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HEALTH DISPARITIES RESEARCH:
A PERSPECTIVE ON CULTURAL CONSONANCE

This paper is intended to cast into sharper relief the range of issues connected to cultural consonance model and the causal forces involved in it. First I examine the reasoning about the properties of culture as a type of chronic stressor implicit in cultural consonance theory. Then I provide a selective review of literature on sociocultural factors in health focusing on the social stress model, and offer a range of criticisms to the current formulation of the cultural consonance model reflecting on its potential to explain the observed inter-informant differences in mental health attributable to one's incongruence with a cultural standard.

Keywords: cultural consonance theory, psychosocial stress, social stress hypothesis, mental health disparities, individual-culture congruence, cultural models.

Congruence with cultural standards and cultural consonance

The importance of congruity with cultural standards for one's well-being and self-concept is often cited in anthropology, psychology and sociology literatures in connection with psychosocial stress model and health disparities research [4; 11; 45; 46]. Recent cross-cultural studies present evidence of reduced levels of well-being and self-esteem in individuals whose behavior or beliefs deviate from their society's axiological/normative profile [21]. The negative consequences of nonconformity to societal expectations have been documented for a diverse range of personal attributes including morality, religiosity, employment, and personality traits [36; 35; 16; 44; 46]. In this vein, the biocultural perspective in medical anthropology examines how shared normative culture can generate social stress and thus affect individual health in individuals incongruent with its requirements and prescriptions, and how systematic sociocultural stressors are converted during enculturation process into measurable variation in health outcomes across individuals and social groups. One of the most active research directions applying biocultural approach to health disparities addresses how the perceived degree of individual congruence with society's standards along various cultural dimensions affects individual health [1; 19].

The biological mechanism underlying the social gradient in health (the negative relationship between morbidity/mortality and socioeconomic status) is one of the promising lines of investigation in the area of health disparities at the moment. The empirical evidence has been consistently linking it to the psychosocial stress associated with social position (i.e., as a notion reflecting the individual's relative cultural value). This line of work relies on a broad network of theoretical reasoning in various social sciences. An important instance of conceptualizing the interrelationship between cultural standards, individual lifestyle and objective health outcomes is represented in the cultural consonance theory – a framework within a biocultural approach to health and illness that is bound to psychosocial model of stress [11; 13].

Cultural consonance is defined as "the degree to which individuals approximate, in their own beliefs and behaviors, the prototypes for those beliefs and behaviors encoded in shared cultural models"[1] [11]. It represents an important instance of the interrelationship between culture, mental life and psychosocial stress. Understandably, there has been much interest in understanding the effects of cultural consonance. Conceptually, this model integrates collective culture with individual cognition, behavior and health, and emphasizes the negative health outcomes in individuals failing to match a cultural standard [11]. Its central empirical claim posits that one's failure to match a socially desirable standard encoded in a cultural model results in the decrease in individual physical and mental health [11; 15]. Research in Brazil and the United States has shown that one's failure to realize cultural models in one's

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[1] A cultural model is presupposed, taken-for-granted models of the world that are shared within a society and that play an enormous role in its members' understanding of the world and their behavior in it [7; 40]. Cultural models reflect the cultural regularities in cognitive organization of collectively shared experiences, thus resembling the notion of the 'life world' [17]. These regularities are reflected in logical connections people make, and as such are accessible for analysis and interpretation [37; 38; 40].

behavior is experienced as stressful and is associated with greater psychological distress, higher arterial blood pressure, and greater body mass [11; 13; 14]. At the same time, cultural consonance researchers report that perceived stress partially mediated the impact of cultural consonance on depressive symptoms in two domains (e.g., family life and lifestyle) out of four when cultural consonance was assessed for each domain separately; the mediation effect disappeared when generalized consonance across all four domains was measured [10]. Furthermore, Dressler and associates [6; 12] were able to link inter-informant variation in the ability to better learn and internalize culture to a genetic predisposition for depression, which has previously been systematically linked to neuroticism [23]. Psychological research on neuroticism and depression show that both are partly heritable and highly intercorrelated traits [24]. All in all, one can draw a preliminary conclusion that in order to better explain socially generated stress in the context of congruence with culture, joint efforts from different social sciences are required. Interdisciplinary competence is imperative if we are to explore the relationship between culture and human cognitive machinery that supports it, as the two are intertwined and one cannot be explained without invoking the other.

