Towards a Model for the Identification of Cultural Values in Health Communications: Discourses of Food and Health in the Appalachians

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Health outcomes from food-related issues are particularly poor in Appalachian regions; obesity, malnutrition, type 2 diabetes, stroke, and heart disease are prevalent. Recognizing that "old" and "new" Appalachian culture are perhaps not the same, there still appears to be a disconnect between those whose goal is to increase the health of Southern Appalachian citizens—medical professionals, nonprofit clinicians, and rural health and advocacy groups—and those citizens themselves. In an era where culturally-sensitive persuasion is largely accepted as effective, health communications have seemingly not caught up. While health is certainly not cut-and-dry and involves complex mitigating and influential factors and circumstances, one consideration is that information is not "getting through" to the audience in a meaningful, persuasive, or actionable way.

Food, cooking, and meal-making and sharing are inexorably tied to cultural values. In order to determine whether values embedded in a given nutrition-oriented health communications align with the cultural values of food and health held by the targeted audience, research must first consider *how* to identify values in nutrition communications targeted to a specific audience. Building on research confirming the success of culturally-sensitive approaches to health communications, this study lays the groundwork for a model of cultural value identification in targeted nutrition communications using theory and data from peer-reviewed literature that addresses cultural values within discourses of health, food, or nutrition within

cultures or defined communities similar to those of Appalachia. Having this model—an accurate and applicable method of discourse analysis—will enable practitioners to both identify values within current micro and macro-level discourses and effectively tailor future communications targeted toward Appalachian people and other regionally and culturally-specific populations.

This study uses meta-synthesis as an approach to explore data, theories and methods of measurement relevant to values, cultural identity, food culture, and health communications in Appalachian-like communities. The apparent cross-connection between fields (public health, health communications, public policy, and advertising for example), theoretical models, and research data produced from the 17 studies included in the synthesis indicates the need for further exploratory research linking the theories of Schwartz, Hofstede, and Inglehart (or other emergent models of cultural values) with current communications theory and practice, and validates the valuableness of this work. Many values evident in the studies on Appalachian health aligned with those proposed in Schwartz, Hofstede, and Inglehart, therefore any of these models could be potentially useful, providing a theoretical structure and/ or schema to assessments of discourses of nutrition targeted to specific populations or cultures such as those of Appalachia.

# TOWARDS A MODEL FOR THE IDENTIFICATION OF CULTURAL VALUES IN HEALTH COMMUNICATIONS: DISCOURSES OF FOOD AND HEALTH IN THE APPALACHIANS

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# DEDICATION

To my dear Jason—my friend, love, and partner in all things—thank you for giving me the space and support to accomplish my goals. You make me better, and I adore you.

To my two small lovies, Clara and Alice: though you be small, you are fierce. Be yourselves and you will flourish. You are my heart.

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# CHAPTER 1

## INTRODUCTION

Most of us have waited in a physician's exam room longer than desired, scanning the walls for something interesting to occupy the minutes until the doctor's arrival. Recently, I found myself in that situation in Hendersonville, a small southcentral Appalachian town in Western North Carolina. The walls were adorned with educational information about nutrition and exercise, blood sugar maintenance, and smoking cessation. Health risk factors like obesity, smoking, and deficient levels of physical activity are significantly higher in Appalachia than in the US overall, as are mortality rates for cancer, diabetes, and heart disease, among others leading causes of death (Appalachian Regional Commission, 2017). These issues are well-known; Appalachia is an area riddled with stereotype, but also rich with diverse cultural characteristic. The health-related propaganda in the office—authored by federal and other governmental organizations, as well as for-profit pharmaceutical entities—did not appear to acknowledge or embody any of the cultural, societal, or regional characteristics (or even stereotypes) of Appalachia. In an era where culturally-sensitive persuasion is largely accepted as effective, health communications have seemingly not caught up. While this thesis does not speculate as to why there is a lag, it provides one mechanism for confirming this inclination.

Humans embody individually, socially, and culturally-based values. We exist within societies and cultural groups that have systems of values that color and influence our perception of reality. These values are evident through the words, phrases, metaphors and symbols expressed in both communicative media and inter-personal interactions (between doctor and patient, marketing coordinator and public, lawmaker and public, or other institutional representative and client for example) intended to educate and persuade an individual to amend

their understanding, attitude, and/ or behavior. The usefulness of the ability to identify values cannot be understated. As persuasive communication, or the ability to influence another's perspective, is involved in everything—conversations between patients and physicians, lobbyists and politicians, or pharmaceutical advertisement to consumer for instance—understanding the mechanisms and vocabulary by which someone makes decisions and formulates opinions pervades everything.

### 1.2. Statement of the Problem

Health outcomes from food-related issues are particularly poor in Appalachian regions; obesity, malnutrition, type 2 diabetes, stroke, and heart disease are prevalent. There are myriad types of organizations—regional health systems, regional advocacy organizations, health and wellness programs, food banks, etc.—on the ground in these areas, all assumingly tasked with the dispersal of accurate and persuasive nutrition information. With the increasingly low health status of Appalachian areas, however, there is clearly room for improvement in these efforts. While health is certainly not cut-and-dry and involves complex mitigating and influential factors and circumstances, one consideration is that information is not "getting through" to the audience in a meaningful, persuasive, or actionable way.

Health communication is a growing sub-field of technical communication which incorporates foundational theories and practices from across disciplines. One charge of health communication is to impart technical health-related information to individuals to convince them to act, behave, or think in a different way—usually one that is beneficial to their health or well-being. Health and medical practitioners are on the frontlines of health communication; however, other roles are also pivotal to imparting health-related information, particularly in rural and underserved geographic areas. Health clinic administrators, public service campaign marketers,

food bank staff, and rural health wellness program directors can have direct impact on the information that is received in areas limited by access.

Food, cooking, and meal-making and sharing are inexorably tied to cultural values. The populations of Appalachian areas are traditionally understood—at least in popular culture—to be rich in food traditions, yet challenged in nutrition and health. As health problems continue to rise, it is difficult to ignore that the culture of the South and its historical relationship to food, community, and the agrarian life has also shifted. Recognizing that "old" and "new" Appalachian culture are perhaps not the same, there still appears to be a disconnect between those whose goal is to increase the health of Southern Appalachian citizens—medical professionals, nonprofit clinicians, and rural health and advocacy groups—and those citizens themselves.

### 1.3. Purpose of Study

This thesis project comprises the first phase of a proposed multi-phase qualitative research study. It became clear during early research for this project that identifying values embedded in nutrition-focused communications in Appalachia would be difficult without an understanding of the available and applicable analysis methods and tools. While literature exists around Appalachian food studies and value systems, best practices in culturally-oriented health communication, and individual values assessment; there is little literature to support an identification and assessment of those values in the communication that providers put forth. Therefore, the research approach in this first phase is meta-synthesis—a systematic, narrative, literature review—and will explore data, theories and methods of measurement relevant to values, cultural identity, food culture, and health communications in Appalachian-like communities. This meta-synthesis will be grounded by establishing the current methods and

channels and media through which health communications are disseminated to targeted populations. Ultimately, the goal of this meta-synthesis is the development of a value identification model applicable to nutrition communications targeted to specific cultural groups.

Building on research confirming the success of culturally-sensitive approaches to health communications, this study 1) argues the need for a peer-reviewed method of cultural value identification in targeted nutrition communications, and 2) lays the groundwork for that model using theory and data from peer-reviewed literature that addresses cultural values within discourses of health, food, or nutrition within cultures or defined communities similar to those of Appalachia.

### 1.4 Research Questions

To determine whether the values embedded in a given nutrition-oriented health communications aligned with the cultural values of food and health held by the targeted audience, the research must first consider *how* to identify values in nutrition communications targeted to a specific audience. There are two primary research questions of this research project:

1) what are models of cultural value identification applicable to discourses of nutrition (food and health)?
2) what social and cultural values around nutrition (food and health) are apparent/ evident in research about Appalachia?

