

**The Concept of Acculturation  
in Health Research: Assumptions  
about Rationality and Progress**

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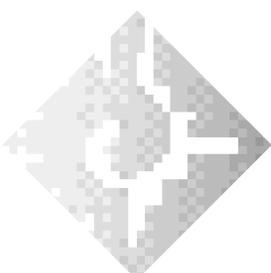
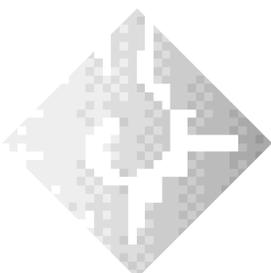
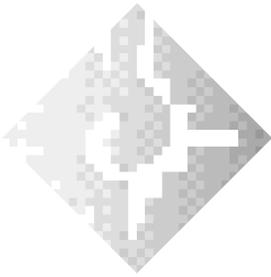


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### **ABSTRACT:**

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Recent research designed to explain differences in health and illness among ethnic minorities often focuses on cultural influences on behavior and lifestyles, viewing individual behavioral choices as based on cultural beliefs and traditions. Commonly, ethnic culture is operationalized and measured as “level of acculturation,” which is then correlated with various health outcomes. In this paper, the conceptual basis of “acculturation” in health research is examined. It is argued that the notion of culture is poorly articulated in this research, relying instead on “common-sense” ideas about the origins of valued and disvalued ideas and behaviors. As a result, acculturation health research is driven by *a priori* evaluative assumptions about the sources of rational and irrational behaviors. While failing to explicitly define ethnic and “mainstream” culture, ethnic culture is implicitly conceived as foreign, exotic, and antithetical to rationality; at the same time “mainstream” culture is viewed as its opposite. The model is rife with historical and conceptual difficulties. It is derived from folk wisdom about rationality and progress, which is galvanized in the ostensibly scientific construct of “acculturation.”

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# The Concept of Acculturation in Health Research: Assumptions about Rationality and Progress

The impact of culture on health has recently received much attention in health research, as both an explanatory factor and as an aspect of intervention. However, the concept of culture in this research has developed with little input from the fields of anthropology and other social sciences. Instead, it is based on widely encompassing, common-sense meanings, which are embedded in implicit assumptions about cultural and ethnic difference. In this paper, I argue that current research on culture and health is largely couched in questionable notions of ethnic difference, promoting folk concepts of rationality and progress in the guise of science.

Recently, federal regulations have emerged mandating inclusion of women and ethnic minorities in federally funded health research, resulting in intense attention to ethnic difference in health and a growing awareness that poor health is disproportionately concentrated among ethnic minorities. A great deal of health research is now attempting to explain these differences, the ultimate goal being to develop strategies to correct them.

Three conventional models are used in health research addressing ethnically based health inequalities: a racial-genetic model, a socioeconomic status model, and a health behavior or lifestyle model (Dressler, 1993). While both the racial-genetic model and socioeconomic status model are of some currency, in this essay, I focus on the health behavior or lifestyle model, considering how the concept of culture is articulated in this research.

The health behavior or lifestyle model, as applied to ethnic minorities, posits that culturally-based differences between ethnic groups in knowledge, attitudes and beliefs cause people to make behavioral choices that result in the observed health inequalities. Essentially, it presumes individuals choose or reject behaviors based on what they believe, and that such choices are prime factors impacting their health. In this sense, “belief” serves in health research as what Byron Good has termed “an important odd-job word” (Good, 1994:21), readily imbued with a wide array of poorly articulated assumptions and expectations about the sources of valued and disvalued concepts. Implicitly, behaviors presumed to be based on individual rationality, insight and responsibility are ascribed to “mainstream” cultural beliefs, while behaviors thought based in irrationality, ignorance, instinct or irresponsible choices are ascribed to ethnic cultural beliefs. When this logic is used to explain ethnic differ-

ences in health, ethnic culture comes to be viewed as determinant of behavioral choices. The current prominence of such thinking is evident in the burgeoning industry concerned with “objectively” measuring the impact of ethnic culture on health.

