The Concept of Culture: A Core Issue in Health Disparities

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ABSTRACT *Contemporary discourse contains numerous examples of use of the concept of culture by social and behavioral scientists. Simple reification, where the speaker makes culture into a thing capable of action exemplifies one usage in public discourse. Some quantitative social scientists attempt to characterize people's cultural identities by means of a single categorical variable, which often "lumps" people into categories such as "Hispanic" or "Black" that in fact have numerous culturally bounded subcategories. Approaches that emphasize cultural process are preferable to those who attempt to categorize; more complex measures of acculturation help investigators to make convincing analyses of circumstances in which health disparities occur. Examples in which investigators make appropriate use of cultural characterizations demonstrate their utility in investigating health disparities in Haitian American women, injecting and noninjecting drug users, Hispanic youth, and adult Hispanics at risk of HIV infection. Focus on culture in the study of health disparities can identify entanglements between structural factors such as poverty and lack of education and cultural factors such as beliefs about health. Qualitative methods coupled with quantitative methods have great potential to improve investigators' grasp of cultural nuance while capturing the distribution of qualitatively derived behaviors.*

KEYWORDS *Culture, Health disparities, Qualitative study, Social science.*

INTRODUCTION

Culture as a concept probably did not exist at all before 1750, and since then, it has undergone many transformations.¹ In 1871, Tylor² offered the first anthropological definition of culture, equating it with civilization and providing an inventory of the aspects of human life included under it. Tylor noted that "Culture, or civilization, taken in its widest ethnographic sense, is that complex whole which includes knowledge, belief, arts, morals, law, custom, and any other capabilities and habits acquired by man as a member of society."² This first definition emphasizes that people acquire patterned ideas and behaviors through the course of living their lives with other people. It also takes a comprehensive stance in its inclusion of all aspects of the human condition.

From that starting point, anthropologists and other social and behavioral scientists have made various contributions to the concept. Morgan,³ Boas,⁴ White,⁵ and Harris¹ stimulated the generations of anthropologists to think of process rather than content as they are conceived of cultural theory. These theorists in anthropology and many more in other disciplines (e.g., Durkheim,⁶ Parsons,⁷ Marx,⁸ Triandis,⁹ Pederson,¹⁰ and

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Freud¹¹) have struggled with the idea of culture for about one-and-a-half centuries, and their efforts continue to exert influence over the conduct of social and behavioral research.¹²

CULTURE AND ITS PITFALLS

Usages of culture as a concept often involve simple reification (making real and transitive something that is neither) of culture, for example, “— culture [*verb*],” making culture the subject of a transitive verb, as if culture were an entity that could do something. Public discourse has become riddled with this particular misuse of the cultural concept, but social and behavioral scientists rarely commit it in print.

In the quest to incorporate “cultural factors” into analysis of human behavior, an investigator may elicit the cultural background with which respondents identify, usually in the answers to one or two questions. These characterizations sometimes involve the identification of respondents by blanket terms such as “Black” or “Hispanic.”^{13,14} Many researchers exemplify this kind of usage in the literature on drug use among youth. Although such research has many valid uses in the quest to understand drug use among youth in the United States, people who may live in different contexts are clustered into single categories that can lead to unreasonable explanations of human behavior.

National origin characterizations are somewhat more useful than “race/ethnic” categories in assessing behavior in large populations, but they do not necessarily reflect cultural contrasts among the nationality’s component groups. For example, in a cultural sense, poor Cubans of color may have much more in common with poor Puerto Ricans or Dominicans than with White, middle-class Cubans.

Possibly, the most theoretically acceptable example of culture’s usages in analyses of health disparities involves acculturation scales that attempt to summarize immigrants’ internalization of the “host culture’s” life ways. These scales have considerable background in the study of drug use in Hispanic populations, because the large data sets have clearly identified problems related to what some authors¹⁵ call “nativity.” Several studies^{16–19} have pointed out that different segments of Hispanic nationalities have markedly different rates of drug use, based on the length of time they have been in the United States. This finding of the “immigrant effect” forced investigators to ask whether or not the process of adapting to life in the United States had the effect of causing drug use to develop among more acculturated individuals in the Hispanic populations of North America.

The work of Gil and Vega²⁰ incorporated an acculturative model with an adolescent developmental model to take into account the factors suspected to be most important in predicting drug use among Hispanic adolescents. Not only does this work operationalize the concept of culture for multiple items, usually forming ordinal or interval variables, but it also recognizes that the underlying concept of culture involves process, rather than state. Contemporary anthropologists, such as Agar²¹ and Sidky¹² favor thinking and writing about culture for process, rather than static descriptions of culture traits and customs. Because investigators such as Gil and Vega²⁰ use the approach of attempting to measure the degree to which immigrants have learned and adopted the language and behaviors of their new place of residence, their work would seem consonant with contemporary anthropologists’ thoughts on how to use the concept of culture.

