

# Reinventing Therapeutic Expectations in Silicon Valley

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This was a PowerPoint Presentation with commentary  
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Slide 1

Comments

## Reinventing Therapeutic Expectations in Silicon Valley

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I am Dr. Jan English-Lueck, Professor San José State University and Research Affiliate, Institute for the Future. I am revisiting a topic that I began at the beginning of my career as a doctoral student at UC Santa Barbara, which examined medical epistemologies—how people think about health, their models of well-being and illness, and their understandings of appropriate therapeutic action.



## Silicon Valley Cultures Project (1992-2007)

- **Health as tool**
- **Self as project**



I took a long detour in my own research into the anthropology of work and technology, and developed, along with my colleagues Chuck Darrah and James M. Freeman, a 15 year project broadly looking at the cultures of Silicon Valley. Part of everyday life here is, of course, issues of health. It was striking that the logic of everyday life, highly instrumental and pragmatic, often includes many features of the new age worldview I had documented among the holistic healers. Indeed, during the more halcyon days of affluence, we noted that the personal assistants and lifestyle coaches of the industrial elite were former holistic health practitioners. In this context, health was seen as a tool for productivity, being healthy meant being productive. Indeed, writ large, beyond the high-tech workers themselves, life was discussed as if it were a project and working on self—ones education, ones skills, ones network, included working on ones self—making a healthier self, or at least mitigating the detrimental effects of workaholism.

## Fast Forward to 2003

- **Institute for the Future, Health Horizons”**

(Research for corporate and non-profit clients in the health sector)



- **Personal Health Ecologies of “consumers”**

(Rod Falcon, Leah Spaulding from IFTF, Jan English-Lueck, Erika Jackson and Leah Cook from SJSU)

I had long collaborated with the Institute for the Future, a non-profit think tank located in Menlo Park near Stanford University on emerging patterns of work, technology, innovation. They had long housed a Health Horizons program (doing research and forecasting for corporate and non-profit clients in the health sector, ranging from pharma companies to HMOs). Much of their work had been quantitatively and economic in focus. Then in 2002, they began to take a more anthropological approach, looking at the experiences, relationships and choices of “consumers,” people who are defining health and seeking strategies for managing their own health. Having been sensitized to the role of networks as information agents, they began to think about individuals’ Personal Health Ecologies. In the second year of this study Rod Falcon, and Leah Spaulding brought me on board along with two SJSU student interns, Erika Jackson and Leah Cook. This work is continuing in 2004 with a focus on adult onset diabetes and coronary artery disease.

## The “Findings”

- **Identified ranges of strategies**

(ranging from “mainstreamers” to “integrators” and “holistics”)



- **Identified use of networks**

- **Identified choices (consequences and costs of “empowerment”)**

That Personal Health Ecologies project focused on exploring how people managed information and relationships in their personal health ecologies, especially in the lives of people managing chronic illness, involved developing an ethnographic interview and observation protocol. We sampled 25 people, ranging in age, culture and health status. In addition, the Institute conducted an online survey of 1000 adults representatively sampled nationwide—knowing that would bias the survey toward the computer literate, but also understanding that such computer literacy was integral to the phenomena of being an “engaged health consumer.” In the qualitative portion of the project we collected health histories, all placed in the context of other life events, even projected the trajectory of their lives into the future. We asked people to take us on tours of their household, so we could discuss and document spaces, artifacts and activities related to health. We also collected network maps, trying to establish the roles of people, organizations, websites, even pets, in shaping health definitions, choices and actions. The Institute was able to take the data, both qualitative and quantitative and identified a number of strategies people employed based on their access to resources and their fundamental health beliefs. We were able to identify how networks were used and how people managed the onslaught of information relating to health, often couched as empowerment but experienced as overwhelm.

## The Anthropological Insight

- **A shift in the “rules of engagement”**
- **From adherence to agency**

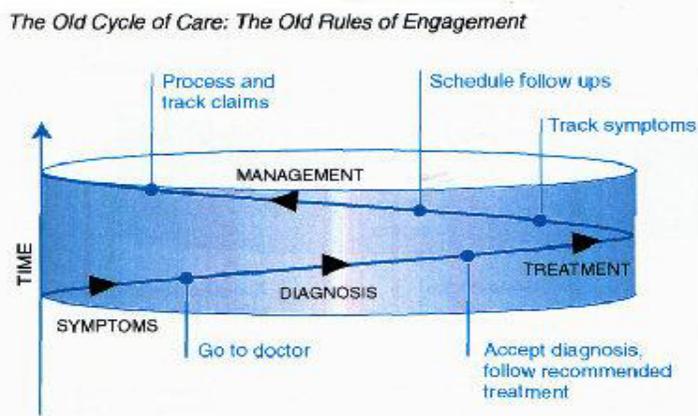


The clients, again ranging from insurance companies to hospitals, were stunned by seeing a point of view that they rarely had gotten from other researchers. We were able to communicate that there had been a shift in the “rules of engagement” so that, from the consumer/patient/person’s point of view, the issue was less a matter of adherence (complying to the orders of the health professionals) to one of agency, taking control of a broad series of activities that they, not the health establishment, defined as healthy.