These research questions will be answered in order to argue the need for and offer a theoretical foundation for the development of a model of value identification applicable to macro and micro-level discourses of food and health in southcentral Appalachia. Having this model—an accurate and applicable method of discourse analysis—will enable practitioners to both identify values within current micro and macro-level discourses and effectively tailor future

communications targeted toward Appalachian people and other regionally and culturally-specific populations. These research questions lie at the intersection of the communications, public health, and cultural studies fields (among many possible sub-fields). The research produced from the meta-analysis is a first step toward integrating these fields for communications research and practice purposes. While this thesis limits itself to answering the above research questions, subsequent work must be done to map connections between macro-level (pharmaceutical advertisements, internet-based "advice" columns and articles, and WebMD for instance) and micro-level (patient-provider interpersonal communications), as well as to gauge those micro and macro-level discourses. In addition, further work to connect current and emergent socio-cultural value theory with the health communications and public health education arenas. Subsequent proposed phases and methodologies will be addressed in Chapter 5: Further Studies.

## 1.6 Limitations of Study

While it is unknown if *any* currently proposed value system is appropriate for telling information about people's responses to health communication, this thesis begins that exploration. Many suspect that values systems are the gateway through which a communication campaign or effort is channeled and ultimately accepted or rejected, therefore it is useful research to explore avenues for this. In addition, meta-synthesis is an imperfect method, but one useful for gathering and making meaning of large swaths of research and data—an essential step toward the development of a model of cultural value identification in health communications.

# CHAPTER 2

# LITERATURE REVIEW

The following literature review will ground the meta-synthesis per both prevailing theoretical models of cultural values and best practices for culturally-sensitive health communications. The first section (2.1) of the literature review is concerned with the connection between values and nutrition, food and health choices, the second section (2.2) explores culture-centered health communications practices, and the third (2.3) establishes a working understanding of theoretical models of cultural values and their assessment.

## 2.1 Values, Food and Health.

*Health Rhetoric as Epideictic.* The rhetoric of health contain deeply embedded and often *obscured* meanings. While some meanings are consciously employed through recognizable metaphor and are thus easily registered as persuasive language, other meanings are more camouflaged. When values are obscured within metaphor, communication assumed to be objective and based on fact cannot be appropriately registered as value-laden or critiqued (Segal, 2005). Segal discusses the metaphors of "medicine is war", "medicine is a business", "heroic medicine", "diagnoses equals health", and "the person is genes" largely in terms of their effect on health policy, but the importance of the identification of metaphors—metaphors laden with societal values—is applicable to any discourse. Our values around health, therefore, are both overtly present and hidden within layers of metaphor, catch-phrases, and slang. These values, subtly, influence our thoughts and beliefs about scenarios, shaping our understanding and feeling of our health and the health of others. If the "person is genes", then the locus of control in a

medical scenario—say diabetes—is external to the individual. The generator of the "faulty" gene could be god, chance, or fate, but it certainly is not the person with the diagnosis. If this metaphor persists under the surface, then what does that mean for health education or preventative medicine? If a person considers themselves "destined" to become diabetic because their father, mother, or other family were also afflicted, then that fatalistic view could influence food and other lifestyle choices that affect health. These metaphors erode our ability to consider a health situation comprehensively, obscuring possible causation or mitigation through the emphasis of one aspect.

Blakely (2011) examines pharmaceutical and technology advertisements in popular media sources for embedded cultural values and finds strong rhetoric of praise and blame—epideictic rhetoric—within. Blakely's students reviewed a series of advertisements from *Parade* and *USA Weekend* magazines, broadly available and targeted to a wide-ranging and largely non-specific American audience; asking them to analyze for those attributes that made them seem either educational or promotional. Identifying for indications of values of praise versus values of blame, she concluded that "ad makers were implicitly praising common if simplistically conceived values" (694) and assigning blame in a similar manner. The students identified values in both pharmaceutical and technological ads that were not product-specific, but were evocative of American value structures. For example, values praised in both included: control over one's life, increasing availability, youth, modernism and futurism, freedom from limitations, and an enhancement of abilities. Values blamed include loss of control and accessibility, disease, and diminished productivity or ability.

*Values and Food Choice.* Sobal and Bisogni (2009) call to attention the multi-disciplinary origins of decision–making and decision-analysis science, and review models of food choice in terms of those theoretical bases. They find support for constructionist thinking, which aligns with the Schwartz model and others of cultural value theory. Allen and Baines (2002) confirmed their prediction that consumer food choice is restricted or colored by a product's associated cultural values, and that an individual's sensory perceptions—a physical manifestation of preference--are influenced by symbolism—an abstract conception of imbued values. Allen, Gupta, and Monnier (2008) go a bit further, explaining that not only are an individual's food choices influenced by associated values, but that their tastes and preferences can actually be altered by changing the associations.

Andrulis and Brach (2007) explore how health literacy—the ability to understand information as presented—is constructed, finding that culture is a prominent factor. Their definition of culture here is focused more on the evidence of tendencies, or a group phenomenon recognizable by patterns. Dutta and Basu relate to the concept of culture as pattern too, but instead view it as patterns of meaning and understanding by a distinct group. In advocacy for culture-centered approaches to health communication, the authors unearth socially-constructed values, or structures of meaning, when de-constructing health discourse in West Bengali. Kreuter, Lukwago, and Bucholtz agree that health communications messaging should be culturally informed in order for it to be well-received, and call for a "cultural tailoring" approach.

Allen and Baines (2002) evaluated the decision-making process by many Americans to, in their assumption, over-consume meat and under-consume vegetables, through the lens of product associated human values. The authors hypothesized that the sensory process—the real

perception of a food through sight, taste, smell, and feel—is altered based on a product's association with values as perceived by the purchaser or imbiber. While they did not conclusively show that the sensory experience was changed, they did show a change in feelings and behaviors when awareness of a value-association was revealed: "This model suggests that consumers form attitudes to products by evaluating the human values symbolised by a product against the values that they endorse. An endorsed value evokes a more favourable attitude and greater intention to purchase, whereas a value that the individual rejects results in a less favourable attitude and weaker intention to purchase." (Allen, 119)

Through their manipulation of individual's value awareness, they recognized the possibilities that such symbolic choices open. If a consumer is swayed, not necessarily by taste or quality, but by their deeply ingrained value associations, then the approach to the rhetoric could and should be shifted accordingly. The authors had already established that there were solidified affiliations between preference for authoritarianism and social hierarchy and preference for meat in a prior 2000 study (p. 120). This study's goal was to test whether those preferences could be shifted by making visible the symbolic associations with certain foods and food choices.

The researchers distributed surveys via mail, with follow up three weeks after. The questions placed informants on scales using questions relating to the following dimensions: current food consumption, openness to meat avoidance, diet choice confidence, endorsement of dominance, food perception, anticipated food consumption, attitudes toward animals, current food consumption, diet change, and attitudes toward meat production and food animals. Two other sections, salience manipulation comprehension and salience manipulation interpretation, manipulated the respondents by building awareness of the connection between food choice and

the value of social dominance. Those connections were outlined in graphic form within the survey as an informational aside, and the questions contained in the survey were designed to ascertain comprehension and agreement with the information presented.

While the shifts in behavior after manipulation were small, they were statistically significant. Those respondents who scored low on the social dominance scale, meaning that they were not inclined to feel that social dominance was a "good" value, decreased their reported affinity for meat and increased their affinity for fruits and vegetables after the connection between dominance valuation and treatment of animals was brought to the fore. By exposing and emphasized certain symbolic associations (the connection of beliefs about the dominance and the treatment of animals for example), the researchers were able to remind individuals of their value systems. Interestingly, actual food choices (self-reported) did not necessarily change, but the individuals' remembrance of those choices showed that they wished to have done so. Those who scored high on the dominance scale showed little affect with the manipulations, as expected.

Allen, Gupta, and Monnier go a step further in 2008, attempting to show that sensory taste can be influenced by value manipulation. The research explored *value-symbol congruency*; that judgements about experiences are colored by already instilled beliefs and knowledge. According to the framework of self-congruity theory used in this study, which addresses cognitive processes and decision-making, individuals make decisions and thereby choose products that are perceived to fall in line with their individual values and beliefs, because inconsistency is an uncomfortable phenomenon for humans (Allen, 2008, 296). Participants were asked to complete a Schwartz Values Theory based questionnaire about a hypothetical individual that might be associated with each brand—both for various soda brands and for a meat and vegetarian sausage product. They then conducted blind taste testing where participants were to

indicate their preferences and guess the brand. There were significant associations with meat eating and social power while an affinity for the vegetable-based product generally correlated with a rejection of power. Similarly, the soda brands that had been associated with certain lifestyle choices and values (often derived from campaign and marketing campaigns)

Sobal and Bisogni (2009) present a foundational look at food choice in context of current theories of decision-making and decision-analysis. Acknowledging that decision-makings multi-disciplinary roots—psychology, economics, philosophy—present some contention as to legitimacy of any one model or theory, they explore food choice in terms of the prevailing models applicable to social decisions: rationalist, structuralist, and constructionist-based. They acknowledge that while some may view food choices as merely circumstantial or indiscriminate, representing one of the more uninteresting choices in life, those choices are in fact imbued with significant meaning driven by symbolism. (Sobal et al., S37) They also make the observation that food choice is a *social* phenomenon, not just an individual one.

