more balanced diet. This is because these people may have changed their perception on food choices due to them valuing their health and bodies more after such an event whereas they took this for granted previously. This will greatly influence the foods they chose and subsequently select. My second patient, who had suffered a mild heart attack at an early age a few years ago, now eating a much healthier more balanced diet than previously, demonstrated this. Since his life event he values his health far more than previously. Also his children in contrast had much less regard for their bodies and had the exact opposite ideas about health as their father. This was due to them deciding not to follow any advice given to them by their father, despite him recently experiencing a heart attack, which has changed his way of thinking. My other two patients, who were far older than my previous patient, and had not experienced any recent life events but still ate healthy well balanced diets. This is most probably because of their ages and what they have learnt about health throughout their lives.

Another factor affecting the choice and selection of foods is ethnicity. Different ethnic groups will choose and select different foods. This is because people who belong to ethnic groups will have been raised and brought up in a certain style and manner. This means factors such their outlook and attitudes towards life and people, health and even food choices will be greatly influenced by their ethnic group. These factors among others are instilled into individuals of these groups at an early age. The different values, which influence these factors, emanate from the country where each of these ethnic groups originates. For example African and Afro Caribbean groups will usually consume foods, which contains a lot of various meats and a lot of wheat and rice. Eastern and far eastern groups will consume foods, which contains a lot of various herbs and spices. Typical western groups will consume foods, which are much dryer and plainer than other ethnic groups. However once again

there is high meat content in the foods. This was demonstrated to me during my community placement by all three of my patients. For example, my first patient was an Indian woman who was brought up in India and came to England in her late teens. Most of her meals were traditional and contained a lot of herbs and different spices. Her meals also contained lots of vegetables and no meats. In contrast to this my second patient was a man who was born in Cuba, raised in Barbados then came to this country. As a result his cooking influences were very varied and the foods he prepared was a mixed blend from these different countries. He ate a lot of meats usually with rice or various wheat germ products. He cooked with little oils and few spices or herbs. He also ate little fruits and vegetables with his meals. If he ate them at all it was usually as a side dish or in a dessert. My third patients were an Irish couple who ate a well balanced diet. However they had very little variation in their meals and cooked with home made meals by baking or frying their foods. They ate a good balance of different meats and vegetables despite living a long way from a wide variety of shops. They also tend not to experiment with their foods or try new recipes or dishes very often.

My last factor is allergy to various foods. None of my patients I interviewed had any allergies to any foods, however some patients may be allergic to certain foods. For example lactose intolerance and nut and nut oil product allergies are common among the British population. As a consequence, these patients cannot eat these foods or foods with these present in them. This is because if these foods are eaten an allergic reaction will occur in response to these actions, which will cause illness, and possibly death in the patient.

There are many personal factors, which affect the choices and selection of different foods. Health care professionals must be aware of these factors in order to be able to work and subsequently help people from a wide range of different cultures and ethnic groups. As a result it is necessary to appreciate and acknowledge the large impact culture and ethnicity has on food choices, eating styles and patterns.

References

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