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Racial and Ethnic Identity in Nursing Research

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Nurse researchers collect information on the race and ethnicity of study participants for many reasons. These include meeting federal regulations to ensure adequate representation from underrepresented minorities (National Institutes of Health [NIH], 2001). Additionally nurse researchers increasingly strive to explain demographic characteristics of study participants so that other scientists and clinicians can more adequately assess issues of generalizability (Drevdahl, Phillips, & Taylor, 2006). Most importantly nurse researchers need to inform policy and practice decisions designed to decrease health disparities (Thompson, Mitchell, & Williams, 2006). However, as the meaning of race and ethnicity continues to change (Harawa & Ford, 2009; Moscou, Anderson, Kaplan, & Valencia, 2003; Smedley & Smedley, 2005) the need to carefully examine methodologies used to collect information on race and ethnicity also needs to change. This article will review the current issues surrounding the categorization of race and ethnicity and will suggest several practical methods to improve accurate collection of these types of demographic data. These practical suggestions were developed while conducting study on factors underlying preterm birth (xxxx., 2009)

Changes in Federal Guidelines on the Categorization of Race and Ethnicity

In 1977 the Office of Management and Budget issued Directive 15 that mandated that data on race and ethnicity both be collected (Office of Management and Budget, 1997). Race was categorized either as American Indian or Alaskan Native, Asian or Pacific Islander, Black or African American, and White. There were two categorizations of ethnic background (of Hispanic origin and not of Hispanic origin). Race and ethnicity, according to this directive,

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could be determined either by interviewers or by self-identification. Although self-identification of race and ethnicity is the most commonly used methodology in the United States today (Kaufman, 1999; Stephan & Stephan, 2000) differences in accuracy have been found using these two different methods (American Anthropological Association, 2012). Indeed, our research team, in identifying potential participants for our study, found an 11% discrepancy between the categorization of race and ethnicity on hospital demographic forms when patient's self-identified their race and ethnicity compared to when interviewers (in this case patient care attendants) asked the same patients about their race and ethnicity using the same categories.

Federal guidelines on how to categorize race and ethnicity were revised for the 2000 census so that there were five categories of race (Asian and Pacific Islander were separated) and respondents also had the ability to have themselves categorized as "some other race" or to add a category (Census 2010). These same methods were used in the 2010 Census.

Although the changes in the 2000 US Census, which allow for multiracial categorization, were designed to improve accuracy, questions arise as to how many categories researchers need to create to accurately capture self-identified race and ethnicity without creating so many categories that the results of specific studies lack generalizability (Trimble, 2007). Health disparity researchers now face the challenge of how best to examine differences in health outcomes based on race and ethnicity when commonly accepted definitions of race and ethnicity in the United States are in question (Fiscella, Franks, Doescher, & Saver, 2002; Malat, 2002).

Because how individuals categorize their race and ethnicity has been found to be place, time, and context specific some health disparity researchers are now suggesting that federal guidelines be used only to collect information needed for reporting purposes. For purposes of decreasing health disparities, some researchers suggest that other categorizations be used such as asking about group characteristics (culture and nativity) and on group location within a social hierarchy (minority vs. majority status). These categories might be more accurate in identifying appropriate cultural groups and their risk of facing health disparities (Ford & Harawa, 2010).

Underlying questions as to how best to categorize race and ethnicity, are philosophical concerns as to whether this categorization is helpful to minority populations or if in fact the very act of categorization leads to marginalization (Burchard et al., 2003). An additional concern is that differences in health outcomes may be wrongly attributed to race and/or ethnicity when underlying factors such as differences in education, socioeconomic status, population density, community safety etc. may really be the causative factors (Braun, 2002; Nazroo, 2003; Sheldon, & Parker, 1992). However, given both the disparities in access to care and in health outcomes (Braun, 2002) and the requirements of funding agencies, racial and ethnic demographic information will continue to be collected in nursing research. Therefore, it is important that researchers understand some of the underlying methodologic problems inherent in collecting racial and ethnic data, as well as the historical and societal issues that surround the categorization of race and ethnicity, and that researchers have some practical tools to help in optimizing the accurate collection of this demographic information.

