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Cultural humility: Essential foundation for clinical researchers

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Abstract

Cultural humility is a process of self-reflection and discovery in order to build honest and trustworthy relationships. It offers promise for researchers to understand and eliminate health disparities, a continual and disturbing problem necessitating attention and action on many levels. This paper presents a discussion of the process of cultural humility and its important role in research to better understand the perspectives and context of the researcher and the research participant. We discern cultural humility from similar concepts, specifically cultural competence and reflexivity. We will also explore ways to cultivate cultural humility in the context of human subjects research. Mindfulness is one approach that can be helpful in enhancing awareness of self and others in this process. With a foundation in cultural humility, nurse researchers and other investigators can implement meaningful and ethical projects to better address health disparities.

Keywords

Nursing; Research; Culture

1. Introduction

Understanding and eliminating health disparities requires a close examination of our past work and future focus in health care research across settings. How we approach the many factors that contribute to health disparities and social inequities requires an examination of the environment, context, and culture of those experiencing these disparities. Attention has been given to role of culture in the health care field recently. As the different parts of the world become increasingly diverse and multicultural, health care providers have been

encouraged to become aware of cultural differences and their impact on health. Much focus

has been given to be preparing health care providers, such as nurses and physicians, to give

culturally competent care at the bedside (Waite & Calamaro, 2010). However, minimal

attention has been on researchers to conduct culturally competent research. Nurse

researchers are trained to view health and illness from a holistic approach and therefore

should lead the way in this area to address the role of culture in the conduct of research.

Papadopoulos and Lees (2002) acknowledge the need for culturally competent researchers in

order to produce valid research and improve practice; they also note that for too long,

research has been unicultural although generalized to a multicultural world.

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Initially discussed in the context of clinical practice, cultural humility is a process of self reflection and discovery to understand oneself and then others in order to build honest and trustworthy relationships (Tervalon & Murray-Garcia, 1998). It is a promising approach with utility for researchers as well and can play a role in addressing health disparities in

research. The purpose of this article is to provide a thoughtful examination of cultural

humility with practical relevance for investigators involved in human subjects research. The concepts discussed are applicable to any clinical researcher who is studying someone

different from her/himself—different in race, ethnicity, gender, religion, sexual preference, socioeconomic status, and geographic location—in any cultural context and in any part of

the world.

2. Cultural humility - what it is and what it's not

As we learn to appreciate the value of cultural humility in research, it's important to explore the foundations of this concept and to clearly describe it. There are also related concepts (i.e., cultural competence and reflexivity) that may be inappropriately used interchangeably, so it's important to understand the subtle differences among them.

3. What it is

Cultural humility, originally described as a tool to educate physicians to work with the increasing cultural, racial and ethnic diversity in the United States, is useful for all researchers involved in human subjects research. Cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities (Tervalon & Murray-Garcia, 1998). This critical consciousness is more than just self awareness, but requires one to step back to understand one's own assumptions, biases and values (Kumagai & Lybson, 2009). Individuals must look at one's own background and social environment and how it has shaped experience. Cultural humility cannot be collapsed into a class or education offering; rather it's viewed as an ongoing process. Tervalon and Murray-Garcia (1998) state that cultural humility is "best defined not as a discrete end point but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves" (p. 118).

This process recognizes the dynamic nature of culture since cultural influences change over time and vary depending on location. Throughout the day, many of us move between several cultures, often without thinking about it. For example, our home/ family culture often differs from our workplace culture, school culture, social group culture, or religious organization culture. The overall purpose of the process is to be aware of our own values and beliefs that come from a combination of cultures in order to increase understanding of others. One cannot understand the makeup and context of others' lives without being aware and reflective of his/her own background and situation.

4. What it's not—related concepts

4.1. Cultural competence

In cultural competence training programs, the focus is to learn and examine the patient or research participant's belief system. Many institutions have made cultural competency training required for clinicians to sensitize them to the special needs and vulnerabilities of different populations. The programs often focus on caring for racial and ethnic minorities and on traits and practices of these groups, with the goal to break down cultural barriers to quality health care. Unfortunately the traditional approaches of cultural cross-training have been criticized for potentially promoting stereotyping (Kumagai & Lypson, 2009). Also despite the emphasis on cultural competence in health care, a national survey of over 3,000

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physicians found that one in five felt unprepared to deal with socio-cultural issues—such as patients with religious beliefs that impact treatment decisions, patients that mistrust the health care system, new immigrants, and patients with health beliefs at odds with conventional medicine (Weissman et al., 2005).