Commonly, current research attempting to study ethnic culture as a variable impacting health operationalize and measure it as “acculturation.” Acculturation is purported to be a quantifiable characteristic of members of ethnic populations, reflecting how much they embrace “mainstream” versus ethnic culture. It is measured with “acculturation scales,” which are then correlated with measures of health outcomes. Although efforts to measure levels acculturation have long been challenged by social scientists in a number of arenas (i.e. in the international development and education literatures), in the health literature, this field of research is progressing at an alarming pace, with very little critical reflection about the central concepts upon which it rests. A recent Medline review showed a nearly three-fold increase in studies of “ethnic groups” between 1976 and 1997, and a four-fold increase in studies with “acculturation” as a textword during the same period, listing more than 500 studies in the last five years alone. This work is haunted by important methodological difficulties resulting from the poor conceptualization of the phenomenon (Dressler, 1993; Recio Adrados, 1993; Stanfield, 1993; Edgerton and Cohen, 1994; Harwood, 1994; Ponce, n.d.). Here, I wish to examine the conceptual basis of “acculturation” in health research, and its relation to cultural stereotypes and assumptions about rationality and progress.

## *The Concepts of Culture and Acculturation*

The current NIH grant proposal guidelines, in discussing the inclusion of minorities in research, states: “Researchers should be cognizant of the possibility that these racial/ethnic combinations may have biomedical and/or cultural implications related to the scientific question under study” (PHS 1995). This statement reflects a widespread belief in health research: that ethnic identity is associated with cultural traits that can impact health. For example, a common notion in such research is that ethnic minorities reject appropriate practices or interventions because they conflict with beliefs or customs of their cultural tradition (Foster, 1987; Hahn, 1995; Ponce, n.d.), accounting in part, for their comparatively poor health outcomes.

## *Examples of Acculturation Scales*

Most acculturation scales take a bipolar approach to acculturation, presuming the existence of dichotomous cultures: “mainstream” versus ethnic. They also commonly presume a unidirectional and permanent process wherein ethnic cultural traits are replaced as an individual takes up traits of the “mainstream” culture (Recio Adrados, 1993; Harwood, 1994). The questions and response options in acculturation scales are structured in a way that force a choice between the two cultures (Rogler et al. 1991).

Acculturation scales always include questions about the individual’s use of English versus minority language in various settings, with various people and for mass media. Some also include questions about the individual’s preferred ethnic identity, and that of their friends and associates; as well as their and their parents’ place of birth and residency patterns. A few also ask about knowledge of historical events from the country of origin, subscription to family values, and gender roles associated with the ethnic group (Cuellar et al. 1980; Hazuda et al. 1988; Marin and Marin, 1991; Balcazar et al. 1995).

After much research on scale composition, Marin and Marin (1991) have found that linguistic items alone give equally good results as do more complex sets of questions for determining acculturation levels. They note that language alone is often taken as a shorthand measure for evaluating acculturation. Currently one of the most popular measures used in clinical research on Hispanic populations is a 4-question scale developed by Marin and Marin (1991:38). Their “Short Hispanic Acculturation Scale” consists of four questions: **1.** In general, what language do you read and speak? **2.** What language do you usually speak at home? **3.** In Which Language do you usually think? **4.** What Language do you usually speak with your friends? The response options for all questions are: Only Spanish; Spanish more than English; Both Equally; English more than Spanish; Only English.

In discussing this scale, Marin and Marin include the caveat that acculturation tends to be highly correlated with level of education, and that education must be carefully considered as a co-variate (Marin and Marin, 1991:39). Still, health research most often takes a simplified view of acculturation, which excludes serious consideration of educational and related linguistic issues.

It is troubling that most studies concerned with culture and health do not include any definition of a *culture*. Instead, “culture” is implicitly understood to be a cluster of conceptual and behavioral traits carried by individual-group members, with a presumed objective reality that can be studied as an independent variable (Horn, 1993; Lock, 1993). This failure to explicitly define *culture* results in its passive, common-sense construction as the central tenant of acculturation in health research.

The concept of “acculturation” itself is likewise only rarely or vaguely defined in this literature. For example, Rogler et al. (1991:585), in a definitive literature review on the topic, defined acculturation as “the process whereby immigrants change their behavior and attitudes toward those of the host society.” Fuller delineation of the concept is left to presumed understanding of what adapting to a new cultural system might entail. Considering that *measurement* of acculturation is key to this research, it is surprising that more precise definitions do not exist.

Of particular concern is failure to consider what the specific nature of the host or “mainstream” society might be. The acculturation model, in its health research application, implicitly posits the existence of an unproblematic and identifiable “mainstream” culture to which people are adapting. This presumption seems ill advised, given the extreme complexity and multi-faceted nature of Western society. A more accurate representation might be one that assumes an intricate pattern, wherein a variety of sub-groups contribute to the overall fabric of the larger society (Berry, 1993). In such a model, the difficulty of accurately assigning traits to “mainstream” versus ethnic culture would become more obvious.