Race

Issues surrounding the categorization of racial and ethnic identity center on concerns that race is a social construct and not a biologic reality (Malat, 2002). Racial classification emerged in the 17th century prior to the development of modern genetic theory and was originally developed based on the work of the taxonomist, Linneus (Harawa & Ford, 2009). The categories attributed to Linneus are based on phenotypical similarities, but we now

know that in terms of genetic similarities races are not distinct and that the overall genetic variation within races is often higher than the genetic variation between races (Crow, 2002; Senior & Bhopal, 1994; Weiss & Lambert, 2010; Williams, Lavizzo-Mourey, & Warren, 1994).

The four distinct racial categories based on phenotypic and geographic origin that were attributed to Linnaeus were generalized broadly on personality traits, skill level and ability which ranked the races with the white, European race at the top and the black, African race at the bottom (Cameron & Wycoff, 1998; Harawa & Ford, 2009). In the past the social construct of race in the United States supported political ideologies (e.g. slavery) that favored majority populations and were discriminatory to minority populations (Harawa & Ford, 2009).

Modern science supports the belief that the human species originated in Africa and the migrated to various parts of the world where populations evolved independently explaining phenotypic differences between populations (Sue, 2003). Changes in skin color are thought to be an adaptation to different climates that occurred less than fifty thousand years ago and which were not associated with concomitant changes in genetic structure (Crow, 2002). This lack of genetic difference between people, heretofore categorized as belonging to different races, belies biologic differences between populations and supports the notion of race as a social rather than scientific construct (Ford & Kelly, 2005; Kaufman & Cooper, 2001).

Ethnicity

Ethnicity is different from race although many people do not differentiate between the two (McGoldrick, Giordano, & Pearce, 1996). Ethnicity is derived from group social relations and identity (Ford & Kelly, 2005) and plays a role in what people chose to eat, where they work, how they celebrate religions or holidays, and how they view important parts of life, such as birth and death (Fuligni, Witkow, & Garcia, 2005). Ethnicity combines hereditary influences and social factors. Ethnicity is a broader construct than race, because it takes into account heritage, cultural tradition, common history, and religion simultaneously (Burchard et al., 2003) and not just physical attributes. For health disparity researchers, ethnicity is important as it relates to whether ethnic groups have minority or majority status. Whereas in the history of the United States specific ethnic groups faced acknowledged discrimination because they were Irish, Italian etc. these ethnicities have now reached majority status. For health disparities research and for federal reporting purposes, questions regarding ethnicity help to identify problems surrounding discrimination and social hierarchy.

Challenges in collecting self-identity of race and ethnicity

In the United States where intermarriage and intermingling of health behaviors is common the strength of an individual's self-identified ethnic identity may be a more significant determinant of behavior than the individual's actual ethnicity (Baker et al., 2006). However, the discrepancies between interviewer data on self-identity and self-report mentioned earlier may stem in part from the use of forced categories that do not always match the words that patients would use to identify themselves. As such, self-identification is not always inclusive which may contribute to patients failing to provide both ethnic and racial information (Rockquemore, Brunnsma, & Delgado, 2009).

Racial and ethnic identity occurs as a variable process that evolves over a lifetime and includes critical influences of social, cultural, and spatial contexts (Phinney & Ong, 2009). A participant's understanding of why a researcher is asking about race and identity is a critical element in obtaining accurate information. Clearly, contextual factors do affect how individuals self-identify race and ethnicity. This may be especially true for multi-racial

individuals who change racial identification depending on a variety of contextual factors, including varying life experiences and social influences (Quintana, 2007; Quintana et al., 2006). Both positive and negative associations with racial and ethnic identity are influenced by the experience of racism and discrimination (Leventhal, Xue, & Brooks-Gunn, 2006). This may be another reason why self-identification is not static. Another example of how context influences self-identification of race and ethnicity is immigrant status, as immigrant children have been found to possess a stronger sense of ethnic and cultural identity than non-immigrant peers of the same ethnic background (Harris & Sim, 2002).