Culture as a type of chronic stressor

Cultural consonance researchers take a cognitive perspective on culture, focusing on its knowledge-organizing properties and on patterned sharedness and intersubjectivity of cultural meanings. An important notion stemming from this reasoning is that of *cultural competence* which embodies the degree of overlap between individual knowledge about a cultural domain and the corresponding collective knowledge profile. As discussed elsewhere [30], K. Romney's culture consensus theory provides the theoretical foundation to cultural consonance model. Both culture consensus and cultural consonance models consider culture and, therefore, cultural knowledge as measurable variables. Cultural competence is also understood of as a measurable individual-level statistic which can be compared across individuals and correlated with the group average. Methodologically, both models include a conceptualization of the interplay between the individual and collective knowledge, and how the two are integrated with behavior into day-to-day practice. This influences the way cultural consonance operationalizes cultural variables and explains the effects of cultural factors on health.

Cultural consonance theory focuses on the material aspect of congruence with culture (thus emphasizing the significance of one's owning certain items and leading a certain lifestyle rather than having a matching axiological profile or a substantial amount of cultural 'expertise' for culture consensus). Using these estimates contingent on various elements of lifestyle, cultural consonance researchers associate departures from the lifestyle index (computed for the group and for the individual) with suboptimal health outcomes on the individual level.

The central juncture between culture and health, as conceptualized within cultural consonance framework, is embedded in culture's ability to exert stress. This socially generated stress, in its turn, can contribute to worsening health outcomes, first of all for mental health. This approach is grounded in the social model of stress which generally conceives of the discrepancy between a socially desirable trait and the actual trait as stressful or causing distress. The social stress model has long been the predominant paradigm in research on the relationship between social factors and mental health [18]. From this perspective, normative culture – with its prescriptive codes, requisites and standards – is one of the systematic (chronic) stressors in daily life. In the context of mental health, those sociocultural stressors that have a more generic ambient effect also can add a unique source of stress that may explain how disadvantaged social statuses (i.e., not living up to the material index of the social standard) produce mental health problems [43].

Explaining health disparities: cultural consonance and alternative approaches

Dressler's cultural consonance model is a useful framework that can explain both the emergence and maintenance of health disparities and such fundamental questions of human culture as its participation in individual and collective cognition [15]. However, that said there are several instances of conceptualization of the interrelationship between culture, cognition and behavior that need to be further researched and perhaps amended due to several factors. (1) In its present formulation cultural consonance theory does not offer an explanation of the *mechanism* of cultural consonance (which I propose is related to the inter-informant variation in norm internalization and cultural competence expressed as high individual scores on domain-relevant normative knowledge) [26–28]. Moreover, (2) in its current formulation the effect of cultural consonance is linked *directly* to one's failure to

match the cultural standard. As the success of replications of this type of research design varies, it is possible that the relationship is conceptualized inaccurately (e.g., the directness of the relationship is assumed erroneously).

(3) Furthermore, individual congruence with the cultural standard, operationalized as individual informant's correspondence to the average (normative) profile [49], has been shown to affect subjective well-being (SWB) in various populations. However, the results with respect to SWB are inconclusive [cf. 2; 28; 29]. Methodologically, much of the published work on the relationship between the internalized cultural standards and mental health does not distinguish between cognitive and material aspects in this process, and uses self-reports on individual access to the socially desirable material possessions (tv-sets, kitchen appliances etc.) as a measure of individual consonance with normative culture [cf. 13]. Although I recognize the advantages of such approach to cultural models, being able to isolate the cognitive aspect of this phenomenon from its material context would improve our understanding of the psychological mechanism of cultural consonance, which so far received little attention in anthropological and psychological literatures. It would therefore be useful to test the effects of deviating from cultural standard in the domain of normativity (morality, values, norms, social axioms etc.) on mental health. It would also be interesting to see if the characteristics of norms (e.g., pro-social vs. pro-self) or availability of social support would have any significant effects in this.

