



Culture: The missing link in health research



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ABSTRACT

Culture is essential for humans to exist. Yet surprisingly little attention has been paid to identifying how culture works or developing standards to guide the application of this concept in health research. This paper describes a multidisciplinary effort to find consensus on essential elements of a definition of culture to guide researchers in studying how cultural processes influence health and health behaviors. We first highlight the lack of progress made in the health sciences to explain differences between population groups, and then identify 10 key barriers in research impeding progress in more effectively and rapidly realizing equity in health outcomes. Second, we highlight the primarily mono-cultural lens through which health behavior is currently conceptualized, third, we present a consensus definition of culture as an integrating framework, and last, we provide guidelines to more effectively operationalize the concept of culture for health research. We hope this effort will be useful to researchers, reviewers, and funders alike.

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1. Introduction

All human behavior is culturally informed. Yet no other variable used in health research is so poorly defined and untested as culture (Dressler et al., 2005; Hruschka, 2009). Subspecialties within the major social and behavioral science fields focus on the impact of culture on medicine and health outcomes, e.g., sociology and anthropology, however, more robust integration of these theoretical frameworks across social/behavioral fields with health care and public health is needed to more accurately, explicitly and effectively use the concept of culture to understand variations in human behavior, and to more effectively address inequalities and inequities in diverse populations (Carpenter-Song et al., 2007; Fox, 2005; Fuller, 2002).

This paper provides a multidisciplinary, consensus effort to define culture and identify how cultural processes influence health and health behaviors. To do so, we first identify how the lack of an agreed upon definition of culture has hindered progress in the health sciences to explain differences between and among diverse population groups and more effectively and rapidly bring equity in

health outcomes. Second, we highlight the primarily mono-cultural lens through which health behavior is currently conceptualized, third, we present our consensus definition of culture, an outline of how culture functions as an integrating conceptual framework for the social determinants of health, and last a brief guide to operationalize culture in health research.

The U.S. has been a multicultural society for over 400 years, and differences and disparities in health outcomes in incidence, prevalence, and mortality from disease between population groups have been well documented (Smedley et al., 2003). In 1972, the OMB Federal Directive 15 required collection of data on the 5 major racial/ethnic groups, which further documented differences in health and social outcomes by population groups (US Census Bureau, 2005). But, equity in health outcomes remains elusive (Anderson, 2012). Culture is often proposed as an explanatory variable for these differences, yet, paradoxically, little work explicates the precise cultural processes involved that are valid, relevant to the communities of focus, and sustainable. Part of this oversight is likely due to a bias in U.S. society and science to assume the universality of the European-American ways of thinking and viewing reality (Hartigan, 2010; Henrich et al., 2010), and also a lack of clarity regarding definitions, measures, and theoretical models of culture. However, the recent changing demographics in the U.S., and internationally, with the shifting diversity and proportion of

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populations of different social classes, cultural backgrounds, social structures, and economic restraints have brought cultural dissonance to the forefront in health care.

Researchers, practitioners, and community members all reflect this diversity (Good et al., 2011; Weisner, 2009). As Weisner notes, intra-group variation is the current default expectation, and distributional models of cultural beliefs and practices should now be standard approaches. Accordingly, homogeneity would be the surprising finding. However, our traditional health behavior research tools are not adequate to identify and understand this diversity (Kagawa Singer et al., 2014).

In the last 15 years, concerted efforts have been made to clarify and develop consensus on the use of race and ethnicity as variables in health research, but, no consensus exists across health-focused disciplines on what culture is and why it should be used in health research. Researchers are left to craft measures that implicitly or explicitly operationalize their personal concept of culture (Goddard, 2005; Trickett et al., 2011; Viruell-Fuentes et al., 2012). Such ambiguity results in lack of comparability and accuracy across studies.

Culture is often operationalized with superficial, simplistic, and crude measures, such as dichotomous nominal variables based ostensibly on race (e.g., African American, non-Hispanic white, Japanese) or singular, stereotypical beliefs (sociocentric, fatalism or familismo). These nominal proxy cultural “markers” reflect truncated, static conceptualizations of culture that hamper our ability to understand the actual forces informing behavior at the individual, group or institutional levels of society, including health care itself. When such variables are entered into statistical analyses as proxies for culture, the findings are inconclusive or, at best, contribute negligible explanatory weight to the variance of health outcomes. “Culture” is then dropped from further analysis (Dressler et al., 2005), usually leaving social economic status to account for the greatest percentage of the variance. The explanatory power of culture is unnecessarily missed. Hruschka (2009) found 95 articles published in 2008 in the American Journal of Public Health that referenced ‘culture’ or ‘cultural’ in the abstract or body of the text. Authors claimed that culture influenced health behavior in 40% of the articles and 18% described culture as a source of measurement problems. In many cases, culture was mentioned as something that influenced health outcomes, but the authors never specified particular pathways. In a few cases, culture was used as a last attempt at explaining group differences or contradictory findings that could not be accounted for by other factors, i.e., as residual variance.

