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The Challenge of Acculturation Measures: What are we missing?

A commentary on Thomson & Hoffman-Goetz

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With the swelling number of immigrants coming to the US, there has been a growing concern about development of measures that capture the gradual process of acculturation; yet there has been no consensus on what to measure and how to measure it. Acculturation (i.e. defined as a multidimensional process of the adoption of U.S. cultural norms, values and lifestyles; see Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005) and enculturation (i.e. defined as the preservation of native cultural values, norms or lifestyle patterns), have been hypothesized to be linked to health outcomes of different ethnic groups such as Asians and Latinos (Kim & Ominzo, 2006). Federal reports and research studies over the past three decades continue to document that acculturation is a critical factor associated with a wide range of health outcomes and health behaviors (Alegria, Sribney, Woo, Torres, & Guarnaccia, 2007; Amaro & De la Torre, 2002; Andreeva, Unger, Yaroch, Cockburn, Baezconde-Garbanati, & Reynolds, 2009; Caetano, Vaeth, Ramisetty-Mikler, & Rodriguez, 2009; De La Rosa, Vega, & Radisch, 2000; Fuentes-Afflick & Hessol, 2008; Johnson-Kozlow, 2009; Montez & Eschbach, 2008; Sussner, Lindsay, & Peterson, 2007). During this same period, empirical investigations have reported inconsistent findings regarding the role of acculturation, mostly attributed to the pronounced variation in the assessment of acculturation, the proxy nature of many of these measures and the lack of cross-cultural validity of the measures (Rogler, Cortes, & Malgady, 1991; Stevens & Vollebergh, 2008).

The article “Defining and Measuring Acculturation: A Systematic Review of Public Health Studies with Hispanic Populations in the United States” by Thomson & Hoffman-Goetz (2009) is an excellent step in the right direction, as it helps the research audience take inventory of what measures are available and what these measures can offer. In their paper, Thomson and Hoffman-Goetz (2009) systematically review the definition and measurement of acculturation among Latino populations in public health research over the past 30 years. A similar review of studies by Rogler and colleagues conducted almost twenty years before (Rogler et al., 1991) shares many of Thomson and Hoffman-Goetz’s concerns about acculturation measures. Thomson and Hoffman-Goetz (2009) conclude that existing acculturation scales have significant limitations. In particular, they highlight a lack of precision, erroneous use of unidimensional scales, and neglect of acculturative change processes in measurement, which

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may lead to a less comprehensive understanding of the relationship between acculturation and health. Thus they recommend the development of theoretical models which incorporate acculturation into the practice of public health.

However, as discussed in this review, one crucial aspect of the acculturation debate comes from the tension between what we *need* to measure, and what we *can* measure, particularly within the constraints of epidemiological and large health surveys. As a result, the field has been inundated with single item measures (such as language, place of birth, nativity, time in the US, and generational status) which serve as proxies for the acculturation process, rather than more lengthy acculturation scales that measure a whole range of behaviors and preferences for media/entertainment/food/others, and social interaction with Anglos as compared with Latinos (Lara et al., 2005; Zane & Mark, 2003).

While not ideal for all circumstances, studies have demonstrated that proxy acculturation items can be useful to assess acculturation in situations where use of a more comprehensive acculturation scale is impractical (Cruz, Marshall, Bowling, & Villaveces, 2008). Advantages to using shorter proxy measures include: simplicity of assessment, feasibility of collection in large health surveys, and limited respondent burden. Three proxy measures in particular have been shown to have high internal consistency and strong correlation between existing acculturation scales: language spoken (during interview or at home), proportion of life lived in the US, and generational status (Cruz et al., 2008). Language is considered the strongest single predictor of acculturation (Arcia, Skinner, Bailey, & Correa, 2001; Marin & Gamba, 1996; Rogler et al., 1991) while proportion of life lived in the US and generational status afford an assessment of the level of exposure to U.S. culture. Although often ignored, country of origin is also an important proxy measure that can provide important insight into the historical context, baseline cultural characteristics of respondents, and geographical context of exit. Therefore, when more thorough assessments of acculturation are unfeasible or unavailable, proxy measures that examine language usage, length of time in the US, generational status and country of origin are suitable substitutes (Alegria et al., 2007; Cruz et al., 2008).

However, if we are to truly understand the underlying mechanisms linking acculturation to health, public health researchers must move beyond simple proxy measures. Proxy acculturation measures fail to differentiate between the *process* of acculturation (i.e. language acquisition) and the *consequences* of acculturation (i.e. family conflict; acculturative stress). This lack of precision may contribute to our inability, thus far, to identify the underlying mechanisms that link the acculturation process to negative health outcomes. Another serious limitation is that they give us scarce information about an individual's enculturation.

Acculturation studies have also been hampered by confounding the effects of changing social position and socio-structural factors, such as workforce participation and disruption of marital status (Alegria, Takeuchi, Canino, Duan, Shrout, Meng et al., 2004), and the acculturation process. Although often attributed to the acculturation process, these social status factors may actually be associated with generational or social mobility trends, independent of the process of acculturation. An important failure in many of these measures is thus the assumption that these processes are only occurring in the foreign born population. Measuring whether social mobility of the younger generation as compared to the older generation can lead to intergenerational conflict and family dysfunction should also be assessed independent of nativity. Only then can we distinguish acculturation from changes in social position.