(4) Another issue that should be noted here is that most research on cultural consonance is not attuned to the psychological aspects of the phenomenon but instead tends to scrutinize the material perspective on culture and stress, and to increasingly privilege the genetic explanations to account for inter-informant variation in suboptimal health outcomes of individual-culture incongruence [6; 12]. As a result, the work on cultural consonance does not make use of the related literatures in psychology, e.g. person-environment fit or culture-personality clash hypotheses [3; 35]. Both these frameworks deal with phenomena that are likely participants in the general mechanism that cultural consonance is part of.

The present article considers several major points that call for amendments with respect to research on formulation of cultural consonance and psychosocial factors affecting health disparities:

I. Most of the literature on the neurophysiology of norms focuses on instances of norm violation and its negative feedback. The range *of rewarding positive experiences* ensuing from conforming to

normative standards is discussed infrequently and, as in the case of cultural consonance framework, the investigation of individual incongruence with culture is often focused on its socioeconomic determinants (e.g., material manifestations) rather than the psychological component. While cultural consonance theory and similar research on psychosocial factors in health disparities specifically target the negative health outcomes of individual incongruence with the cultural standard, adding a perspective on psychological rewards of cultural consonance would be benficial.

II. While cultural consonance theory is built on the methodological and conceptual foundation of culture consensus model [41; 42], it does not offer a conclusive account for the role of its central concept, *cultural competence* (the degree of individual congruence, or overlap, with collective knowledge) in cultural consonance. Cultural competence and its deficiency being not only the most easily testable measures for an ethnographer [cf. 49] but also highly plausible candidates to affect mental health, not knowing their exact status in the conceptualization of cultural consonance causes difficulty in cross-cultural replications and makes cultural consonance more difficult to use (e.g., less reliable) in studies focusing specifically on mental health and psychological variables [2; 26; 27]. Establishing the role of cultural competence and validating the results across different samples (from outside the USA and Brazil) and/or contrasting the effects of cultural competence deficits of the natives with that of naturalized migrants would advance our understanding of and offer methodological enhancement in this research area.

III. The empirical results indicate that routinely experienced positive and negative emotions systematically influence SWB levels. It is plausible that one's appraisal of one's degree of congruence with culture, subjective or objective, is not only self-referential but also inherently emotionally valenced. Cultural consonance model, however, does not consider the *role of positive and negative affect* arising as an individual response to (in)congruence in the mechanism of stress generation process. As a result it does not include the requirement for explicit testing of how positive and negative emotions affect SWB in congruent and incongruent individuals.

Additionally, it has been shown that the pattern of how emotions impact SWB varies cross-culturally for negative but not positive emotions. It implies that the mechanism is not only more complex than a direct relationship, but also potentially *not uniform* in cases of incongruence. Therefore, in this context a separate concern is that cultural consonance model does not contrast societies with different 'theories of

emotion' (including sampling from Western and non-Western nations). Both these theoretical drawbacks translate into suboptimal methodological choices in testing the health outcomes of health disparities.

IV. In its current formulation, cultural consonance does not consider the possibility of the *buffering effects* of *coping strategies* and *social support* in negative mental health outcomes of incongruence with culture [8; 29; 32; 48]. Given the findings from the extensive research on social support and health, there is a pressing need systematically incorporate this aspect in cultural consonance research and to explore both relationships with a range of qualitative and mixed methods, in order to isolate the effects of social support and coping, and to discriminate them from those of cultural competence.