The authors review food choice within the context of three primary theoretical backgrounds. The rationalist perspective, one that considers choice as a social behavior, views individual decisions as an internal assessment of benefit and cost. An individual rationally weighs the benefits and related costs of a food choice decision in order to increase one and reduce the other. The authors acknowledge that in order for this to be a legitimate model, individuals must actually obtain and fully understand the information needed to make an informed decision—which is not the case in some scenarios where there are language or other barriers.

A concept of choice reliant upon social facts, or a perspective rooted in structuralism, is the view that there are external norms and values imposed upon an individual—consciously or

subconsciously—that influence choice. External constraints act as blinders; a society or cultural effectively edits the boundaries of an individual's perceptions of reality. This can be either an enhancing or a limiting phenomenon.

Finally, the third theoretical perspective that Sobal and Bisogni review is a constructionist view, where social definitions are dynamic, and choice is decided and then re-decided. In a sense, this view takes into account both the rationalist and structuralist view: "people experience, define, interpret, negotiate, manage, and symbolize the world in the process of decision-making." (Sobal, S39) An individual both processes decisions based on information given, and also experience with individualized settings and institutions. There is continual interaction between external and internal meanings, symbols, and definitions that ultimately determine individual choice.

This third point of view is largely where the authors determined their model of food choice, and is the theoretical basis most aligned with the constructionist bent of Schwartz's and others' models of socio-cultural values. They use the "Food Choice Process Model" developed by researchers at The Cornell Food Choice Research Group to outline three primary factors in a food choice: 1) life course, 2) influences, and 3) personal systems. A person's "life course" is their general trajectory as determined by their age, stage of life, the events that have occurred in their life, and their early familial and cultural upbringing. This factor is highly dynamic, and develops over time as an individual encounters new contexts, enters transitional times, and experiences turning points. The "influences" included here are those a) cultural ideals, b) personal factors, c) resources, d) social factors, and e) present contexts that form the overall environment or background from which an individual will make a choice. "Cultural ideals" are those norms set byt heir cultural group with which they identify. "Personal factors" are those

circumstances—biological condition, perceived risk of illness, and other personal attributes—that are individualistic in nature, while "social factors" refer to the consideration of group needs (family, community, etc.). "Resources" are the assets that establish range of choice; money for example. These influences are all situated within the life course and actively shape choice.

An individual's "personal systems", where cultural value theory will be most applicable, denotes the development, negotiation, classification, and strategization around values and is a cognitive process personal to the individual. Values as defined here are the meanings and feelings that people associate with cost, taste, health, convenience, and relationships.

They find, ultimately, that no one thing makes or breaks food choice. As there are multiple factors that influence choice, there are also multiple perspectives on how we view that process. Values are both dynamic and situational.

### 2.2. Culture-centered health communications

The 2007 article "Integrating literacy, culture, and language to improve health care quality for diverse populations" by Andrulis and Brach explores aspects of health literacy beyond traditional constructs of literacy—or the ability to read and write in the language at hand: "Health literacy is not determined solely by and individual's capacity to read, understand, process, and act on health information. It is the product of the individual's capacities *and* the demands the health information places on individuals to decode, interpret, and assimilate health messages." (Andrulis, S123)

The authors go on to define culture's role in health literacy: "It is through the lens of culture that people define health and illness and perceive and respond to health messages." (S123) Here, that notion of culture is the broad concept of human behavioral patterns or

tendencies defined along group lines. Those groups could be ethnic, racial, religious, or a host of other delineable social groupings. The authors call attention to the various health outcomes affected by culture, including: "from whom health care is sought, how symptoms are described, how treatment options are considered, and how a medical treatment will be chosen and adhered to." (S123)

Andrulis and Brach relate the different "best practices" advocated by health communication theorists, cultural competence theorists, and linguistic competence theorists. To overcome health illiteracy, health communication theory asserts that there should be limited messaging in each conversation (to simplify and hone), that the messaging should be jargon-free, and that the patient should engage in repeating back the goals and actions required to ensure understanding ("teach-back" method). Those focusing on cultural competence often attempt to ground the clinician in the patients' health beliefs through use of targeted questions like the *Kleinman Questions*. The question and answer session, or cross-cultural exploration, reveals a mutual agreement and understanding about the next action steps needed. Linguistic competence is generally not concerned with culture, rather literal language translation. This may not address needs caused by cultural or health communication illiteracy. (S126) The authors recommend an integration of best practices in all three areas in order to address interpersonal communications, written materials, prescription labels, technology (how individuals prefer communication, personal assessment tools), outreach (beyond the walls of traditional medical institutions and into the realm of community health workers), multidisciplinary staff, and facility navigation tools. (S127-S128)

Kreuter, Lukwago, and Bucholtz, in a 2003 article about cultural appropriateness in health promotions work from the generally accepted understanding that messaging relating to

health should be tailored specifically to the recipients' culture. (Kreuter, 2013) Kreuter et al. are concerned with the generational aspect of culture, how values and other cultural concepts are transferred through the generations. In this study, they review five prominent methods of culturally-sensitive health communication and propose a sixth approach, *cultural tailoring*. The five grouped strategies include peripheral, evidential, linguistic, constituent-evolving, and sociocultural approaches; each implementing targeting to a slightly different aspect of a group's culture. Cultural tailoring involves all of the above, with messaging tailored beyond the cultural considerations and incorporating an individual-sensitive approach. The authors use values surrounding spirituality extensively in the article, which is not expressly addressed in the Schwartz value theory.

Dutta and Basu (2008) ground a study of West Bengali health issues in a culture-centered approach to health communication discourse. They acknowledge the increasing prominence of geographic and culture context in regard to health communications practices, and used a survey of 18 rural West Bengali men to explore recurring themes in practitioner-client health communications. Ultimately, they unearthed the importance of trust between practitioner and client, and collective health as resource and community responsibility.

The authors operate from a definition of culture drawn from Geertz, that it is an "acted document" (p. 218) and that it is comprised of "socially established structures of meaning" (p 219). The men interviewed all shared the same culture, as well as the same restrictions of healthcare access. The culture-centered approach used by the authors dictated that the individual's culture must first be understood before data can be interpreted. For this reason, in-depth, responsive dialogue with the men was the most critical aspect of the study. Researcher and interviewer must share similar cultural grounding before clear analysis of the discourse can

take place. The (cultural) values held by the West Bengali men in turn influenced their perspectives on political, economic, and social systems as well as the resultant communication practices.

## 2.3. Theories of Cultural Values

### Hofstede, Ingelhart-Welzel, and Schwartz.

There are many recognized theories of a model of cultural values. Three well-known and prevalently cited models are outlined here: 1) Hofstede, 2) Inglehart and Welzel, and 3) Schwartz. Each offers a theoretical structure for categorizing and understanding values within a culture. Hofstede was focused on culture's effect on values, behavior, and action, while the Inglehart-Welzel model determined cultural value classifications through analysis of their incidence with other variables, namely development and economic-oriented factors. The Schwartz model was more complex than both prior models in terms of breadth, and has been largely substantiated by further research. Interestingly, the work done to validate the Schwartz model also validated many aspects of both the Inglehart and Welzel models, affirming that used in tandem, each provided a useful vantage point for the same data set. (Schwartz, 2006)

Hofstede, a former IBM executive whose research originated for organizational development and cross-cultural communications purposes, determined that there are six cultural dimensions. His dimensions—individualism-collectivism; uncertainty avoidance; power distance, masculinity-femininity, long-term orientation, and indulgence vs. self-restraint—became evident using primarily factor analysis of a survey completed on IBM employees over a period of six years. He conceptualized each based on issues that all societies commonly encounter.

