Is culturally sensitive research achievable?

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Culturally sensitive practice, both in the clinical and research context, is becoming more important as the world becomes increasingly multicultural. The aim of this article is to look at culturally sensitive research in the context of a study completed as part of a clinical psychology doctoral thesis. The article examines whether we can be culturally sensitive in research, as well as addressing barriers and possible solutions.

THE WORLD OF RESEARCH is changing to accommodate the many studies that focus on different cultures, and not just the dominant cultures in the western world. In the last decade in particular, we have seen an increasing number of research studies focusing on diverse cultures, particularly in the field of mental health and psychological wellbeing. Understandably, this calls for culturally sensitive approaches and has led to increased discussions around conducting research that examines different cultural groups from the perspective of one culture (the dominant culture). The aim of this paper is to discuss issues around addressing cultural sensitivity arising from our personal experiences of conducting research with a population of British Muslims of South Asian origin (see Pilkington, Msetfi & Watson, 2011). The research was conducted as part of a clinical psychology doctoral thesis.

In order to contextualise these discussions, we will summarise the background and aims of the Pilkington et al. (2011) study. We were interested in finding out how feelings of shame affected the likelihood of people seeking out psychological help. Although personal shame and humiliation in relation to the perceived stigma of mental health problems has been a frequent topic of study (e.g. Cinnirella & Loewenthal, 1999), shame can be a distinct construct with particular meaning for some cultural and religious groups. For example, in individualistic cultures, feelings of shame relate to reflections on the self (Mesquita, 2001). However, within South Asian cultures reflected shame is related to 'izzat'. This is a term that is used to describe a complex set of rules that must be adhered to in order to protect the family honour and keep position within the community. Previous qualitative research had identified izzat as playing a role in help seeking and using mental health services (e.g. Anand & Cochrane, 2005), and one aim of our study was to examine the predictive value of izzat using quantitative methods.

The theoretical framework used for this research was the Theory of Planned Behaviour (TPB: Ajzen, 1985), which has been reported to generalise across cultures (e.g. Phoenix & Winnie, 2009). TPB can be applied to intentions to carry out any kind of behaviour but is most frequently used in the field of health behaviours. Utilising this framework, we also examined more established predictors of intention to access psychological services. These included beliefs about the cause of mental health difficulties (biological/social-environmental and religious), levels of acculturation and demographic variables such as age and education.

To briefly summarise the results, levels of education and acculturation were positively related to intention to seek help, whereas biological beliefs about the causes of mental health disorders and izzat were negatively related. So, stronger beliefs in biological causes and higher levels of izzat predicted less intention to seek help. However, when data from individuals that had migrated to Britain during their lifetimes was examined separately to individuals that were born in the country, the picture was somewhat different. Levels of education remained a key predictor of intention for both groups. However, for individuals that were born in Britain, only acculturation predicted intention. For the migrant group, increased length of time in Britain predicted

stronger intention and higher levels of izzat predicted lesser intention. Although there are always power issues in relation to splitting samples in this manner, it seemed equally important not to ignore differences between migrant individuals and those born in Britain. It was this finding in particular that prompted us to consider issues around conducting culturally sensitive research.

At a fundamental level, cultural sensitivity is being aware and accepting of other cultures. Within our research, we deemed culturally sensitive practice to include an awareness that differences may exist between the culture of the dominant group and that of the target population. This included differences at a number of levels including conceptualisations of psychological difficulties, beliefs, values and behaviours. We also felt it was important to immerse ourselves in the traditions of the cultural group that we were examining. It is important to note that one of the researchers was from a South Asian background. Finally, our research aims and questions were defined by previous research and not by preconceptions about British Muslims of South Asian origin.

As in any good research, it is important to reflect on the research process once the study has been completed. We did feel that we had met the criteria we set for ourselves to ensure that we had been culturally sensitive in our approach to the study (for full details see Pilkington et al. 2011). However, when reflecting on the research process, a number of further issues arose.

The design of our study had a fundamental flaw in relation to cultural sensitivity as we were unable to provide translated versions of the measures. It would seem to be quite obvious that, in order to ensure culturally sensitivity, we should provide participants for whom this was necessary with translated versions of the measures. However, the majority of the questionnaires used in this research had not previously been translated into and validated in the relevant languages. The required translation, back translation, and validation process would also have been beyond the scope of this project carried out, as it was within the framework of a clinical psychology doctoral thesis. However, we then started questioning whether, even if we had been able to provide translated versions of the measures, we would then have met the criteria for conducting culturally sensitive research.

In particular, it is important to think about the process of translating measures that are designed from the perspective of a particular culture and then utilising them within different cultures. Although it is important to ensure that measures are linguistically accessible, this does not mean that a direct translation of a measure makes it linguistically sensitive to different cultures (Edwards, 1994). Therefore, simply translating the words from the English language to different languages would be unlikely to account for grammatical differences, variations in semantics and conceptual equivalences.