How and where individuals are asked to self-identify race and ethnicity has also been shown to affect an individual's response (Viglione, Hannon, & DeFina, 2011). Given that self-identification is not always inclusive of both race and ethnicity, that racial and ethnic self-identity may change over time and be influenced by current experience, that racial and ethnic identity may be influenced by why questions of race and ethnicity are being asked and by how this information is collected, techniques to increase the accuracy of self-identification in research are necessary.

Overview of how information on race and ethnicity was collected

During recruitment for the current study, the research team encountered multiple clinical situations in which discrepancies arose between how race and ethnicity were being self-identified and this led us to more carefully examine how self-identification was accomplished. To improve the accuracy of self-identification of race and ethnicity we learned that when explaining the study to potential participants we obtained the most comprehensive results when we separated questions about ethnicity and race and ask information about ethnicity first. The ordering of ethnicity and race questions was based on the work of previous researchers who documented that Hispanic and Latino study participants often do not view their ethnicity as separate from their race (Baker et al, 2006). Asking information about ethnicity first acknowledged the importance of ethnic heritage and allowed potential participants to consider their ethnic background and race as separate identities.

After reviewing electronic records and identifying potential participants, these potential participants were told that the researcher was doing a study on pregnant women who were black or of African ancestry and were asked if the researcher could explain the study further. In the course of providing informed consent for the study the participant was again asked to self-identify their race in order to confirm eligibility. The majority of the potential participants in the clinic were of Hispanic ethnicities (approximately 60%) and in terms of race identified themselves mainly as being white or African, African American, or Caribbean American. Many women came from families who were from Caribbean countries or from Guyana.

Some participants were confused about whether they would consider themselves to be Hispanic or Guyanese (ethnicity) and "Black," (or another race) as they primarily identified with their Hispanic or Guyanese ethnicities and did not have strong self-identification in terms of race. Many of the Hispanic patients, despite being of mixed African descent, associated the term "Black" with solely consisting of African descent and having no other racial or ethnic mixing, including Spanish or Native American ancestry. For some participants, the lighter one's skin, the better they are treated and perceived in their country of origin, and the more opportunities they are afforded, so latent racism may influence self identification of racial background (Hirschman, Alba, & Farley, 2000; Hochschild & Weaver, 2007)

Others did not consider themselves to be African American because they had recently emigrated from Africa and so considered themselves to be African. We also quickly learned that Caribbean American women did not self-identify as Black or African American because their Caribbean American identity was strong and needed to be acknowledged in this patient population. Again, this is consistent with studies that have found that using open ended questions about race and ethnicity provide the most comprehensive results (Rockquemore et al, 2009). Additionally we found that discussing both culture and nativity helped to provide a fuller picture of race and ethnicity.

Clinical Experience

Clinical Scenario One: Hispanic or Black?

A clinic patient was approached who had identified as Hispanic, but had a non-Hispanic, Anglo-Saxon surname. The demographic form on the chart listed the patient as being “Hispanic”. Phenotypically, the patient appeared to the research assistant to be of African descent and therefore eligible for inclusion the study. The researcher introduced herself and the study to the patient and the patient said she was not eligible to be in the study as she was not Black, but Puerto Rican-Hispanic. She stated that her father was a “dark Puerto Rican” and her mother was a “light skinned Puerto Rican, with blond hair and blue eyes.” The patient explained that this was the reason she came to have darker skin. The patient identified that she was brown but was not “Black”. This woman, who declined to be in the study, self-identified her race as Hispanic, although the Federal government defines Hispanic as an ethnicity and not a race. This reinforced for the research team the need to separate self-identification of ethnicity from race.

Clinical Scenario Two: Hispanic and Black?

After being asked ethnicity, patients who originated from mixed Afro-Caribbean countries, such as Jamaica and Trinidad, almost universally identified as being Black, despite being of other mixed racial identity as well. For example, a patient from Jamaica who identified as Black had phenotypic attributes of a mixed Caucasian individual. The patient had a light complexion, brown/red hair, and blue eyes. When asked to self identify, the patient stated she was Black and that her ethnicity was non-Hispanic. Again, this reinforced the appropriateness of asking patients to identify their ethnicity first and then to identify their race. If a patient stated that she was Hispanic we asked the patient in Spanish if they considered themselves “Black Hispanic” using the Spanish colloquial word “Morena”. Patients responded very positively and many ultimately consented to participate as the confusion between ethnicity and race seemed to be clarified by this approach.