## Talcott Parsons Revisited

### Old rules of engagement

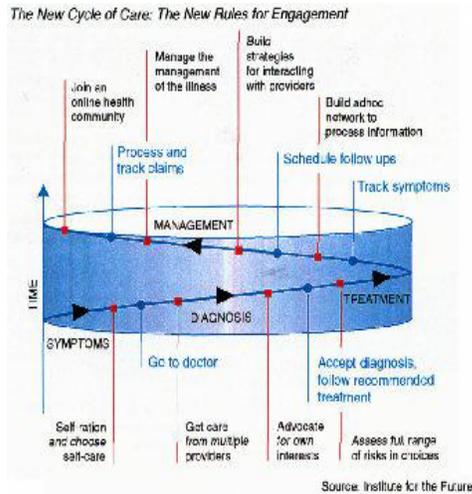
(Still seen as valid descriptor from within health care institutions)



Although this model has faded from the academic scene in anthropology and sociology as being entirely too normative to be useful, especially in a health-care universe characterized by lack of access and chronic disease, it is still very much the way health industry professionals view the therapeutic process—symptoms, diagnosis, treatment and management, with the locus of knowledge and trust clearly with the practitioners, so that adherence, once called compliance is the primary duty of the patient. Individual agency in defining health, understanding illness, determining treatment and management are severely constrained.

## New Rules of Engagement

- **Increased complexity**
- **Shift in locus of trust**
- **Increased modularity**



This graphic represents the rules of engagement as viewed from the users. It is far more complex, involving multiple complementary, contradictory or even competing understanding of health and illness. What causes disease may be contested. Multiple sources of information need to be found, and integrated. Diverse people and organizations take information and see if it can be negotiated into the person's models and practices. These entities, who may include practitioners, but may also peers, brands, websites, and organizations become the locus of trust and knowledge. The process is very much more complex than the streamlined normative model of the past. A striking feature of this process is that the information is fragmented, existing in modules, packets of information, that move, are transformed and reintegrated into a customized understanding. Herein lies an interesting point in cognitive anthropology.

- “breaks complex wholes into elementary units that are understood to be recombinable into a variety of different patterns.”

Bradd Shore, 1996,

Culture in Mind



- “Chunking and Recombining. A common strategy is to take longer sequences of activities and decompose them into smaller chunks...”

C. N. Darrah, J. A. English-Lueck, and J. M. Freeman, 2000 “Living in the Eye of the Storm: Controlling the Maelstrom in Silicon Valley”

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## **Chunking of Diagnostic, Therapeutic and Management Processes**

### **Debbie Miller Complex Personal Health Ecosystem**



- **Combines:**
  - **Chinese medicines,**
  - **homeopathic remedies**  
**and pharmaceuticals,**
  - **even non-formulary medicines**

I am going to focus on one particular case, given the constrain of time, to illustrate this process of health chunking. Debbie's health world is complex. She manages her own health, and those of her adult sons, her second husband and her cat. Her health network is an amalgam of past and current work-related friends, family, HMO professionals, and complementary alternative medical practitioners that she met through a women's spirituality network. She manages her own chronic conditions including ADD with depression, extreme chemical sensitivity, migraines, menopause, chronic fatigue. She typically takes her diagnoses, obtained from physicians at the HMO, and aggressively vets diagnoses and treatments through her naturopath. She uses the Internet competently to piece together information and deals for herself, her family and her aging parents.

- **depression, extreme chemical sensitivity, migraines, menopause, chronic fatigue**
- **Obtains diagnoses at HMO**
- **Vets diagnoses and treatments through naturopath**
- **Web literate**
- **Roots in women's spirituality**

She maintains files on each health transaction, organizing records, pharmaceutical information and noting consequences, maximizing her physical and spiritual well-being to the best of her ability. Her medica materia is drawn from diverse traditions—Chinese, homeopathic and pharmaceutical. She is adept at pushing her HMO into proscribing non-formulary medicines, which she views as more predictable and higher quality than generic medicines. A reaction to a medicine, increased fatigue or loss of sexual desire, will trigger a new effort to obtain a diagnosis—perhaps decreased testosterone levels—that can then go through the process of evaluation by Kim, her naturopath, and treatments from diverse traditions. Debbie has increased her level of control, her agency, by using her networks to provide a wider universe of information drawn from different medical epistemologies. She can then recombine the treatments from one tradition, spirituality or Chinese herbalism, with the conventional diagnosis from her HMO. She has found a way to chunk and recombine each aspect of the therapeutic process.

## **Implication**

**Consider investigating how the cognitive concept of modularity changes therapeutic expectations**

- **As a function of increased pluralism**
- **As source of patient agency**

Such instrumentality among health care consumers has long been noted in the way indigenous health care is combined with “Western” medicine opportunistically, especially in Asian medical pluralism. Yet, it is a new frontier for applied anthropologists working with the medical industrial establishment. In urban arenas, even ones considerably far removed from alternative lifestyles, the proliferation of culturally different medical choices abounds. Increased demographic pluralism and the Internet make the health market more global. Feng shui may be part of the urban planning process in the Bay Area, that comes as no surprise. However, when midwestern Safeway’s stock herbs and remedies, then OTC alternative medicine is not so exotic. Given this environment, the medical establishment is now alert to the possible reinvention of therapeutic expectations. It is our job to help them understand the phenonena.