As impressively vague, arbitrary and problematic the acculturation concept may be, it is a central notion in the flourishing field of behavioral and lifestyle health research on ethnic minorities. The acculturation construct forms the basis of a disturbing rush to measure and statistically model the cultural influences on health among minorities. Critical discussions about acculturation in the health literature focus on issues of its measurement; while, the construct itself remains unchallenged. This may be because, being based on widely held stereotypes, it appears routine and reasonable, consistent with implicit conceptions about the source of rational and irrational thoughts and behaviors (Ponce, n.d.).

Downplaying the obvious questions about differential access to resources and information that the lack of English might imply, language is treated as a proxy for culture. Language is presumed to reflect the presence of a whole set of cultural traits, and thus is judged to be an objective measure of individual levels of ethnicity. In this sense, language preference is treated as though it were diagnostic of culture, with preference for English over the ethnic language taken to indicate an individual's progress in the shedding the ethnic traits, and taking on the traits of the "mainstream" culture.

### ***Assumptions about History and the Source of Rationality***

Behind the whole undertaking of establishing the relationship between acculturation levels and health inequalities lie some very basic assumptions about knowledge and belief that are rooted in an Enlightenment tradition (Foster, 1987; Good, 1994). The acculturation model begins with an underlying logic of "modernization." Becoming acculturated into Western European "mainstream" culture is equated with becoming increasingly rational, efficient and complex, and by implication, less primitive and underdeveloped (Harding, 1991; Lucas and Barrett, 1995).

It is a social evolutionary model, tautologically pre-defining the ethnic culture as composed of traditionalism and questionable beliefs, with acculturating individuals inevitably moving away from these orientations and toward the more advanced knowledge of the "mainstream" culture (Hahn, 1995; Lucas and Barrett, 1995). It is noteworthy that, while "mainstream" culture is never overtly examined or explicitly defined, it is understood to consist of legitimated and valued concepts and orientations against which the ethnic culture is contrasted.

At a fundamental level, this presumes new contact is occurring between two clearly distinct cultures. Hazuda et al., for example, describe acculturation as a "multidimensional process, resulting from intergroup contact, in which individuals whose primary learning has been in one culture take over characteristic ways of living from another culture" (Hazuda et al. 1988: 690). However, in most cases, the idea of a confrontation between two dichotomous cultures is a presumption of dubious validity (Hahn, 1978; Edgerton and Cohen, 1994). While this model may make some sense for colonial or new immigrant situations, for most ethnic minorities to which it is

applied in the health literature, the idea that two distinct cultures are coming into new contact amounts to historical fiction. The origin culture is rarely if ever completely distinct or analytically separable from the receiving culture (Harwood, 1994). Almost without exception, acculturation scales are applied to groups who, in fact, have been long time active participants in global or metropolitan cultures, where it is impossible to separate the influences of Western European cultures from other sources of cultural attributes. For example, Hispanic culture in Mexico and the United States is not historically separate from the rest of Western European culture, nor can the influences of the West be reasonably excluded from any cultural history of present-day urban India, Columbia, or Cambodia (Edgerton and Cohen, 1994).

Disregarding the prevalence of global culture, the acculturation model posits two analytically separable and competing cultures: the "mainstream" culture to which all science and rationalism are attributed, and an ethnic culture constituted in traditionalism and irrationality. This amounts to a blatant appropriation of the urban, educated and scientific aspects of the ethnic culture as rightfully pertaining to the nebulous "mainstream" culture, and in turn ascribing all superstition and erroneous belief to the ethnic culture. Thus, rather than reflecting objective differences between two cultures, *a priori* suppositions about the source of valued and disvalued features generate the typology itself.

To illustrate this point, let us consider for a moment two types of game birds, doves, that occupy South Texas and Northern Mexico. One is a large grey dove prized by hunters for its meaty breast. The other is a small brown dove that is too thin and bony to be valued. In common parlance, the large prized bird is called the White-Wing Dove, while the scrawny bird is known as the Mexican Dove. In that the doves occupy the same geographical region and ecological niche (Terres, 1991), the choice of names tells us much about the presumed source of their valued and disvalued characteristics.

A similar process of ascription occurs in the health literature on acculturation. Coexisting valued and disvalued characteristics of multi-faceted individuals are separated into modern and primitive elements by virtue of the acculturation construct itself. These elements are arbitrarily uncoupled and assigned to the "mainstream" versus "ethnic" culture by virtue of the *a priori* categories of the scale itself.

Thus far, I have argued that there are serious flaws in the conceptual basis of the acculturation model used in health research, particularly in its assumptions about history, rationality and cultural difference. This poor conceptualization allows ample room for the “ideologically determined and culturally biased production of knowledge” (Stanfield, 1993) prevalent in studies of ethnicity and health. This becomes strikingly obvious when considering how the findings of this type of research are typically interpreted.