Despite many resources devoted to cultural competence education, shortcomings have been identified. Kumas-Tan, Beagan, Loppie, MacLeod, and Frank (2007) systematically reviewed the most frequently used cultural competence measures and identified assumptions embedded in these measures: culture is usually equivalent to ethnicity and race, and little attention is given to other components of culture such as gender, class, geographic location, country of origin, or sexual preference. These instruments assume that culture is possessed by the patient or client or the 'other'. In many of the measures, for example, whiteness is understood and represented as the norm. Cultural incompetence is due to a lack of knowledge about the 'other' and maybe related to the provider's discriminatory attitudes toward the 'other'. Education about the 'other' is the key to developing cultural competence. Therefore, cultural competence does not incorporate self-awareness since the goal is to learn about the other person's culture rather than reflection on the provider's background. Finally cultural competence is about the provider being confident and comfortable when interacting with the 'other'. The authors conclude that the assumptions taken together create a worldview that culture is a confounding variable that white providers must control when they care for people of different races than themselves (Kumas-Tan et al., 2007). The goal of cultural competence is to produce confident, competent health care providers with a specialized knowledge and skills that can then serve the communities of ethnic or racial minority groups. Other terms such as cultural awareness, cultural knowledge, and cultural

sensitivity often are supported by these same assumptions of cultural competence (Table 1).

4.2. Reflexivity

Reflexivity, a technique used in qualitative research, calls on the researcher to explore personal beliefs in order to be more aware of potential judgments that can occur during data collection and analysis (Jootun, McGhee, & Marland, 2009). Being reflexive often requires an awareness and reflection of what is happening while being present to one's perceptions and internal experience in the moment. Reflexivity by the researcher is done by placing her/himself within the experience and meaning of the study participant and then examining the participant-researcher relationship (Hofman, 2004). In the absence of such contextual information, researchers and study participants are engaged in an impersonal and, often, hierarchical relationships. Reflexivity is often used with qualitative studies where sample sizes are small and the researcher and the research participant interaction is often somewhat intimate, however this process can be beneficial in all types of studies, including large quantitative trials, whenever researchers study groups different from themselves.

5. Cultivating cultural humility in research

Cultural humility is a process of reflection to gain a deeper understanding of cultural differences in order to improve the way vulnerable groups are treated and researched. Cultural humility does not focus on competence or confidence and recognizes that the more you are exposed to cultures different from your own, you often realize how much you don't know about others. That is where humility comes in. Ideas of ethnocentrism and racism, where the underlying idea implies that the problem is due to the difference, are abandoned. Humility requires courage and flexibility. Strengths and challenges of individuals and groups are explored as well as the advantages and privileges of certain group membership.

When used by the researcher, this process of reflection includes the unpeeling of the layers that make up a person and incorporates an examination of personal, professional, and

research values that may guide the researcher's actions. In order to continue the process of cultural humility, this personal review is followed by an inspection of the research participant's perspective.

6. Inventory of values

6.1. Reflection of person

In the process of cultural humility, personal values, beliefs, and biases that are derived from your own culture must be examined. Beliefs about race, ethnicity, class, religion, immigration status, gender roles, age, linguistic capability, and sexual orientation are explored. Family experiences and values, peer influences, relationships with different types of people are also reviewed. Where you live or grew up matters (i.e., rural, urban, suburban, affluent, or impoverished) and shapes your views of others. What neighborhood you live and work in influences who you deal with on a day-to-day basis and how you define community.

Everyday activities such as where you shop, how you travel to work, and what you eat tell something about your values. Political views and the way you express them are important. All of these attributes and the value given to them are important to examine.

Examining and defining one's culture is a complex process especially since today most individuals in the United States and other countries are a combination of more than one culture with many different variations and mixtures. Group identities often define our cultural perspective but these groups, whether based on religion, race, or ethnic classification, are broad categories. Minority groups such as American Indians, Alaska Natives, African Americans, Hispanics, Asians, or Pacific Islanders are often given certain cultural characteristics, but those descriptions can miss the mark. Within each group, many subpopulations exist with very different cultures, historical experiences, and views on health and illness. An individual's culture is not a single identity; rather it's a rich mixture of many influences and values. Thus understanding oneself and others is a complex and lifelong process.

6.2. Reflection of profession

Professional identity of the clinical researcher is also an important area to reflect on.