Emphasis on process, combined with an avoidance of using the noun “culture” when talking about cultural phenomena can facilitate discussions about “the cultural”

with rigor and clarity. If, for example, the speaker (or writer) wants to make an observation about people identified with a certain cultural tradition, he or she can begin the statement with, "People living in (appropriate modifiers) cultural context. . . ." This kind of statement allows the speaker/writer to modify the generalization that fits a group of people delineated by the appropriate modifiers. These modifiers necessarily limit the group to which the cultural statement applies, giving the writer the opportunity to specify exactly the people for whom the statement was intended. In qualitative research in general (Strauss and Corbin²²), the writer is required to delineate clearly the group to which the qualitative study pertains, establishing boundaries for the generalizations that result from a qualitative study. The "—— cultural context" model appears to be a suitable way to delineate intercultural boundaries in a qualitative study.

The same kind of specificity is often necessary when investigators of health disparities analyze data on populations in which different cultural traditions are present. In most cases, however, the cultural identities of the respondents are not defined clearly enough to differentiate among those cultural traditions. Examples of this lack of clear delineation of cultural diversity include the characterization of "Hispanics" or "Blacks" in the United States as people at risk for HIV infection and AIDS. In fact, different cultural traditions subsumed under the "race/ethnic" classification may encompass a variety of behavioral patterns that have highly varied effects on individuals' risks of infection by the HIV.¹³

DISAGGREGATION OF "HISPANIC"

Hispanic populations in the United States offer a case in point for this particular area of health disparity.^{13,23} Taken in aggregate, people identified as Hispanic have elevated rates of HIV infection and AIDS. If we examine this population even in gross regional terms, however, we find quickly that Hispanics in the northeastern United States have high rates of HIV infection and AIDS,²³ whereas Hispanic populations in California have more or less proportional rates, and the Hispanic population in South Florida has less than proportional numbers of AIDS cases. A closer look at the origins and arrival points of these Hispanic populations informs about the process of HIV risk, especially as it relates to drug use. Puerto Ricans who migrated to the northeast, especially New York, landed in parts of the city where injecting drug use was already highly prevalent and had been so for one or two decades, specifically, the Lower East Side, East Harlem, and the Bronx. In circumstances of high availability, social disorganization, and poverty, many young Puerto Ricans took up heroin injection, and that behavior became widespread in the Puerto Rican population of New York. The arrival of HIV some time later correlated with high levels of injecting drug use on the part of Puerto Ricans, and a subsequent outbreak of AIDS among Puerto Rican heroin users.

By contrast, the Cubans who fled Fidel Castro's communist regime between 1958 and 1979 settled in parts of Miami/Dade County in which little or no injecting drug use was taking place.²³ The area now called Little Havana took form in a section of Miami formerly called Shenandoah, settled decades earlier by people from Virginia and Ohio (the Shenandoah River Valley) who were lower middle class and of English and Scots-Irish ancestry. There was no pattern of injecting drug use from which the newly arrived Cubans or their children might have learned self-injection behaviors. There was drug use in the area,^{24,25} but some of it had come with the Cuban immigrants, and some had resulted from the social turmoil of the 1960s,

primarily related to the interest of white non-Hispanic youth in marijuana and LSD. This combination of factors led to low numbers of injection-related AIDS cases among Hispanics in Miami/Dade and an underrepresentation of Hispanics in AIDS surveillance data, despite Hispanics constituted more than half of the county's population.

This level of characterizing HIV risk among Hispanics in Miami/Dade still does not fully explain the cultural complexity among Cubans. One cannot conclude, for example, that Cubans do not inject drugs. In fact, Cubans who lived among Puerto Ricans in Puerto Rico or New York did take up injection behavior, but they were typically recruited through networks of Puerto Rican injectors. Cuban immigrants arriving in Miami/Dade after 1979 often settled in places where injection drug use was common, at the edge of the northwest sector of the county or on the beach. Inevitably, some learned to inject and thereby to incur risk of AIDS. Nevertheless, this relatively recent wave of immigrants did not incur sufficient risk to change the proportion of Hispanic AIDS cases appreciably.

KEY CONCEPTS IN THE STUDY OF CULTURE

The examples described above reflect the importance of improving our understanding of intercultural variation when considering questions of health and related behavior. Some basic guidelines for conceptualizing cultural aspects of health and behavior could help to establish this improvement. First, we need to review our operational definition of culture. The following definition contemporizes Tylor's somewhat, removing sexist language and avoiding a laundry list of content areas: "The complex of behaviors and the ideas and values that underlie them that comprise the conduct of the human condition."