*Table 2.3.1. Hofstede's (2011, p. 12) cultural dimensions*

| Values | Definition |
|---|---|
| Individualism-collectivism | The relationship between the individual and the group. |
| Uncertainty avoidance | The extent to which members of a culture feel threatened by ambiguous or unknown situations. |
| Power distance | Social inequality, including relationships with authority |
| Masculinity-femininity | The social implications of having been born as a boy or girl. |
| Long-term orientation | Achievement, personal dignity and "face". |
| Indulgence vs. self-restraint | Perception of life control, importance of leisure. |

Hofstede's model has its detractors. The six dimensions that Hofstede identifies are presented as non-intersecting, bi-polar and according to some, restrictive, classifications of more intertwined and complicated cultural identities. As McSweeney (2002) states: "But Hofstede's dimensions exclude such coexistence and conflict and thus are blind to key cultural qualities. All of us… have the ability not only to hold incompatible ideas/values in different situations but we may, in James Joyce's apt phrase, have 'two tinks [sic] at a time'." (McSweeney, 2002, p. 105) The bi-polar nature precluded cultures from being inclusive of two values that were opposed. For example, a country or cultural group could not be both indulgent and encompassing of certain types of self-restraint. In addition, with the distinct nature of the values that he identified through his research, there is some concern that they are arbitrary; they were the most apparent, not necessarily most meaningful, indicators of cultural value.

The Inglehart-Welzel Cultural Map uses the World Values Survey (WVS), a tool developed in 1981 by a multi-national group of social scientists to measure the change over time of beliefs and values in peoples across the world. Cultures are mapped along an x-y continuum according to their placement toward traditional values versus secular-rational values and survival values versus self-expression values, forming groups of like-minded cultures such as "Confucian" (Taiwan, China, Hong Kong), African-Islamic (Ghana, Iraq, Zimbabwe), and Catholic-Europe (Slovakia, Spain, Austria). In this model, traditional values and secular-rational values are opposing tendencies, with the traditional representing an attunement to religion,

traditional family orientations, and nationalism and secular-rational indicating the opposite. Similarly, self-expression and survival values are opposed, with "self-expression" indicating an openness to others/ outsiders, and a participatory outlook, and survival indicating an inward/ethnocentric view focused on security of one's inner circle.

*Table 1.3.2. Inglehart-Welzel (2004), http://www.worldvaluessurvey.org/WVSContents.jsp?CMSID=Findings) World Values*

| Values | Definition |
|---|---|
| Secular-rational | Less emphasis on religion, traditional family values and authority. Divorce, abortion, euthanasia and suicide relatively acceptable. |
| Traditional | Emphasis on religion, parent-child ties, deference to authority and traditional family values. reject divorce, abortion, euthanasia and suicide. High levels of national pride and a nationalistic outlook. |
| Survival | Emphasis on economic and physical security. Relatively ethnocentric outlook and low levels of trust and tolerance. |
| Self-expression | High priority to environmental protection, growing tolerance of foreigners, gays and lesbians and gender equality. Rising demands for participation in decision-making in economic and political life |

Schwartz's research and resulting *value theory* seeks to situate values across cultures and nations, and establish a set of common categories through which cultures can be compared and contrasted, and which are relevant and meaningful to each. (Schwartz, 1992, 2005, 2006, 2006, 2012) Two tools used by Schwartz and his cohort, the *Survey of Basic Values* and *Portrait Values Questionnaire* (PVQ), were used to assess personality differences, evidenced through level of adherence to 10 different value concepts: power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security. Table 2 exhibits the conceptual definitions of Schwartz's basic values presented in his 2012 refinement of his value theory (p. 664).

*Table 2.3.3. Schwartz's (2012) Basic Value definitions*

| Value | Definition |
|---|---|
| Self-direction | Independent thought and action—choosing, creating, exploring. |
| Stimulation | Excitement, novelty, and challenge in life. |
| Hedonism | Pleasure and sensuous gratification for oneself. |
| Achievement | Personal success through demonstrating competence according to social standards. |
| Power | Social status and prestige, control or dominance over people and resources. |
| Security | Safety, harmony, and stability of society, of relationships, and of self. |

| | |
|---|---|
| Conformity | Restraint of actions, inclinations, and impulses likely to upset or harm others and violate social expectations or norms. |
| Tradition | Respect, commitment, and acceptance of the customs and ideas that traditional culture or religion provides. |
| Benevolence | Preservation and the enhancement of the welfare of people with whom one is in frequent personal contact. |
| Universalism | Understanding, appreciation, tolerance, and protection for the welfare of all people and for nature. |

Schwartz's consideration of values within the context of cultural orientation is apropos to Kenneth Burke's concept of identification in rhetoric: "I view culture as the rich complex of meanings, beliefs, practices, symbols, norms, and values prevalent among people in a society. The prevailing value emphases in a society may be the most central feature of culture (Hofstede, 1980; Inglehart, 1977; Schwartz, 1999; Weber, 1958; Williams, 1958). The prevailing value emphases express shared conceptions of what is good and desirable in the culture, the cultural ideals." (Schwartz, 2006, p. 139-140) Schwartz argues that culture, while being difficult to define, assess, and compare between peoples and societies, is primarily based upon values. Therefore, identifying and cataloguing those values can reveal commonalities and differences that are useful in inter-cultural engagement. Whereas Burke considered identification in terms of an alternative to the commonly-held understanding of persuasion—one individual or institution attempting to identify and espouse values that relate to another in order to make connection—Schwartz sees a more direct opportunity in the dynamics of cultural differences; opportunity to influence decision-making, attitudes, and behavior.

**Applicability of Value Theory, and PVQ, to Market Analysis.** Roz and Gouveia (2000) review and explore different models of cultural values theory—Hofstede, Ingelhart and Welzel, and Schwartz—in terms of their usefulness, applicability, and validity. Both Krystallis, Vassalo, and Chryssoides (2012) and Price, Walker, and Boschetti's (2014) studies utilize cultural values theory and aligned measurement tools to explore choice and decision-making. While Krystallis et al. attempted to predict consumer choice for marketing purposes using the PVQ, and altered that device to their specific product/ field, Walker and Boschetti assessed

individual's feelings about climate change in terms of their "cultural orientation" using questioning pulled directly from the PVQ and Hofstede's model. Both found that cultural values theory was directly applicable to behavior and choice, and that valid predictions of individual behavior and beliefs occurred within the findings, to varying degrees depending on the tool.

There is precedence of using value theory (this and others) in marketing (websites, collateral materials) and health education initiatives. Krystallis, Vassallo, and Chryssohoidos explored the usefulness of Schwartz' value theory to predicting and assessing consumer motivation in a 2012 article in the *Journal of Marketing Management*.

The authors studied the applicability of value assessment tools, such as Schwartz's Portrait Values Questionnaire, to marketing analysis and consumer choice. They do not, however, use the tool in its original form, but rather re-orient the tool according to the specific context it is designed to measure. In this case, they are measuring values in terms of a specific product. "The present work shows the usefulness of contextualising theoretical justifications initially developed for the systematic assessment of general consumer behaviour phenomena." (Krystallis, 2012, p. 1439) Moving beyond generalized systems of beliefs and values, the researchers aim was to tailor the theory and tool to a specific product, showing its adaptability as a measurement device. Their hypothesis was that measurement of human values thematically related to the issue or product at hand could reveal more effective strategies for market segmentation, consumer behavior analysis, and marketing campaigning.

This article also provides the most comprehensive validation of the PVQ that the researcher encountered, citing 30 different research studies addressing Values Theory and specific behavioral contexts, including political, sexual, religious, work, service, and risk management choices (Krystallis, 1442). They also document the correlation between certain

value orientations and certain types of food consumption and purchase. Their survey was informed through the Food-related Lifestyle and Means-End Chain theory used in food consumer behavior research, and corresponded to the PVQ associated values.

**Individualism and Collectivism.** Roz and Gouviea (2000) explore the situation of individualism and collectivism within macro-social and macro-economic cultural values according to models of cultural value theory developed by Hofstede and Schwartz. While Hofstede's model views cultural values as aligning along one or the other, a polarized view, Schwartz's model considers a more bi-dimensional approach, with both individualism and collectivism able to be represented within a single value. The authors' intent was to test alignment of cultural value data from tested countries with demographic variables (birth rate, agricultural activity). "A variable is cultural when it reflects the mean of a country." (p. 28)

The discriminant values were Individualism and Power Distance, from the Hofstede model, and Autonomy and Conservation, from the Schwartz model. They found not all variables were statistically significant in correlated to any of discriminant variables (cultural values). Countries that scored low on individualism scored similarly lower on gross domestic product and higher on illiteracy. Conversely, countries with high rates of wealth and low rates of illiteracy scored highly on individualism. Countries that presented low scores in power distance had higher rates of human development, gross national product, life expectancy, and higher rates of illiteracy. High power distance scores correlated with lower human development and a lower gross domestic product.