Clinical Scenario Three: Black, Hispanic, or both?

Some patients self-identified their race based on the hereditary influences, customs, culture, and traditions in which they were raised. One patient from this specific category was approached about the study. She reported that she was not “Black” but Hispanic, and had always been raised by her Hispanic mother’s side of the family, immersed in Spanish food, customs, and practices. Only after a few minutes of discussing ethnicity and race as two separate categories and discussing both nativity and culture did this patient reveal that her father was African American, but then quickly stated that she herself was not Black. In this and other situations, patients identified more with whatever culture they felt best represented them. Patients most strongly identified with the culture in which they were raised, which was often associated with maternal influence. Again, asking ethnicity first and then asking patients to think also about race as well as discussing nativity and culture helped to have patients to present a fuller picture of their race and ethnicity.

Another similar clinical scenario involved a patient whose racial ancestry was mixed Caucasian and Black. The patient seemed eligible for the study because she was of Afro-Jamaican descent and her phenotypic attributes was that of a black-Hispanic and Caribbean American. However, the patient claimed that she was Hispanic because she was raised in a Caucasian-Hispanic household and identified more with Hispanic culture although she identified herself as non-Caucasian.

The patient and the research assistant had an in-depth conversation about culture, nativity, race and ethnicity, often using words in Spanish. When asked the patient's race, the patient identified as "other," "black Hispanic," ("Morena") and "Caribbean American." In the conversation between the research assistant and the patient, the research assistant acknowledged that all Hispanics were different, and it is difficult to pick one category because we (as a population) are all so mixed. Parts of the conversation were in Spanish to help establish a cultural understanding. Terms used to help identify ethnic background included the three main ancestries of the Hispanic patient population in the study area: "Indio/India" (Mexico and Ecuador), "Blanca" (Argentina, Chile), and "Morena" (Panama, Dominican Republic, Puerto Rico). Once ethnicity was acknowledged, racial identification could be seen as separate by the patient. The patient in this scenario ultimately consented to participate in the study but this example further illustrates the complexities of racial and ethnic identification.

Clinical Scenario Four: Guyanese or Black?

Natives of Guyana are often Asian Indian, Native American Indian, Black, or even a mixture of all three races. Guyanese patients often had multiple responses regarding self-identification of race in registration/triage documents including Black, Asian/Indian, Guyanese, or other. Patients who were listed in the hospital record as "other" were always approached to see if they would consider themselves to be multiracial with African ancestry as being one of the races. Some Guyanese patients identified as being solely of Indian ancestry. Others gave a variety of responses including "Guyanese," connoting that it was a race or identified as a mix of Guyanese and Indian. These patients denied any African ancestry. Some potential participants identified as having African ancestry and these women then continued to participate in the consent process. In all of these situations the most accurate data was again obtained by first asking questions about ethnicity (which patients whose families were originally from Guyana almost universally identified as their ethnicity) and then asking about race. Separating these categories and discussing each with potential patients helped to identify which potential participants were of mixed race including having African ancestry and thus were eligible to be in this study.

Recommendations for data collection

Table 1 summarizes the challenges to the collection of racial and ethnic identity that have been documented in the literature and also those that were unique to this study. Although study participants are ultimately what they say they are, there are strategies researchers can use to increase the accuracy of information collected. Participants may confuse ethnicity with race or not view either as a separate construct. Context influences categorization so having a more in-depth conversation about the reasons for a study especially if the study is designed to decrease health disparities is important. As health disparities occur based on how the health system sees an individual, as well as how an individual sees themselves, these conversations about race and ethnicity are vital to ensure contextually appropriate categorization.

Asking study participants to identify their ethnicity as well as their race and to think about questions of nativity (who their parents are) as well as culture (which may include more

information about how an individual aligns themselves with specific groups) allows individuals to think about ethnicity and race as different parts of their whole identity (Cokley, 2007). This became very important in the current study as many women identified strongly with their Hispanic ethnicity and reported their race as Hispanic.