When we talk about culture, we should talk about it in a context for human behavior that involves constant adaptation and reframing.^{12,21} Some features of cultural context are strongly conservative, changing very little over centuries (e.g., the use of wine and wafer in the Roman Catholic mass), whereas others shift constantly (e.g., language). Conceiving of cultural contexts and traditions rather than cultures adds rigor to discussions of cultural diversity, because the emphasis is on process, rather than on state. The success of Gil and Vega²⁰ in deciphering the question of differential drug use within Hispanic subpopulations exemplifies the advantage of the process-oriented approach to conceptualizing culture.

Not all circumstances of cultural contact involve immigrants adapting to a "host" group's ways of life. In the United States and elsewhere in the world, enclaves of people from distinctive cultural traditions live in persistent cultural contrast to their neighbors. The Jews in Europe and North Africa maintained their distinctiveness throughout centuries. African American people in the United States have maintained cultural distinctiveness from the country's other inhabitants for several reasons, including racial prejudice and unfair denial of access to housing imposed by other people, as well as a self-driven desire to maintain the vitality and appeal of African American traditions. If poverty and lack of access to health care are inextricably bound together with cultural distinctiveness, then those who wish to improve health care in neighborhoods where African Americans reside must pay attention to the content and meaning of the cultural context in which African Americans seek health care.

This assignment proves more difficult than that of helping the immigrant to adapt to a new system. In the case of persistently distinctive groups, the boundaries

between one way of life and another are blurred. Language use may converge, but always with distinctive usage (e.g., Yiddish, “ebonics,” or pidgin). Traditional healing may be an understudied aspect of health-seeking behavior. Biomedicine has an important role in health care-seeking behavior, but culturally distinctive (and possibly marginalized and ghetto warehoused) groups will approach the decision to seek care very differently from other groups.

In the consideration of cultural process, three key processes deserve primary attention:

- **Inculcation (or enculturation)**—The process of learning how to operate within a cultural context by growing up within that context.
- **Acculturation**—The process of an individual’s acquiring knowledge of a cultural context other than the one in which he/she grew up.
- **Cultural contact**—In some circumstances, people from different cultural traditions come into regular contact. This contact often results in trading or borrowing of cultural items.

Other processes, such as innovation, revitalization, and deculturation, have received attention elsewhere in the literature, but the three listed above have particular relevance to health disparities. Inculcation and the human experiences that it entails lay the groundwork for much of what an individual does as an adult, including diet, exercise, use of drugs, and visits to primary caregivers. Acculturation connotes the experience of an adult when he or she tries to learn sufficient culturally patterned behaviors to live and operate in an alien cultural context. It takes an entire lifetime to produce a fully functional adult in any cultural tradition. To accomplish this, an individual must (1) become fluent in a language; (2) learn a full repertoire of behaviors to meet basic needs; and (3) learn all of the social relationships, kin terms, hierarchical placements, class affinities, and other nuances that comprise social life within a cultural context.

In situations of cultural contact, people who practice the behaviors and have the ideas associated with two different cultural traditions may persist in behaviors associated with the tradition in which they grew up. Considering how difficult it is to learn other people’s ways of behaving and meeting needs, it is not surprising that in some situations people do not acculturate.

HEALTH DISPARITIES AND ACCESS TO HEALTH CARE

Health disparities are frequently characterized by some combination of socioeconomic disadvantage and intercultural distinctions, and it is important to realize that both often occur simultaneously. For cultural diversity, the United States has groups of people who, because their numbers are large or their resolve to maintain themselves as culturally distinct from other people is strong, or the “host” people through prejudice make it difficult for one group to mix with another, maintain their cultural distinctiveness from other people in the same polity. In this kind of circumstance, both cultural and structural factors may result in one group’s lack of access to health care. The examples that follow illustrate structural and cultural components of problems in health disparities.

The first example involves drug using and nondrug using working class people in Miami neighborhoods. Chitwood et al.²⁶ compared injecting drug users, users of noninjected drugs, and nonusers from the same neighborhoods in Miami/Dade

County. From the point of view of patients, health care and its availability were enmeshed in the structure of care for medically indigent people and the beliefs and values of both the patients and the staff delivering health care. Gender roles also played a part in this highly interactive complex. Chitwood et al.²⁶ found that patterns of using medical care available to patients through the public sector varied according to whether or not the patient used drugs (drug users were less likely to receive care, despite they were very likely to need it), whether or not they had insurance, what gender they were (women were more likely to receive care than men), and whether they rated their own health status as poor or fair. People who are poor find themselves forced to accept whatever care “the system” affords them, usually involving long waits in crowded clinics to see staff who have little prior knowledge of the patients’ problems, other than that afforded by the medical records.