**Cultural values and climate change beliefs.** Price, Walker, and Boschetti (2014) explored effect of cultural orientation on an individual's beliefs about climate change. Acknowledging that "individual perceptions of climate change are informed more by personal experiences, values, and worldviews than they are by scientific considerations like global climate models, greenhouse gas concentrations, social vulnerability, or adaptive capacity" (Price, p. 8), the authors tested whether the model of cultural theory and the measurement of cultural bias in society was applicable to an individual or group's beliefs and feelings about the environmental and climactic change.

The argument, that societal change cannot take place without recognition of the underlying "cultural dimensions" involved in environmental issues and climate change, is based upon the idea that despite overwhelming evidence, large-scale acceptance of carbon emission solutions has been slow. The authors considered that evidence was not the most important factor in decision-making, but rather "cultural biases", here defined as "patterns of shared beliefs and values about the environment" and "which represent partial perspectives about reality" (Price, p. 8). They surveyed individuals to ascertain whether their beliefs about society in general corresponded to their beliefs about the environment.

The authors reviewed various models of cultural theory (or theoretical frameworks) to determine appropriate dimensions on which to measure cultural/ societal beliefs and values and their correlation with environmental concerns. Working from a cultural theory framework, the authors utilized both hierarchical-egalitarian-individualistic-fatalistic and the application of grid-group dimensions to assess value systems. These were just explorations, these connections had not yet been made conclusively by the time of publication, and in fact were largely used to explain societal relations, not environmental. Guiding questions were two-fold: are the

measurable dimensions related to cultural environmental biases in alignment with cultural biases about societal relations, and consequently, if related, do they align along those dimensions? The cultural theory framework, while originally conceptualized as a way to make patterns of values and beliefs visible, is being applied here to code specific traits that influence beliefs, decision-making, and behavior. The authors show precedent for this in risk perception studies.

# CHAPTER 3

# METHODOLOGY

## 3.0. Methodology

This chapter details the methodology used to answer the two primary research questions of phase one of this research project: 1) what are models of cultural value identification applicable to discourses of nutrition (food and health)? and 2) what social and cultural values around nutrition (food and health) are apparent/ evident in research about Appalachia?

## 3.1. Meta-Synthesis as an Approach

Meta-study, encompassing meta-analysis and meta-synthesis, originated as an approach (meta-analysis) in the medical field to analyze quantitative data from disparate experimental research studies. While it remains an approach used more heavily in the health and public health sciences, it is increasingly utilized as a tool to synthesize and assess qualitative theory methods, and findings in the social sciences and other disciplines (meta-synthesis). Meta-study refers to an approach that comes *behind* other studies (Zhao, 1991) and necessitates the existence of a catalogue of prior relevant research, as prior studies form the corpus of data from which meta-study evidence is determined. Meta-study involves reviewing both the findings and protocol of a prior body of work attuned to any given phenomenon, and is a reflective process that can effectively situate an issue or that phenomenon for future work (Zhao, 1991). This reflective approach makes it well-suited for areas where the literature is inconclusive or scant.

Meta-synthesis, or the "science of summing up" (Davey, Davey, and Sing, 2015, p. 2) is a systematic and comprehensive approach to literature review, and is a form of Systematic Literature Review (SLR). SLRs are highly specific, addressing a particular research question,

rather than generalized like a traditional literature review. Whereas a literature review is incorporated into a research study to address the state of the relevant field(s), identifying both areas where research is lacking and areas that support the research question at hand, systematic literature reviews (meta-studies in particular) are a conclusive research method that directly addresses the research question. In addition, SLRs involve a rigorous protocol of search inclusion and exclusion, study selection, study assessment, and synthesis criteria (Boell, 2015)—the clearly pre-defined process of each hallmarks of scientific/empirical research.

Davey, Davey, and Singh (2015), acknowledging the potential in the health sciences that the meta method posits, reviewed in depth two specific approaches, meta-narrative (MN) and meta triangulation (MT). Meta-narrative review/ meta-narrative synthesis (authors use terms synonymously and interchangeably) is used to integrate findings from qualitative studies to inform a particular research question or policy issue. This approach is helpful in revealing current ways of thought about a particular subject from within a particular paradigm, as well as providing a platform to compare and contrast those methods, theory, and findings. Meta-triangulation is used to integrate more complex data and theory, distinct paradigms of thought, that have influence on a particular research question or policy issue. It involves the application of a typical systematic review approach to more ideologically widespread and abstract research and theoretically thus allows for more innovation in mapping paradigms and building theories. (Davey et al., 2015)

There is precedence for meta-synthesis as a research approach across disciplines, but particularly in the public health, communications, and information design arenas. Highlights of recent meta-studies and systematic reviews in the public health field include: an "integrative review and thematic synthesis" of forty-three papers to identify documented support strategies

for rural health practitioners (Moran, 2014); a systematic search and meta-ethnography of the thirty eight studies conducted to ascertain men with long-lasting diseases and conditions' perceptions of self-managed support interventions (Galdas, 2014); a meta-synthesis of twenty seven articles addressing public perceptions of posthumous organ donation (Newton, 2011), a meta-study to identify external influences on healthcare decisions between patients and their medical care providers (Edwards, 2008); and two integrated systematic reviews seeking the link between health and nutrition policies and diets of low-income individuals in the U.K. (Attree, 2006).

There is increased incidence in the past five years of these methods appearing in communication studies, notably in the fields of health communications. These include a systematic review of 69 articles documenting the growth of health branding as a burgeoning practice (Evans, 2015); a systematic review of 87 articles about disaster preparedness communications in the media (Romo-Murphy, 2014); and a systematic review of 48 studies addressing information-seeking behavior in graduate students (Catalano, 2013).

Meta-study as an approach is not without its detractors. Boell and Cecez-Kecmanovic (2015), in response to a growing adoption of SLR in Information Sciences research, caution that the approach has its limitations. In order to be fully reproducible, the research question must be "closed" and cannot involve a "how" or "why". The research question must also be answerable through summarization. In order to build knowledge or generate theory—which is the objective of this study—a SLR must be more flexible in protocol so as to include literature that has more open-ended questions, or "how" and "why" questions, and therefore will not adhere as strictly to this protocol.

In addition, Davey et al. concur that there are limitations in using these methods. Review quality is limited to the quality of the extant data with both meta-study in general and SLR Neither type of review can determine or validate connection between variables with true certainty in the manner of a randomized, controlled trial (Davey, 2015). While most studies that employ a "meta" method (whether analysis, narrative review, triangulation, or synthesis) concede some limitations in the approach, most also confirm its usefulness for aggregating and interpreting large swaths of data and theory as long as 1) rigorous and documented search criteria and research assessment protocols are established and followed, and 2) the search allows for some creativity and latitude to capture relevant data that strict search protocol guidelines inhibit.

### 3.2. Selection of Research

In order to produce a high quality SLR, the database search must have a high degree of recall (number of articles produced) and precision (relevancy of articles produced) (Boell, 2015). Unlike a meta-interpretation or grounded theory method, where the researcher has more latitude with data choice, the SLR form of meta-synthesis is more highly regimented to increase objectivity (Weed, 2008,). A defining characteristic of an SLR is that its goal is to collect the "best evidence", and thus its evidence must be collected: 1) through systematic, pre-determined and documented process, 2) by incorporating strict exclusion and assessment criteria, and 3) by being comprehensive with inclusion of relevant literature. (Weed, 2005)

The literature search for this meta-study was completed between February 2016 and June 2016 using East Carolina University's One Search, a tool that searches both ECU's physical library holdings, as well as a comprehensive database of newspapers, books, academic journals, and other research materials to which ECU students, faculty, and staff have online access. Access to this search portal removed the need for individual journal searches, as the listings were

comprehensive and included the most prominent and recognized academic journals in the fields of communications and public health. The literature compiled, reviewed, and assessed over the five-month period was sought according to a strict regimen of criteria, which are outlined in detail in the next section.