As with any debate in this field, raising one issue inevitably throws up a whole host of other issues. Specifically, even if the measures had been available in different languages, the concepts in these measures stem from a Western theoretical framework. We wanted to examine people's understanding of the causes of mental health difficulties and whether they were likely to seek help for such mental health problems. Our measures of these variables were of course predicated on the assumption of a shared understanding between researchers and participants of what constitutes a mental health problem. However, there may be considerable differences between cultural and religious groups as to what a mental health problem is. Therefore, in this type of research it is also important to consider cultural conceptualisations of mental health, and whether the cultural group being researched has a similar understanding of mental health and psychological distress to that of the dominant culture.

For example, there are inherent differences between South Asian populations and Westernised societies in terms of key aspects of the self and context relevant to mental health. There are several approaches to studying cultural differences but the dominant paradigm is that of individualism and collectivism (Oyserman, Koon & Kemmelmeier, 2002). South Asians tend to be collectivist and allocentric, such that value is

placed on collective needs and collective self-definitions (Triandis, 1996). Emotional dependency is also fostered within the family system (Patel & Gaw 1996). Conversely, Western cultures are seen as individualistic, where the rights of the individual and personal goals are emphasised and independence and autonomy are promoted (Phinney, Madden & Ong, 2000). Clearly, it is individualistic notions of self that pervade contemporary theories of mental health.

The collectivist-individualist distinction is not the only framework that has been applied in this domain. Another relevant example is the suggestion of a continuum between 'sociocentric' and 'egocentric' perspectives on thoughts, behaviours and emotions (Gaines, 1982). 'Sociocentric' describes individuals who view behaviours, cognitions and emotions as functions of relationships, whereas 'egocentric' refers to individuals who perceive themselves as autonomous, with behaviours, cognitions and emotions arising from the individual. South Asian identity is thought of as sociocentric, which again is inconsistent with egocentric Western theoretical views of mental health (Triandis, 1996). The implication is, therefore, that Western theoretical perspectives on mental heath may be limited in terms of their explanatory power for members of cultural groups with collectivistic orientation.

The idea that fundamental differences exist in the conceptualisation of mental health between South Asian and Western populations was demonstrated in a study examining the construct of depression in Pakistani groups (Malik, 2000). From interviewing participants who were either living in Pakistan or were first generation migrants to Britain, some differences were observed between the perceptions of participants in this sample and how depression is perceived within a Westernised framework. In particular, it was found that the perceived cause of distress tended to be related to external factors, such as situations and relationships, rather than internalised. Furthermore, the symptoms of distress were expressed in relation to social roles and other people.

Reflecting on the findings of this study made us wonder whether there was not a more fundamental difficulty with the Pilkington et al. (2011) study. Did the use of the measures adopted assume that all of our participants subscribed to a Westernised framework of mental health? If this was the case, then the ideas in the questionnaires may have meant something different to the respondents to that assumed by the researchers. Indeed, most of the measures had not been validated with South Asian populations. This means that we need to exercise caution when generalising from the results, as they may only be relevant to certain groups of British Muslims. Given that the sample recruited into this study were mainly from Britain (and if they had migrated, they had been living in the country for some time), it is possible that they were more familiar with Western frameworks for understanding and treating mental health and therefore the findings of this study may only be generalisable to this group of Muslims.

One solution, which could avoid such problems, is to use instruments that have been designed specifically for the cultural group being studied. However, this is not as straightforward as might be assumed. For example, the Armistrar Depression Inventory is a measure of depression that has been developed and validated in Pakistan. Bhui, Bhugra and Goldberg (2000) tested this measure with Pakistani respondents in the UK and it was found not to be an accurate measure of depression for the UK group. This suggests that the process of migration and subsequent acculturation into a new country leads to some cultural shifts. Therefore, it may be that we cannot view cultures simplistically as either collectivist or individualistic, but rather that there may be a continuum between these cultural orientations, which will be affected by individual experiences, values, behaviours, beliefs and identity.

Zebain, Alamuddin, Maalouf and Chatila (2007) also offer some interesting ideas that could be used to address culturally sensitive research practises retrospectively and

include looking at conceptual and methodological issues as well as employing valid methodological procedures. Finally, it may be a good idea to utilise the resources that we already have and look at literature into service-user led research, thus linking in with different cultural/religious groups to use their expertise in helping with the path towards culturally sensitive research.

Overall, the area is complex and there may be no simple answers that ensure research is culturally sensitive. We feel that there is most probably a spectrum of culturally sensitive practice. This will, of course be affected by practical constraints, as was the case in Pilkington et al. In particular, the research presented was part of a clinical psychology doctoral thesis and this meant that issues of restricted time and finances affected some of the practices around cultural sensitivity. However, we do feel that there are fundamental components that can be adhered to despite such practical limitations. It may be easier to view these as different levels of culturally sensitive practice, ranging from the fundamental level to the gold standard. So, to answer our initial question, we do think that it is possible, at least at some level, to carry out culturally sensitive research.

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