Drug users attempting to use this kind of system, according to Chitwood et al.,²⁶ wait until their condition has become unbearable before presenting at a public clinic. If they perceive their condition as almost completely debilitating, they will present, because they are unable to pursue their other priorities, particularly drug procurement and consumption. Female drug users tend to receive more care than male drug users, but it is unclear whether this tendency is because of their greater willingness to present or their greater likelihood of receiving care from public clinics, or perhaps a combination of the two factors. This is the point at which structure and cultural context meet in the question of how drug users gain access to medical care. The structure of the situation involves their medical indigence and their lack of alternatives to a crowded, impersonal clinic. The cultural context of the situation includes consideration of hierarchies of desires and needs in the patients’ ways of life, with some differentiation in gender role and other differentiation owing to minority status. In addition, many cases of clinic avoidance can be related to fear of apprehension by authorities seeking to arrest the patient, deport the patient or take away the patient’s children.

The findings of Chitwood et al.²⁶ relied on a combination of in-depth elicitation to formulate questions, followed by a large-scale use of these questions in a survey format. They established that drug users, especially minority drug users, tended to seek care only as a last resort, when their condition precluded any other activity. Minority drug users who have any kind of illness or injury, then, will tend not to seek care until their conditions force them into treatment. This finding points out both the challenge presented by drug users with AIDS and the promise of combining qualitative and quantitative techniques to study these problems.

HEALTH DISPARITIES AND HEALTH BELIEFS

Even after the patient has gained access to the system for delivering care and willingly seeks treatment for illness, the communication between clinician and patient may not lead to desirable outcomes. While recruiting Haitian women into a study of response to HIV testing, Wingerd and Page²⁷ found wide variation among participants in their study regarding the women’s comprehension of the HIV test. This variation reflected the women’s level of formal education and their earlier experience with medical clinics and procedures. Observations of these women in other clinical contexts revealed that patients smiled politely at providers and agreed to take prescribed medicines, but did not adhere to clinicians’ instructions.

The problem is both structural and cultural in nature. The structural component of the problem includes the women’s limited education. The women’s health

beliefs, which are cultural in nature and learned in circumstances of poverty may work against adherence to a regimen of medication. One basic belief of this kind is that a person who has no symptoms has no reason to take further medication. In diseases such as hypertension and asymptomatic HIV or tuberculosis infection, this belief can have ruinous consequences for the patient. Intervention to improve health disparities resulting from these circumstances should include both structural and cultural components. In fact, the most desirable structural intervention, universal access to education, would provide the platform necessary to conduct the most effective cultural intervention, modification of beliefs about treatment of asymptomatic disease. An example of successful use of this approach is directly observed therapy which can facilitate adherence to medication among people of culturally distinctive backgrounds.²⁸

The work of Singer and his colleague exemplifies the principles presented here.²⁹⁻³⁴ In their work, this group identifies the differences between structural and cultural factors in health inequities and takes into account the nuances of cultural identity. In these projects, the investigators conducted formative research to develop an approach to the delivery of clean needles/syringes that involved access to ancillary human services, including referral to treatment of drug abuse. As a result of this culturally informed planning, the needle exchange program was provided needed services to the injection drug using clientele.³³

CONCLUSION

The concept of culture has become increasingly important to social and behavioral scientists who strive to understand the processes associated with disparities in health outcomes among inhabitants of the United States. The approach that uses cultural context applies readily to these problems. It leads to theoretically rigorous and useful analyses of cultural processes, and it helps the analyst to differentiate between cultural factors and structural factors in undesirable health outcomes among people whose cultural identities contrast with those of the white non-Hispanic "majority."

When conceptualized as described here, culture provides a tool for breaking down health disparities into their component parts. Although cultural factors can constitute demonstrable impediments to the implementation of interventions to prevent health problems, it is perhaps more important to recognize their underpinnings in structural factors. The discussion of "the cultural" should focus on three key processes: inculcation, acculturation, and culture contact. In each of the examples described here, these processes were essential to furthering the understanding of health disparities, whether they involved lack of access to health care or nonadherence to health care regimens.

Many areas of health require qualitative examination of cultural context to place people relative to their structural (i.e., political economic) position and their immediate cultural context. The works of several investigators exemplify successful application of the combined qualitative and quantitative methods that provide insight into cultural processes and perspective on their distribution in populations of interest (cf. Singer,²⁹⁻³⁴ Gil and Vega,²⁰ and Chitwood et al.²⁶).

Research on health disparities related to drug use and HIV among minorities in various cultural contexts has benefited from combined qualitative and quantitative study that uses cultural process as a fundamental paradigm. Gil and Vega's findings on the relationship between acculturation and drug use among Hispanic immigrant

populations²⁰ provide an important case in point. Key concepts of inculcation, acculturation, and culture contact have enhanced approaches in studying health disparities as related to drug use and HIV in minority populations.^{26,32,33} These enhancements should encourage further research that uses the concept of culture as an integral part of both methods and analysis.

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