### 3.2.1. Inclusion and Exclusion Criteria

**Inclusion Criteria.**

The literature compiled for this review was sought in two phases, in accordance with the two primary research questions. Both searches were conducted by translating thematic components of the research question into corresponding search terms. Boolean logic was used to mandate that at least one term in each column (e.g. “model” OR “scale” OR “inventory”) was present in the resulting literature list. In Table 3.2.a: Research Question 1 and Corresponding Parameters, you will find the search terms used to produce a final (de-duplicated) list of 1,241 literature sources to address the first primary research question: “what are models of cultural value identification applicable to discourses of nutrition (food and health)?” In Table 3.2.b: Research Question 2 and Corresponding Parameters, you will find the search terms used to produce a final list of 84 literature sources to address the second primary research question: “what are the social and cultural values around nutrition (food and health) evident in research about Appalachia?”

*Table 3.2.a. Research Question 1 and corresponding search parameters.*

| Q: What are models | of cultural value identification | applicable to discourses of | Nutrition (food and health)? | FIELD | RESULTS |
|---|---|---|---|---|---|
| "model" or "scale" or "inventory" | "cultural values" or "social values" or "socio-cultural" | "discourse analysis" or "content analysis" or "text analysis" | "nutrition" | Journalism and Communications | 22 |
| | | | "food" | Journalism and Communications | 137 |
| | | | "health" | Journalism and Communications | 247 |
| | | | "nutrition" | Public Health | 197 |
| | | | "food" | Public Health | 365 |
| | | | "health" | Public Health | 872 |
| | | | "nutrition" | Diet and Clinical Nutrition | 50 |
| | | | "food" | Diet and Clinical Nutrition | 44 |
| | | | "health" | Diet and Clinical Nutrition | 47 |
| "model" or "scale" or "inventory" | "cultural values" or "social values" or "socio-cultural" | "discourse analysis" or "content analysis" or "text analysis" | "nutrition" or "food" or "health" | Journalism and Communications or Public Health or Diet and Clinical Nutrition | **1,241 TOTAL*** |

Table 3.2.b.: Research Question 2 and corresponding search parameters

| Q: What are the cultural values | around nutrition (food and health) | in micro and macro-level discourses | In Southcentral Appalachia? | FIELD | RESULTS |
|---|---|---|---|---|---|
| "cultural values" or "social values" or "socio-cultural" | "nutrition" or "food" or "health" | | "Appalachia" or "Appalachian" | Journalism and Communications or Public Health or Diet and Clinical Nutrition | **84 TOTAL** |

**Exclusion Criteria.**

In order to constrain the number of results produced, as well as keep the focus on published, academically sound literature, some types of literature were removed from the search listings. The listings were honed to retain only published literature from scholarly journals, books, book chapters, and conference proceedings; English language publications; and those that were published within the last fifteen years (defined as: January, 1, 2001 to present). These terms of exclusion removed such content types as drawings, book reviews, audio recordings, newspaper and magazine articles, dissertations and theses, presentations, research guides, and transcripts. While some applicable findings were likely lost by limiting the search to fifteen years, it was deemed probable that the more recent research was likely most relevant to the questions at hand. The researcher is only fluent in English; therefore, foreign language publications were not suitable for consideration within the given time frame.

### 3.3. Assessment of Research

The articles produced from the initial search exclusion and inclusion criteria were then culled further by coding each article per the assessment criteria below. Assessment question A for Research Question 1, and both questions E and F for Research Question 2 were crucial to determining relevance and applicability, therefore it was required that articles to be included in the final result must achieve a coding of three toward those corresponding questions. Further, for Research Question 1, it was imperative that the article "directly address" at least one of the other three subject areas (specific type of discourse, systematization of value measurement, or specific values related to health, food, or culture), therefore the lowest total coding for an article to be included was ten (a score of three for question A, three for at least one question B-D, and a combination equaling four for the final two assessment questions). Articles with low coding—

below ten for Research Question 1 and below six for Research Question 2—were discarded, ensuring that the results for Research Questions 1 and 2 included only the most relevant articles.

Research Question 1 (Coding: 0 – does not address, 1 – addresses indirectly, 2 - addresses somewhat, 3 – directly addresses)

A. Is there a stated theory of values on which the study draws its methods?
B. Does this study clearly address values within a stated type of communication or discourse?
C. Does this study employ a systematic method for identifying those values?
D. Does this address cultural, social, or socio-cultural values of health, food, or a specific culture that is applicable, hypothetically or logically, to nutrition in Appalachia?

Research Question 2 (Coding: 0 – does not address, 1 – addresses indirectly, 2 - addresses somewhat, 3 – directly addresses)

E. Does this study clearly address cultural values of food, health, or nutrition?
F. Does this study clearly involve people of Appalachia or within the Appalachian boundary?

Finally, each article's quality was assessed. Only articles with clear research questions, method, analysis, and presentation of findings were included. While the researcher was open to the inclusion of non-peer-reviewed publications to be considerate of work published by those in the Appalachian population specifically, ultimately there were no relevant works that met criteria.

### 3.4. Synthesis of Research

The final list of articles produced were each analyzed individually and the following data collected and summarized:

1. Research question(s)

2. Population(s) researched
3. Characteristics of population(s)
4. Type of discourse/communication studied
5. Phenomena involved
6. Field(s) of research
7. Theory/Worldview(s)
8. Method
9. Data/findings
10. Definition/use of culture/cultural values
11. Model of value identification used (if any)

Content summarized within each of the 11 areas was then analyzed for recurrent keywords, subject areas, and other thematic commonalities. Frequency of each theme was then tallied, indicating prevalence of those themes for each area. These thematic results are presented in tables 4.2.a, 4.2.b, 4.2.c, and 4.2.d.

# CHAPTER 4

# RESULTS

## 4.1. Results of literature search and assessment (Tables 3.2.a and 3.2.2)

### 4.1.1. Research Question 1.

Systematic searches using criteria from Table 3.2.a. produced 1,241 articles that addressed the first research question: “what are models of cultural value identification applicable to discourses of nutrition (food and health)?” Articles were coded per their ability to address questions A, B, C, and D below:

A. Is there a stated theory of values on which the study draws its methods?
B. Does this study clearly address values within a stated type of communication or discourse?
C. Does this study employ a systematic method for identifying those values?
D. Does this address cultural, social, or socio-cultural values of health, food, or a specific culture that is applicable, hypothetically or logically, to nutrition in the central Appalachians?

One hundred and twenty-one articles remained after discarding those articles with scores below three for question A, thereby eliminating studies that did not have clear theoretical foundation in cultural or social values theory or were working from a defined definition of social or cultural values. Discarding those articles with total numeric coding below seven for assessment questions B through D produced a list of 31. Further culling articles for clarity of research question, applicability of method, and evidence of empirical research findings left nine articles remaining for meta-study.

### 4.1.2. Research Question 2.

Eighty-four articles were produced from the search criteria in Table 3.2.b address the second research question: "what are the social and cultural values evident in research about health, food, and nutrition in Appalachia?" Articles were coded per their ability to address questions E and F below:

E. Does this study clearly address cultural values of food, health, or nutrition?
F. Does this study clearly involve people of Appalachia or within the Appalachian boundary?

11 of 84 articles remained after discarding those articles with numeric coding below six for assessment questions E and F. Further culling articles for clarity of research question, applicability of method, and evidence of empirical research findings left eight articles for meta-study.

## 4.2. Synthesis

### 4.2.1. Coding, Themes Present

**Themes in research question 1**. *(Table 4.2.a. and 4.2.b.)*

The resulting roster of nine articles included in the meta-study are listed in Table 4.2.a. below, with author(s) name and publication date, sorted chronologically in the first column. Table 4.2.a. exhibits the studies' phenomena, populations, and discourse types studied, methods used, and a summary of the data collection process. Table 4.2.b. exhibits the studies' theoretical models of values, applicable definitions of cultural, social, or socio-cultural values, and values studied. Below are the resulting commonalities found across the studies, addressed as "themes", and grouped by data category.