V. Another issue in investigating the relationship between congruence with culture and mental health is the *choice of societies* where the data is drawn from to test the model. Most of the data supporting the claim of cultural consonance is derived from the American South or Brazil. Both the USA and Brazil are highly stratified societies. At the same time, a sample from a European nation, or from the East Asian region, or from a society with a strong welfare state system would present a suitable alternative field site to explore this range of hypotheses. Such sample would be socioeconomically and politically distinct from Brazil and the United States where most of the cultural consonance data come from. For example, European nations have comparable understanding of consumption and technology but differ in their notions of hierarchy and social stratification [2], and the sources of psychosocial stress associated with lifestyle [3]. Given the indirect evidence of a different pattern of SES-health outcomes association in Europe compared to the U.S., more cultural samples are required for further exploration of cultural consonance effect and establishing its scope.

VI. A separate concern for researchers of culture-psychology interaction is methodology and cultural sensitivity of chosen research instruments in particular. Cultural consonance involves chiefly quantitative research that relies on cultural domain analysis, which is not the optimal tool with respect to its central research category, i.e. cultural models, which are larger and more complexly organized

agglomerations of information than a cultural domain [31; 48; cf. 12]. Cultural domain analysis does not extract complete cultural models, which are by definition similar to cognitive maps of the group's social landscape in that they are helpful guides in social navigation. It is improbable that a naïve individual could use the information gleaned from domain analysis to successfully navigate highly stratified, social background-conscious society like Brazil, for example. This diminishes the informativeness of the results regarding the prevalent cultural standards against which individual scores for consonance are computed. The literature on cultural consonance and our conceptualization of cultural consonance would be greatly enriched by introducing a more *mixed-methods approach* to extraction of cultural models that would be able to accommodate more complex verbal materials (e.g. *variation* in discourses reflecting individual reasoning and collectively shared ideas, the range and effectiveness of coping strategies in the cases of incongruence with culture, motivation, etc.) necessary due to the nature of the construct in question.

VII. Although cultural consonance theory is a useful methodological tool and presently one of the most active, cutting-edge directions in medical anthropology research on health disparities, in its current formulation it does not explain why the individual response to not matching a cultural model is a decrease in mental health (*ultimate explanation*), nor does it offer a psychological mechanism by which this decrease occurs (*proximate explanation*). Meanwhile, considering the role of internalization in this *cognitive mechanism* would offer one such explanation [26].

VIII. Further limitations of the approach include its potentially confounded associations with psychological phenomena such as *extrinsic motivation* and the effects the *materialistic* aspirations of consumer culture have on emotional health. Internalization of consumer culture ideas has been shown to lead to decreased SWB levels. Kasser and Ryan (1996) have long since proposed a positive link between extrinsic materialist/appearance orientation and depression [22]. Research on self-determination theory [33] and cross-cultural comparison of goal structure [47] furnish support to a similar observation that pursuing things (goals clustered around extrinsic motivation) rather than fulfilling needs that are necessary for psychological functioning (competence, autonomy, relatedness) has negative outcomes for mental health. Methodologically or theoretically, cultural consonance does not analyze these psychological circumstances, although they are likely candidates to affect mental health outcomes the researchers of cultural

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[2] Gini coefficient for Sweden is much lower (24.9, low) than for Brazil (51.9, high) and the U.S. (36.9, medium) (statistics from Eurostat Data Explorer, 2012).

[3] This is a particularly important background characteristic, as the national pattern of social inequality has been recently linked to self-reported happiness [9; 34], and the relationship between socioeconomic inequality and mental health is differently organized in wealthy vs. developing nations [20; 25].

consonance seek to measure. Given the materialistic nature of the index constructed by cultural consonance researchers, there is a chance that it affects the outcome (depression), not the stress generated by incongruence [5].

IX. What is more, the current formulation of cultural consonance does not consider the role of *personality* variables. Ignoring the personality dimension in studying the effects of congruence with culture leaves a large chunk of 'transactions' between individuals and culture unattended. Meanwhile culture-personality mismatch could be a component in non-optimal health outcomes described by cultural consonance, at least with respect to poorer mental health; it could also include not only depressed affect but a general vulnerability to psychiatric disorders [cf. 3]. Further testing with multiple samples from different societies (i.e. less stratified, more secular, less individualistic, more protected by the welfare state etc. than the U.S. and Brazil) would enhance this niche in research.