### ***Ideology and the Interpretation of Findings***

Stanfield (1993: 6) has cogently argued that professional dogma in the field of racial and ethnic studies is highly charged ideologically. To quote: “Because confirmations based in folk wisdom have taken precedence over the pursuit of truth in this research area, it is not surprising to find that the rules of procedure and evidence that usually apply to other less ideologically charged subfields are broken, bent, or ignored when ethnicity or race is the subject matter.”

This is nowhere more obvious than in interpretations of research regarding the impact of ethnic difference on lifestyle factors and chronic illness. These studies are designed to examine statistical correlations between various sociocultural markers and selected behaviors and outcomes. The discussion and recommendations sections of these articles often go well beyond the variables actually measured and draw broad inferences about belief and behavior, reflecting the predominance and persistence of ideologically based constructs more than the evidence at hand. In order to examine these tendencies, I reviewed 13 articles keyworded for both “acculturation” and “knowledge” in Medline between 1995 and 1996, (Balcazar et al. 1995; Hsu-Hage et al. 1995; Kulig, 1995; Marin and Perez-Stable, 1995; Otero-Sabogal et al. 1995; Remennick et al. 1995; Sherman et al. 1995; Harmon et al. 1996; Hubbell et al. 1996; Landale and Hauan, 1996; Moore et al. 1996; Peragallo, 1996; Yi and Prows, 1996).

An interesting feature of the ideological framework of these studies is an impetus to demonstrate that culture operates independently of other socioeconomic factors. Many studies fail to consider differences in Socioeconomic Status (SES), and instead presume that “culture” can be understood as a psychological characteristic of an individual, independent of context. Others treat SES as a “confounding variable,” and attempt to statistically control for SES differences. This amounts to a denial of the

importance of the social structure in the context of culture, and focuses instead on the presumed effects of disembodied ideas and values (Recio Adrados, 1993).

Lacking consideration of the larger institutional contexts and dynamic social processes in which behavior and concepts are generated, “culture” becomes synonymous with unexplained variance (Cohen, 1992). By separating SES factors from the equation, important questions about unequal access to services, information, and economic resources are arbitrarily excluded from data analysis, allowing questionable notions about cultural difference to drive interpretation.

Whether a positive, negative, or neutral correlation is reported between acculturation and the health outcomes in question (Rogler et al. 1991; Recio Adrados, 1993), in interpreting findings, these studies consistently exhibit disturbing presumptions about the sources of rationality and cultural difference. When low acculturation scores are correlated with *valued* behaviors or health outcomes, a “natural” protective characteristic is commonly ascribed to the ethnic culture. When low acculturation is correlated with *disvalued* behaviors or outcomes, the ethnic culture is viewed as having a pathological effect. Whether responsible for good or poor health, the ethnic culture’s effect is understood as “primitive” in nature, either disruptive and degenerate or pristine and harmonious, but always instinctive and inherent, rather than rational and intentional, as the “mainstream” culture’s effect is presumed to be (Lucas and Barrett, 1995).

### ***Conclusion***

I have argued that health research designed to explain ethnic patterns in the unequal distribution of poor health has taken up the notion of “culture” in a poorly articulated way. This research has operationalized ethnic culture as “level of acculturation,” which is generally understood to be a bipolar, unidimensional, unidirectional process. Acculturation models in health research are driven by *a priori* evaluative assumptions about the sources of rational and irrational behaviors. For example, quite commonly, valued behaviors are arbitrarily ascribed to the knowledge base of “mainstream” culture, and disvalued behaviors to the exotic attitudes and beliefs of minority or ethnic culture. Thus, “culture” functions as an ideologically convenient black box wherein problems of unequal access to health posed by more material barriers (such as insurance, transportation, and education) are pushed from the foreground, and ethnic culture is made culpable for

health inequalities. In the acculturation model, ethnic culture is implicitly defined as that which is foreign, exotic, and antithetical to rationality, while “mainstream” culture is viewed as its opposite. In other words, when correlated with poor health outcomes, ethnic culture is conceptualized as an obstacle to good health, a risk factor; while acculturation to “mainstream” culture is presumed to be a road to better health (Horn, 1993). The model, although rife with historical and conceptual difficulties, has become *de rigor* in health research on certain ethnic minorities. In spite of its cloak of scientific jargon, it is derived from folk wisdom about rationality and progress, which are galvanized in the construct of “acculturation,” giving a professional gloss to what in reality may be nothing more than ethnic stereotypes (Cohen, 1992:6).

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