*Table 4.2.a. Method, discourse type and other categorical information for articles addressing research question 1.*

| Authors (Pub. Date) | Phenomena | Population | Type of communication/ discourse | Method(s) | Data collection and analysis |
|---|---|---|---|---|---|
| Baek and Yu (2009) | incidence of health promotion strategies (general) and 1 cultural dimension (individualist/ collectivist) as culture-bound health promotion strategies. | US and South Korea (indirectly) | website - front pages only | content analysis; human coders; inferential statistics: Chi-square and Fisher's Exact test, Independent T-test | Sites found through Google using key words. Culled list through systematic random sampling, dice rolls. Exclusion criteria weeded out inappropriate subjects (sales-only sites or those run by individuals.) 200 selected for coding, 100 each country. Coding scheme developed from health promotion strategies and advertising appeal types. |
| Cheng and Patwardhan (2010) | cultural values present in television commercials | Chinese and Indian culture | television - commercials | content analysis, human coders; descriptive and inferential statistical analysis | Methods established by Nuendorf, 1998 and 2002. Commercials from 3 Chinese TV channels and 3 Indian channels. Data were collected over a 1 week period, resulting in 28 hours of commercials with 687 Chinese commercials and 221 Indian. Coding sheet developed used Cheng's 1994 and Pollay's 1983 frameworks for the typology of cultural values, and product categories and brand origin. |
| Hoffman and Slater (2007) | values present in news about health policy, including alcohol, tobacco, illegal drugs, and crime. | Broadly, journalists and their publics. | print - newspaper forum pages (letters to the editor, editorials, and opinion columns) | content analysis; human coders; measurement of integrative complexity using Krippendorf's alpha; regression analysis | 18 local daily newspapers pulled from six designated market areas (representative of 1/6 the population each) and 1 national daily (USA Today) were sampled during one month. Coding sheet slightly modified from Suedfeld and Weiszbeck |
| Lopez-Class, et al. (2011) | patient's perception of social, cultural, and health care system factors that impact their quality of life and the survivorship experience | Breast cancer survivors, immigrant Latinas | transcripts - interviews and focus groups | content analysis (thematic) using NVIVO 8 software; interviews, focus groups | Qualitative; In-depth Interviews (19), 2 focus groups (9) |
| Pashupati and Vasavada-Oza (2010) | cultural values present in children's television commercials | Children in India and US | television - commercials | content analysis; human coders; inferential statistical analysis: Chi-square | 3 children's networks with 3 time slots in one month |
| Sachau and Hutchinson (2012) | incidence of culturally relevant design features on U.S. and Mexican Web site interfaces. | Adult Latina/os Web site users, specifically of Mexican heritage | web sites | content analysis; human coders; Inferential statistical analysis: T-test | 20 websites selected from 50 US food stamp sites and 31 Mexican state government sites. |

| | | | | | |
|---|---|---|---|---|---|
| Waheed, Schuck, Neijens, and de Vreese (2013) | evidence of values in speeches | Many, indirectly | transcripts - interviews; indirectly, speeches | content analysis; semi-structured interviews; human coders; MaxQDA for data analysis | Interviews with 13 current and former speechwriters at the UN in NY HQ (through snowball sampling). |
| Yoon (2002) | incidence of collectivism/ individualism and hard sell vs. soft sell in advertising between 1987 and 1997. | South Korea | print - magazine advertisements | content analysis; human coders; Inferential statistical analysis: Chi-square analysis | from 4 monthly Korean publications (2 popular with females, 2 popular with males) in the October 1987 and October 1997 issues. |
| Rimondini et al. (2015) | cultural preferences for communication styles in doctor-patient conversations | The Netherlands, the UK, Italy, and Belgium | transcripts - doctor-patient communication – simulated, focus group | content analysis; focus groups, simulated situations; Inferential statistical analyses: Chi-square and adjusted residual analysis | 35 focus group discussions across 4 countries (9 for 3 countries, 8 for 1), feedback on a simulated medical interview. |

### *Fields of Study*

Most of the journal articles were produced from communications-centered publications (6 of 9), with significant representation from Asian journals; journals including *Asian Journal of Communication* (3 articles), *Media Asia* (1 article), *The International Communication Gazette* (1), and *Journalism and Mass Communication Quarterly* (1).

Given the evaluation requirements of "D" in answering research question 1, an expected heavier representation of health and health communications study areas was evident. While there were two studies represented in specifically health-focused journals—*BMC Public Health* and the *Journal of Cancer Education*—three studies published in non-health-related journals addressed health communications as well. Variances in journal focus areas produced, predictably, studies that varied in focus. The communications-focused journals presented health communications research that addressed public health issue reporting, health promotion

strategies, and values revealed in health-related newspaper articles, television advertisements, and printed advertisements. The health journals area of study included doctor's communication and quality of life for Latina breast cancer survivors.

Not all articles addressed health issues. Other topics included socio-cultural values embedded in U.N. speech writer's work (1 article in *Journalism and Mass Communication*), web interfaces for Latino/a web users (1 article in *Education Technology Research*), and cultural values present in children's advertising (*Media Asia*) and adult advertising (*Asian Journal of Communication*).

***Methods, Data Collection, and Discourse Types***

All of the 9 studies used content analysis as the primary method of data analysis, with both descriptive and inferential statistical analysis used across the board as a means to quantify and tally presence of phenomena and to test for significant differences between variables. Discourse types upon which the content analysis was performed, coding sheets, and software packages used for content analysis varied.

The coding sheets were developed largely by human-performed content analysis, although there were software packages-- NVIVO8 and MAXQDA, both qualitative data analysis tools—used in tandem in two studies. Coding sheets were developed using a variety of theoretical backgrounds and prior use in the industry of discourse type under study. (Theoretical backgrounds used in the development of the coding sheets will be discussed under the section below.) Five studies used chi-square analysis (those that were analyzing primarily samples from within one population), representing the most common method of statistical analysis, used to assess observed versus expected incidence of phenomena. Other statistical analysis methods used included T-test analysis, regression modeling, and measurement of integrative complexity.

Studies covered electronic, print, and interpersonal media through the analysis of website pages (two studies), magazine advertisements (one), news forum articles (one), television advertisements (two), and transcripts (three: one focus group-based study, one interview-based, and one study analyzed both interviews and focus groups).

*Table 4.2.b. Socio-cultural values studied and theoretical bases evident in studies addressing research question 1.*

| Authors (Pub. Date) | Theory/ Worldview (related to culture and values aspect of research) | Definition of values/ culture | Values studied |
|---|---|---|---|
| Baek and Yu (2009) | Behavior change theory; including the health belief model, the theory of planned behavior, social cognitive theory, and the trans-theoretical model. Also influenced by theories of relational communication, persuasion, and social marketing. | "Cultural values are characterized as the deepest manifestations of culture within a given society." (p. 21) Hofstede's cultural value typology within field of social psychology, with four cultural dimensions, including: indiv./ collectivism, power distance, masc./ fem., and uncertainty avoidance. | individualism vs. collectivism |
| Cheng and Patwardhan (2010) | 1. convergence and divergence in human behavior (de Mooij)<br>2. cultural values - (de Mooij 2010, Giddens 1989, Hofstede 2001 & 2005, Inglehart 1990, Kluckhohn & Strodtbeck 1961, Rokeach 1968)<br>3. dimensions of national cultural model: individualism vs. collectivism (Hofstede 2001)<br>4. reflection hypothesis and value paradox concept (Tuchman 1978)<br>5. Advertising as a "distorted mirror" (1983) | "A value is an enduring belief that a specific mode of conduct or an end-state of existence" (Rokeach, 1968, p. 160); "*cultural values*, 'the governing ideas and guiding principles for thought and action' (Srikandath, 1991, p. 166)" | 15 values (based on Cheng): modernity vs. tradition, individualism vs. collectivism, hedonism, veneration for elders, manipulation of nature vs. oneness with nature, youth, health, wisdom, patriotism, effectiveness, efficiency, quality, others. |
| Hoffman and Slater (2007) | Schwartz's theory of cultural values (1992, 1994, 1996). (Specifically not Rokeach or Inglehart) | "Values serve as the underlying mechanisms of attitudes and can dictate which attitudes people consider to be personally important. (Kristiansen and Zanna, 1988) Values also transcend specific situations and differ from attittudes in their generality (Schwartz, 1992), can be ranked hierarchically by relative importance (Mayton, Ball-Rokeach, and Loges, 1994; Verplanken and Holland, 2002) and do not decay (Mayton, Ball-Rokeach, and Loges, 1994). People often use values to organize their positions on issues (Jennings, 1991; Tetlock, 1986), and values have been found to determine virtually all kinds of social behavior (Jennings, 1991; Tetlock, 1986). | Power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, security. (Schwartz) |