Allowing participants to identify their ethnicity first and their race second was also helpful. Providing patients with an opportunity to reflect on their ethnic and racial identity prior to choosing a discrete category may allow for a more thoughtful and correct response. One technique used to encourage patient reflection was an acknowledgment that Hispanic ethnicity has many different components and there wasn't just one type of "Hispanic." This allowed for a discussion to occur between the research assistant and the patient about the importance of being able to distinguish between the various Hispanic ethnic origins. Although approximately 60% of the patients identified as being Hispanic, their countries of origin varied greatly, including Mexico, Dominican Republic, Ecuador, Guyana, Argentina, Chile, and Puerto Rico.

Understanding the population being studied and how they use language to identify themselves in terms of ethnicity and race is essential so that questions around self-identification of race and ethnicity are unambiguous. Incorporating population specific terminology (Ford & Kelly, 2005) and asking open ended questions (Rockquemore et al., 2009) as part of the recruitment process will help researchers capture ethnic subpopulations that might not identify with more general descriptions of racial and ethnic groups (Harawa & Ford, 2009).

Information pertaining to racial and ethnic identity that was obtained from patient care assistants (PCAs) was often more accurate than the demographic form filled out as a forced choice by the participant themselves. The PCAs that were assigned to clinic registration in the study hospital were made up of a small group of employees that had consistently worked in the same area for the past few years. Their racial and ethnic backgrounds were representative of the patient population they served and were primarily African American, Afro-Caribbean, and Puerto Rican Hispanic. The PCAs were bilingual in English and Spanish and were able to ask for identifying information in terms that the patient understood the most. Additionally, for this study, having a research assistant who was bilingual and able to ask potential participants if they considered themselves to be white or black Hispanic in colloquial terms was critical to increasing racial and ethnic clarity.

Researchers should explicitly operationalize race and ethnicity to increase accuracy with recruitment and to decrease confusion when reporting results (Cokley, 2007). Although this study had clearly defined procedures for approaching participants and asking about racial and ethnic self-identification, how terms were used was important in optimizing accuracy. It quickly became apparent that potential participants thought the terms "Black" and "African American" were too narrow and resulted in women declining to participate because they were of mixed heritage or recently emigrated and did not consider themselves to be in either category. Changing the terminology to "women of African descent" and including categories such as Caribbean American, African American, and of African descent resulted in a more positive response from participants because it allowed them to acknowledge not only their country of origin but also other aspects of their heritage.

Conclusions

Although imperfect, self-identification of race and ethnicity is considered to be the gold standard for collecting this type of data. Even with specific strategies in place, participants will ultimately self-identify with the racial and ethnic group they feel best represents them.

Researchers can help to ensure that the data they collect is as robust as possible by using population specific language, separating ethnicity from race, understanding how a specific population identifies themselves and using this as a base to have an open ended conversation about race and ethnicity.

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Table 1**Challenges to Self-Identification of Race and Ethnicity**

Identified in the Literature
Ethnicity is a broad, context-specific, multifactorial concept ¹⁶
Ethnicity valued differently within societies ¹⁶
Ethnic self-identity may not match forced categories for data collection ³¹
Ethnic identity is a variable process that evolves over time ³²
How and where racial and ethnic identity is elicited affects response ³⁷
Multi-racial individuals may change racial identification based on life experiences ^{33,34}
Latent racism may influence self-identification of racial background ^{38,39}
Identified in the Current Study
Racial and ethnic identity associated with cultural upbringing (maternal influence)
Strong Hispanic ethnic identity without strong racial identity
Not considered to be of African race if of mixed African descent
African-American not considered an accurate description of race for women from the Caribbean or recently emigrated from Africa
Discussion of culture and nativity necessary for more accurate racial and ethnic identification
Spanish colloquial terms needed to clarify African or Caucasian racial background among patients who initially identified as Hispanic
Bilingual (Spanish) research assistant needed to assist in conversations with Hispanic patients for discussion of difference between race and ethnicity