Specifically nurse researchers first must identify that their own values, perspectives, and biases are derived not only from their own cultural origin, but also from the biomedical world view of their professional training. Health care itself is a cultural system with its own specific language, values, and practices that must be translated, interpreted, and negotiated with patients and family members. Training in Western medicine using a bio-medical

framework often influences how one sees the world. This perspective often defines 'normal' as the modern Western culture. In the stereotypical perspective, difference is generally defined as anyone who is non-white, non-Western, non-heterosexual, non-English speaking, and non-Judeo-Christian. Often the values of medical training, and to some degree nursing training, reflect a strong inclination toward medications, procedures, and cure, and less focus on psychosocial and spiritual influences. In addition, health care providers and clinical researchers must consider the privilege and power of their profession and its effect on practice and research.

6.3. Reflections of researcher

An additional set of values worthy of examination are the values embedded in research often guided by ethical principles. Autonomy, beneficence, and justice are the basic ethical principles that should underlie the conduct of biomedical and behavioral research (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Every clinical researcher must have at least basic training in these values

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and Institutional Review Boards (IRBs) ensure that researchers incorporate these values in their studies. Researchers need to keep these principles in mind when they select participants, obtain consent, and conduct research.

How researchers define and operationalize these ethical principles in their research is important since research values may be conceptualized differently from person to person. At each step of the research process, thoughtful consideration of these values and principles is needed. For example, during informed consent, how does a researcher proceed when a patient is capable of making decisions for her/himself yet instead prefers that the family decides? For some, value is given to family-centered decision making instead of individual autonomy. In addition, the very definition of family is variable and evolving, sometimes including self-selected family members rather than the traditional family. The standard consent form that an individual reads and signs is only one part of the process and should take decision-making into account, which varies between cultures. The timing and flow of

the research process may need to be adapted to allow for discussions of the risks and benefits based on a study participant's personal values. The scientific values that the researcher brings to the potential participant may not be appreciated by others whose values are grounded in other areas such as religious teachings. Research procedures involving informed consent, confidentiality, and patient safety may look differently when dealing with different groups. A researcher must consider how a participant's cultural values align with the values of research and to be wary not to make assumptions about the values of others.

In health research, cultural stereotypes and assumptions derived from notions of difference find their way into explanations of study findings (Hunt, 2005). Researchers often explain their findings and base their conclusions by making assumptions about cultural groups. It is problematic when researchers use cultural and racial stereotypes based on someone's ethnic identity or national origin to explain study findings. For example, researchers have explained their study findings by saying that the reason foreign-born Mexican Americans had less mental illness compared to U.S. born Mexican Americans was due to (the researcher's belief that) Mexican families being close knit; no measure of family structure or quality was included in the study measures (Grant et al., 2004; Hunt, 2005). Using cultural stereotypes in this way disregards the heterogeneity of groups and wrongly assumes that cultural beliefs and behaviors always go along with ethnic identity. In another example, a study about amniocentesis decision-making, clinicians described Latinos as part of large extended families, being especially family-oriented, and highly influenced by opinions of family members (Hunt & de Voogd, 2005). In contrast, the sample of Latino women in this study did not behave as expected. The women made independent decisions about the testing and the clinicians seemed to steer the patients in certain direction due to the assumptions made about the patients' cultural values. Therefore, when research results are reported, the bias of the researcher must be acknowledged.

Research values also come from the larger research community, which has traditionally taken a paternalistic approach and sometimes denied participants the opportunity to evaluate the cost and benefits of research participation in light of their own goals and values. Also, unfortunately researchable questions go unanswered because researchers shy away from doing research with vulnerable groups because of bureaucratic complexities, such as IRB policies created to protect vulnerable individuals. Regrettably, such well-intentioned protections may have compounded the issue. After some groups had experienced coercion, deception and disrespect, policy makers found it was easier to exclude or limit research

participation of entire groups in order to prevent any further violations against them (List, 2005). These policies can be problematic because they exclude groups from participating in research and therefore also exclude groups from reaping the benefits of research. For example, many have voiced concern about conducting research with individuals at the end

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of life (Gysels, Shipman, & Higginson, 2008). Despite these concerns, a study of patients at the end of life showed that the majority reported no burden associated with participation in research and noted benefits of participating including social interaction, sense of contributing to society, and opportunity to discuss their experiences (Pessin et al., 2008).

End-of-life research certainly has some limitations and necessary precautions, yet it is a high priority topic (National Institute of Nursing Research, 2011), particularly with our current aging population. These examples highlight the importance of examining the values of the larger research community.