Such practice reproduces stereotypes and over-generalized representations of cultural practices or identities that have questionable external validity and are of little use in either improving equity in the health status of diverse populations or moving the science of health behavior forward. Not surprisingly, efforts to eliminate disparities across diverse populations and bringing equity to health outcomes have been stunningly disappointing. In fact, the disparities are, in many cases, growing (Anderson, 2012, 2003). Herein lies the major scientific challenge addressed by this paper.

Given that the ultimate goal of health behavior science is to translate this knowledge into effective interventions that would improve the well-being of all populations, locally and globally, the lack of attention to culture takes on heightened significance for the science of health behavior. We posit that greater precision in both the conceptualization and measurement of culture, as a fundamental force in human behavior, is essential for understanding how and why behaviors occur in certain circumstances, and how cultural processes could be mobilized to mediate or moderate the interactions among the multidimensional and multilevel

environmental factors to improve health outcomes. Multiple leverage points at various levels of an ecologic framework would have a higher likelihood to systemically dislodge barriers to better health outcomes. Singular strategies, as often tested in randomized controlled trials for behavioral research tend to promote counterforces that return the system to the status quo (Lewin, 1964). A more comprehensive identification of cultural processes would also promote the development of new theories and expansion of current theories that could inform better designed, cross-culturally valid and relevant programs. Such efforts would increase the likelihood that the strategies would be acceptable, relevant, valid and sustainable to and for diverse populations of focus (Carpenter-Song et al., 2007). However, no paper or panel has expressly defined culture for health research. This paper describes such an effort.

1.1. Evolving efforts towards clarifying culture in the study of health

Recent advances exist to clarify the use of race and ethnicity in the study of health. The Institute of Medicine (IOM) Report on “Speaking of Health” (2002) established guidelines to promote more effective communication practices in diverse communities. In 2004, The Uniform Guidelines for Science Journals recommended guidelines for the use of race for health research (International Committee of Medical Journal Editors, 2010). Winker, the Editor of the *Journal of the American Medical Association*, specified parameters for authors on the use of race in manuscripts submitted for publication (2004). In 2010, Henrich et al. (2010) noted that concepts of human behavior, assumed to be universal, are developed from western cultural norms that are quite ethnocentric. Similarly, Salway et al. (2011a,b) published guidelines for the use of ethnicity in health research and for cross-cultural collaborations on migration that require researchers to acknowledge the lack of universality of the validity of many concepts and measures commonly used in this field. Next, the Leed’s Consensus Panel on Ethnicity in Health set out 10 recommendations for its use in health studies (Mir et al., 2013), and, most recently, Lewis-Fernandez et al. (2013) published a checklist to assess the comprehensiveness and applicability of race, ethnicity, and cultural factors in psychiatric research.

The project described in this paper was conceived to create a cross-disciplinary consensus on a definition of culture that would be acceptable across diverse disciplines and areas of practice. This report, *The Cultural Framework for Health*, provides this definition and a step-by-step process to guide researchers in operationalizing their definition of choice for their research question (Kagawa Singer et al., 2014).

1.2. Project design

Thirty researchers were invited to become members of the Expert Panel (EP) by the project officer from National Institutes of Health Office of Behavioral and Social Science Research (OBSSR), the funding agency, and the PI and co-PIs of the study. The selection criteria for Expert Panelists (EPs) were they had to have: 1) substantial experience studying culture and health, 2) a significant history of funding by the NIH, and 3) represent diverse disciplines in training and work settings. Panelists were trained in seven different disciplines: psychology (3), psychiatry (1) medicine (6), anthropology (11), sociology (6), public health (4) and nursing (2), and most had appointments in departments other than their training discipline. EPs also had expertise in both qualitative and quantitative methods and extensive experience conducting health research in a wide range of cross-cultural, linguistic, national, and international contexts. Their research also covered all stages of the research continuum from basic, formative, intervention, clinical

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