X. Another important point concerns the role and the range of *coping strategies* in non-consonant individuals, and the extent to which they can be effective. For example, is the development of alternative cultural models a good buffer against incongruence with the prevalent cultural model? This aspect is mostly concerned with cognitive-psychological rather than behavioral consonance. Addressing it would greatly enrich the literature on cultural consonance, and enable its broader application in the studies of mental health.

XI. Finally, there is the question of the *functional mechanism* of cultural consonance. One of the ways

to address this issue would be to look into the origins of individual proneness to conform to cultural standards (in behavior and mental habits) by considering the evolutionary evidence. Research on social learning, evolution of norms and gene-culture co-evolution altogether provide most interesting insights that could be of relevance to our question. However, while co-evolution of genes and culture in humans is an important theoretical point in research on culture and health which is mentioned in the works on cultural consonance [6; 12], this theoretical approach is objectively challenging to use for empirical testing. In this vein, instead of attending to the complete culture-gene equation, cultural consonance researchers tends to emphasize the results suggesting heritable interpersonal variation in sensitivity to cultural consonance deficits within a population [12], which makes the 'cultural' portion of cultural consonance misleading.

Conclusions

Cultural consonance is one of the theoretical models that is using social stress framework to account for interpersonal differences in health outcomes due to chronic exposure to different kinds of cultural stressors inherent in different social niches. Explaining and helping alleviate health disparities is a task of great importance – academically as well as socially. It is therefore of practical significance to improve the explanatory potential of this model by integrating psychological theories and employing more fine-tuned methods of instrument development.

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ДОСЛІДЖЕННЯ НЕРІВНОСТІ В ЗДОРОВ'Ї:
ПОГЛЯД НА ТЕОРІЮ КУЛЬТУРНОГО КОНСОНАНСУ

У статті висвітлено низку питань, що асоціюються з моделлю культурного консонансу та фак-торами причинності, якими вона оперує. Спочатку розглянуто розуміння властивостей культури як різновиду хронічних стресорів, імпліцитне в теорії культурного консонансу. Потім наведено огляд дотичної літератури з питань соціокультурних чинників у здоров'ї, зокрема соціальної моделі стресу, та запропоновано критичні зауваження щодо теперішнього формулювання моделі культур-ного консонансу, яке відбивається на її здатності пояснювати відмінності в психічному здоров'ї, що виникають у різних індивідів як результат їх різного ступеня збігу з культурним стандартом.

Ключові слова: теорія культурного консонансу, психосоціальний стрес, соціальна модель стресу, нерівність у психічному здоров'ї, конгруентність індивіда та культури, культурні моделі.

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БАГАТОВИМІРНИЙ АНАЛІЗ СТАВЛЕННЯ
ДО КОНФЛІКТНИХ СУСПІЛЬНИХ ТЕМ

У статті за допомогою множинного аналізу відповідності і факторного аналізу досліджено ставлення респондентів до тем, які входять у поточне дискусійне поле в Україні. На основі підходу Ж.-П. Пажеса вдалося виділити ті самі осі, які дослідник запропонував для розуміння суспільної думки у Франції: «стабільність – рух» і «драматизація – компроміс». Квантифікація змінних у форматі шкали Лікерта ставить під питання її порядковий характер, що може призводити до проблем з використанням факторного аналізу для вивчення суспільної думки.

Ключові слова: множинний аналіз відповідності, конфлікти, суспільна думка, шкала Лікерта, квантифікація.

Дослідження суспільної думки в демокра-тичних країнах відіграє надзвичайно важливу роль, оскільки прийняттю рішень, що вплива-ють на життя та добробут громадян, повинні пе-редувати широкі обговорення, в яких кожна со-ціальна група має право відстоювати власні інтереси. Сама можливість таких дискусій дає змогу запобігти вияву соціального напруження у насильницьких формах. Спираючись на ре-зультати таких досліджень, державні органи, по-літичні партії, групи підтримки й окремі активі-сти мають можливість через засоби масової