7. Mindfulness as a tool to enhance awareness and insight

Mindfulness is both a mental practice and a trait that involves paying attention to present moment experience with an attitude of receptivity and acceptance (Bauer-Wu, 2011; Kabat Zinn, 1990). Shapiro and Carlson (2009) define it as “the awareness that arises through intentionally attending in an open, caring, and nonjudgmental way” (p. 4). Through mindfulness practices one can cultivate self-awareness through noticing bodily cues, thoughts, and emotions, and awareness and sensitivity to others, to context and circumstances, and to the environment. Mindfulness is essentially seeing and experiencing things more accurately (as they are)—without mental filters, self-narratives and judgments—in order to see clearly and respond thoughtfully. In this process, such mental processes are not pushed away or ignored. Rather, they are recognized as opportunities to learn about oneself and one’s biases. It is in this way that mindfulness has a role with developing cultural humility.

Typically, busy researchers and clinicians go about their days on autopilot, going from one task to another, with little if any acknowledgement of their attitudes, assumptions, and biases or how their words and actions are affecting others. More often than not, these individuals are overextended and running short on time, so they may quickly proceed with their activities with little awareness of what they are doing or considering another’s

perspective and how their actions (or lack of) have consequences on others. Mindfulness interrupts “automatic pilot” and allows for more thoughtful consideration leading to wise action (Bauer-Wu, 2011; Kabat-Zinn, 1990).

Evidence is burgeoning on the effects of mindfulness training in areas such as:

- brain function, including perceptual acuity (MacLean, Ferrer, Aichele, Bridwell, & Saron, 2010), working memory and attention (Jha, Krompinger, & Baime, 2007; Lutz et al., 2009);
- self-regulation of emotions (Wadlinger & Isaacowitz, 2011);
- interpersonal attributes of empathy (Krasner et al., 2009);
- recognizing others’ emotions (Kemeny et al., 2012).

It has been shown to be helpful to clinicians and can lead to being more mindful in the clinical setting and other aspects of everyday life (Krasner et al., 2009; Galantino, Baime, Maguire, Szapary, & Farrar, 2005). While no studies have specifically explored if clinical researchers can benefit from mindfulness practices, one can extrapolate such a role based on the evidence to date coupled with the theoretical underpinnings (Brown, Ryan, & Creswell, 2007) (Fig. 1).

8. Building relationships with research participants

After the researcher has an opportunity to explore his/her own issues related to culture, she/he next considers the culture of the research participant. Who is the person, who has a life

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and story of her own, on the other side of the consent form or the survey or lab specimen? Consider the dynamics at play during a dialogue between a person of privilege (i.e., an educated, middle class, healthy clinical researcher) and the vulnerable research participant who may be living in poverty with advanced disease and multiple co-morbidities. The power imbalance between the researcher and participant must be recognized and minimized in the research process (Kvale & Brinkmann, 2009). Cultural humility calls on individuals to be flexible and humble enough to let go of the false sense of security that stereotyping brings and to explore the cultural dimensions of the experiences of each person. Humility is needed

to check the power imbalances that exist in the dynamics of researcher-participant communication. In order to build productive relationships with the participant, the researcher must explore the values, beliefs, and biases of the research participant specific to health care and research participation.

9. Understanding the past and present

In order to understand how research participants may view research, one must be aware of history. Historically some groups have already been deprived of quality health care and have a long history of not being treated fairly and equitably (Smedley, Stith, & Nelson, 2003), and have experienced abuse and disrespect, as is the case with African Americans (Baker, Brawley, & Marks, 2005). The Public Health Service's Syphilis Experiment at Tuskegee is an unfortunate landmark example that illustrates the worst of research with vulnerable groups. For forty years, the U.S. Public Health Service conducted an experiment on black men in the late stages of syphilis who were never told what disease they were suffering from or of its seriousness (Jones, 1993).

This history of mistrust by vulnerable populations has led to skepticism about the purpose and outcomes of research thereby necessitating conscientious effort to build trust (Douglas et al., 2009). In order to build trust, the reasons for mistrust must be uncovered. Some point out that the focus should not be on the participants' mistrust, rather the focus should be on the trustworthiness of the system (Corbie-Smith & Ford, 2006). The lack of trustworthiness in the system is rooted in history as well as the current state of health disparities. The history of slavery, racism, and segregation, and the continuing shortage of minority providers and researchers contribute to mistrust. In addition, poor patient-provider communication and a lack of true cultural understanding by health care providers and researchers influence level of trust (List, 2005). Health disparities and lack of access to quality health care can add to mistrust. How do you answer a potential study participant when he says, "you want me to help you with this research study but I cannot get health care coverage that I can afford."