Another particularly glaring gap centers on the psychological aspects of the acculturation process and how individuals interpret the sequelae of experiences in their process of adaptation and integration. Acculturation can happen at the group and individual level (Berry, Trimble, & Olmedo, 1986; Matsudaira, 2006). However, researchers often overlook what happens at

the psychological level, which is responsible for individual and group differences in terms of what factors one chooses to acculturate towards or disregard (Berry, 2003), and more importantly the reasons why those choices are made. Interestingly enough, evaluating the acculturation process could be not only important for immigrants, but also for US born ethnic/racial minorities (i.e. Native Americans, African Americans) who may disregard certain mainstream US cultural norms, values and lifestyles that fail to resonate with their living circumstances. Known as psychological acculturation (Berry, 1980; Matsudaira, 2006), this aspect of acculturation mediates the adoption of selective aspects of US culture as well as the maintenance of native lifestyle, norms and values and their influence on health.

In order to fully capture the psychological acculturation process, it is critically important to understand what determines the selective adoption of the new culture compared to the selective retention of the culture of origin. The contexts of reception play a critical role in immigrant adjustment (Hull, 1979; Portes & Rumbabaut, 1990; Stevens & Vollebergh, 2008), such as immigration policies and the racial/ethnic composition of one's neighborhood. The receptivity to immigrants in those contexts, either perceived or experienced (i.e. exclusion to public services, exposure to discrimination and discriminatory practices that welcome same-ethnicity groups in the host country) may dramatically influence which cultural characteristics an individual chooses to preserve. For example, a newly arrived Cuban immigrant who settles in a Latino enclave in Miami may be better able to retain Spanish language skills and cultural characteristics of his/her country of origin compared to an immigrant who moves to a rural area in Nebraska isolated from other Spanish-speaking Latinos. Isolation from or inclusion in social networks may be an important force to comprehend the maintenance of native cultural values, norms or lifestyle patterns or adoption of US cultural values, norms or lifestyle patterns. In this way, certain aspects of the acculturation process can be understood as coping strategies that immigrants and other ethnic and racial groups use in order to adapt to their contextual circumstances in the U.S.

Another contextual factor that may mediate the psychological aspects of the acculturation process and health outcomes is contact with the country of origin. Although immigration to a foreign country has been traditionally associated with erosion of ties to the country and culture of origin (Gordon, 1964), studies demonstrate that this erosion can be mitigated through frequent visits to the country of origin; thereby buffering the negative effects of the acculturation process. In fact, a recent study by Tamaki, Takeuchi, & Alegria (under review) found that direct contact with the country of origin can provide a protective mechanism for immigrant health. Visiting your country of origin with some frequency appears to reduce the risk for depression by 50% among Asian immigrants. It is hypothesized that this relationship occurs through the fostering of ethnic attachment as well as through an intergenerational pathway where parents of immigrant youth expose their children to the language and values of the home country and maintain a relationship with extended family. It is thought that greater attachment to one's ethnic heritage may result in an enhanced sense of belonging that may serve as another resource for positive adaptation to stressors (Resnick, Bearman, Blum, Bauman, Harris, Jones et al., 1997). These examples illustrate that acculturation is not a uniform process. Instead, contextual factors such as the receiving context and the ability to return to one's country of origin greatly impact the degree to which one acculturates to the host culture or retains aspects of the native culture. However, existing acculturation measures do not capture this interaction between context and individual level processes, nor do they examine which contextual factors lead one to select or retain certain aspects of culture.

An additional relationship that must be disentangled is variation in health outcomes (Finch & Vega, 2003; Thoman & Suris, 2004) associated with acculturative stress. Differentiations between acculturative stress and acculturation are hard to come by, and seem to be conceptually distinct by the perceived disproportion of cultural demands and accessible resources that

generates stress (Smart & Smart, 1995). That is, acculturative stress refers to the challenges and stresses that immigrants face as they try to successfully navigate a cultural understanding necessary to live and negotiate their new circumstances (Berry, 2006). As mentioned above, contextual factors are likely to impact how an immigrant copes with this situation and what are the potential factors that might cause acculturative stress (i.e. discrimination, new job requirements like English language fluency). However, it is unknown if health outcomes differ if the adoption of the new culture is forced (e.g. if an immigrant feels they have to develop language capacity to avoid being discriminated in their job environment) compared to if the acculturation process is more voluntary (e.g. if an immigrant moves to an isolated area and acculturates to work and succeeds in that context). Also of importance would be to identify how acculturation shifts over different developmental periods (i.e. early adolescence, early adulthood, later life). So under different circumstances, it might be that pressures to develop language capacity in English might be positive to immigrant children trying to integrate to school networks but negative if they create family conflict in adolescence by limiting communication with parents and extended family in their native language.

We have to move away from simplistic explanations that state that incorporation of U.S. customs and traditions are harmful to health. We have an opportunity to seek a more nuanced and multidimensional approach to acculturation measures. This will require distinguishing between cultural transactions and psychological impacts of acculturation, between aspects of acculturation and those of enculturation and the reasons behind those choices, as well as whether those transactions are seen as enhanced coping or as stressors, voluntary choices or sociopolitical coercions. More importance needs to be given to how acculturation happens in different contexts and the immigrant-context interactions that lead to successful and healthy integration in US society. Investigation of the benefit of maintaining traditional cultural ties and understanding which aspects of acculturation could have detrimental health consequences should also be part of the upcoming agenda of new acculturation measures.

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