Equally important to the recognition of historical influences is the need to understand the heterogeneity of groups. All racial and ethnic groups are heterogeneous and may have different histories and follow different lifestyles. Education, religion, sociocultural factors, geographic location, gender, sexual orientation, and age affect attitudes toward research as

much as historical events. Also values, beliefs and attitudes may differ based on age and generational factors, need to also be considered (van Ryn & Burke, 2000).

10. Breaking down stereotypes

Relationships between the study team and study participants must be thoughtfully and courageously examined along with barriers imposed by the use of stereotypes to classify individuals. For example, many stereotypes exist about the poor and are often communicated with little hesitancy or shame (Lott, 2002). Common descriptors used to describe the poor include: uneducated, lazy, dirty, stupid, immoral, criminal, abusive, and violent (Cozzarelli, Wilkinson, & Tagler, 2001, Kemeny et al., 2012). Health care providers may also hold these stereotypes. For example they may perceive patients with lower

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socioeconomic status as having more negative personality characteristics, lower level of intelligence, less likely to be adherent, and less likely to want active lifestyle even when controlling for other demographic factors (van Ryn & Burke, 2000). Clinical researchers must be cautious to avoid stereotyping groups and must consider the individual who may be distinctly different than others in a similar group. Beyond being a study “subject”, the research participant is a partner who is an expert in her/his own experience. Paternalistic behaviors and gate keeping activities specifically in research recruitment need to be replaced with honest communication and respect.

11. Conclusion and recommendations

Cultural humility, a process of reflection and lifelong inquiry, involves self-awareness of personal and cultural biases as well as awareness and sensitivity to significant cultural issues of others. Core to the process of cultural humility is the researcher’s deliberate reflection of her/his values and biases. Looking toward the future, cultural humility and practices that cultivate it, like mindfulness, ought to be an essential component of the training of clinical researchers. Given that nursing naturally espouses a holistic perspective, it is logical that nurse researchers take a lead in this area. With a foundation in cultural humility, nurse researchers and other investigators can implement meaningful and ethical projects to better address and minimize health disparities.

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Scenario: You, a nurse researcher, are planning to conduct a study with low-income immigrants from a different racial and ethnic background than yourself. You are quickly working on the details of the study procedures to meet an impending grant deadline. You take a few minutes to incorporate mindfulness techniques.

Mindfulness tools you can use (sequentially):

- 1) Intentionally pause from what you are doing.
- 2) Take a few slow deep breaths, bringing awareness to the experience and sensations of breathing in and breathing out.
- 3) Reflect on what it might be like to be one of the immigrants participating in the proposed complex clinical trial. Consider how your life is different from these people. Reflect on how difficult their lives are and how participation in this study will be a burden to their already stressful lives.
- 4) Tune in and notice: how your body feels (i.e., sense if your heart is beating fast or if your shoulder muscles are tense), thoughts coming to mind (i.e., is the study sensitive to the nuances of these individuals or is it asking too much of them?), and emotions arising (i.e., anxiety or worry).
- 5) Take a few more slow breaths with awareness.
- 6) Further reflect on the specific issues and circumstances that the immigrants face and consider aspects of their living and working environments.
- 7) Again, take a few more mindful breaths.
- 8) Proceed with writing the study protocol with a greater sense of clarity and kindness toward the marginalized study population whom you're studying.

Fig. 1.

Example of mindfulness as a tool for cultural humility in clinical research.

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Table 1

Difference between cultural competence and cultural humility.

Attributes Cultural Competence Cultural Humility

View of culture •Group traits •Unique to individuals

•Group label associates group with a list of traditional traits and practices •Originates from multiple contributions from different sources.

•De-contextualized •Can be fluid and change based on context

Culture definition •Minorities of ethnic and racial groups •Different combinations of ethnicity, race, age, income, education, sexual orientation, class, abilities, faith and more

Traditions •Immigrants and minorities follow traditions •Everyone follows traditions

Context •Majority is the normal; other cultures are the different ones

•Power differences exist and must be recognized and minimized

Results •Promotion of stereotyping •Promotion of respect

Focus •Differences based on group identity and group boundaries

•Individual focus of not only of the other but also of the self

Process •A defined course or curriculum to highlight differences •An ongoing life process •Making bias explicit

Endpoint •Competence/expertise •Flexibility/humility

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