| | | | |
|---|---|---|---|
| Lopez-Class, et al. (2011) | Cultural and social anthropology approach, cross-cultural communications and cultural competency. There are multidimensional elements of culture that affect health, perceptions of disease, and medical care. Culture also creates meaning or structure when faced with uncontrollable events. Culture may affect recognition of symptoms, treatment options, care expectations, etc. | "Culture--or coherent and dynamic belief, lifestyle, and value systems passed from generation to generation--contribute to people's definition of health and well-being and influence how people interpret and manage the world around them." (p.725) | personalismo, or "warm, personal, and empathetic way of relating to others" (725); simpatia, or a "relational style that emphasizes expressions of graciousness and charm"; and "respect for individuals", or "feelings of high esteem for a person and a willingness to be influenced by that person."; familism, "strong attachment with one's nuclear and extended family"; "pudor", or a "sense of humility, modesty, or reserve related to self"; fatalism; religiosity; gender roles, female caregiving and male machismo. |
| Pashupati and Vasavada-Oza (2010) | Hofstede's cultural dimensions' theory (2001). Coding categories developed from typologies in Resnik and Stern (1977), Ji and McNeal (2001) (who came from Pollay, 1983, and Barcus, 1977). | *Not defined.* | Power distance, uncertainty avoidance, Individualism, masculinity, long-term orientation (Hofstede, 2001) |
| Sachau and Hutchinson (2012) | Hofstede's cultural dimensions' theory (2005) - They developed their coding instrument using 10 features drawn from Hofstede's work. | *Not defined.* | Power distance, collectivism, uncertainty avoidance (Hofstede's values) represented through prior studies in web site design analysis (various). |
| Waheed, Schuck, Neijens, and de Vreese (2013) | Rokeach (1973) and Schwartz (1992, 2001); interviewed speechwriters, influential on public discourse to assess former speeches written as well. Coded using Mayring (2000) and then later adapted to Schwartz's Basic Human Values (BHV) (1992). | "According to Schwartz (1992), values are desirable goals people strive to attain because they guide the evaluation of actions, policies, people, and events." "Furthermore, they are at the core of every culture which can be observed by people through their practices. (Hofstede et al., 1990)." Culture here is evaluated in terms of being developed or undeveloped. | Schwartz: power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, security |
| Yoon (Yoon) | Cultural dimension framework, as Hofstede and others have postulated. Used Han and Shevitt's (1994) classification of individualist/collectivist appeal coding. | *Not defined.* | Collectivistic vs. individualistic |
| Rimondini et al. (2015) | Hofstede's model of national cultural values. | *Not defined.* | Power distance, uncertainty avoidance, Individualism vs. collectivism, masculinity vs. femininity, long-term vs. short-term orientation (Hofstede; 1991, 2001) |

### *Theoretical models of social and cultural values*

The articles addressed different theoretical backgrounds depending on their area of study. For example, those articles focused on heath communications addressed theories of cross-cultural communications, culturally competent communications, and behavior change theory, while those addressing advertising incorporated relational communications, techniques of persuasion, and social marketing, for example. As this meta-study is focused on cultural values identification, the following frameworks are relevant to understandings of cultural and social

values. While various theoretical models of cultural values and value dimensions were discussed in each of the nine studies, there were only a handful ultimately used as frameworks for the aspects of data analysis concerned with cultural values within these nine studies. Referenced works and models included Geert Hofstede's "cultural dimensions' theory" (2001, 2005), Ronald Inglehart's "world values survey" (1990), Milton Rokeach's "values survey" (1968, 1973), and Shalom H. Schwartz's "theory of basic human values" (1992, 1994, 1996).

***Values studied***

Values studied depended on the author's framework for cultural values (largely driven by either Hofstede or Schwartz's models). The most common values studied were collectivism and individualism (six studies), represented as polar dichotomies by both Hofstede and Schwartz. The full roster of Hofstede's values, including power distance, avoiding uncertainty, masculinity/ femininity, and individualism/ collectivism, were used as an analysis framework for variables in four of the studies. Schwartz's ten cultural dimensions, including: power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security, were used as an analysis framework for variables in two studies. Lopez-Class et al. used an anthropological approach and was the only study to not incorporate Hofstede or Schwartz's cultural values theories into their coding schema or framework (although a few studies incorporated schema related to descriptors outside of a values dimension, such as product type). The Lopez-Class study observed incidence of values evident from anthropological research on the Latino/a culture specifically.

***Limitations and findings***

The articles all could identify cultural values per their framework of choice and within the discourses they studied. Studies focusing on more than one culture were all able to evidence

significant value deviation between cultures within the discourses they observed, although degrees of significance varied.

There were commonalities among the study's limitations. Challenges outlined by the authors in most cases were necessary due to issues of time and access, and included smaller-than-ideal sample size, reliance on a convenience sampling approach, limitations on data compilation times, and inter-coder language barriers (verification of coding across two or more languages). Studies that assessed discourse across multiple cultures faced more challenges due to language differences. Also, most studies with smaller sample size were more adversely affected by the inability to consider individual experiences or backgrounds, instead grouping individuals broadly by ethnic or cultural background.

**Themes in research question 2**. *(Tables 4.2.c. and 4.2.d.)*

The resulting roster of eight articles included in the meta-study are listed in Table 4.2.c. below, with author(s) name and publication date sorted chronologically in the first column. Below are the resulting commonalities found across the studies geographical focus, populations, fields, methods, and socio-cultural values.

*Table 4.2.c. Categorical information for articles addressing research question 2.*

| Author (Pub. Date) | Health Issue | Stated Field(s); Primary/ Secondary | States & Regions | Population Characteristics | Phenomena Studied | Methods |
|---|---|---|---|---|---|---|
| Smith & Tessaro (2005) | Diabetes | Public health/ health behavior | The "rural Southern Highlands", 4 counties in WV representative of the whole | high poverty, low educational attainment; residents of areas with an aging population and high incidence of obesity. | Beliefs about diabetes | 13 focus groups, Transcripts analyzed using QSR-N4 software |
| Coyne, Demian-Popescu, & Friend (2006) | General health | Public health/ medicine | 5 Southern WV counties | Coalfield-heavy areas; have lived most their lives in WV and have family of the same | Self-identity and perceptions about religious faith, gender roles, fatalism, and patriarchy. | 10 focus groups, separated by sex. Used purposive sampling, "content analysis" on transcripts. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Deskins et al. (2006) | Cholesterol and heart disease | Clinical psychology/ public health, rural health | 6 WV counties of varying degrees of rurality, intended to be representative of whole | Rural, impoverished; identified as having increased risk of heart disease, atherosclerosis | Participation in cholesterol screenings for heart disease prevention in schools | 28 focus groups and 23 semi-structured individual interviews. Transcripts analyzed using QSR-N6 software. |
| Hayes (2006) | General health | Gerontology/ public health, rural health | 2 counties in central Appalachian region of TN | Rural, remote areas of mountainous terrain; elderly women aged 75+ years who live alone. | Perceptions of health and healthcare, influence of cultural norms on health choices | Qualitative descriptive study: 28 individual interviews, purposive sampling |
| Barish & Snyder (2008) | Alternative healthcare | Nursing | Appalachian areas of (in order of representation) VA, TN, KY, SC, NC | Rural with limited healthcare access | Choice of alternative healthcare and beliefs about health and healthcare | 125 surveys, 8 individual follow-up interviews |
| Della (2011) | Diabetes | Public health/ rural health | Eastern Appalachian KY, specifically Boyd County | Residents in impoverished areas, those with population declination, and geographically isolated; classified as high-risk for diabetes. | Perception of susceptibility and severity of diabetes | 55-item intercept survey administered in 2 large retail outlets. Descriptive statistics and t-test used to analyze data. Used HIV/ AIDS survey questions as template. |
| Nemeth et al. (2012) | Tobacco use | Public health/ community health | 4 counties in OH, representative of all Appalachian areas in OH | Males who use smokeless tobacco | Cultural beliefs supporting use of smokeless tobacco | 15 focus groups, separated by sex and adult vs. adolescent; 23 individual qualitative interviews |
| Snell-Rood et al. (2016) | Depression | Orthopsychiatry/ behavioral science | Southeastern KY | Women with depression | Socio-cultural values that influence treatment seeking | 28 semi-structured interviews, purposive sampling, "directed content analysis approach" |

***Geographic area.*** All states in Northcentral (Ohio, West Virginia), Central (Kentucky, West Virginia, Virginia), and Southcentral Appalachia (Tennessee, North Carolina, Virginia). were addressed by at least one study. West Virginia populations were the sole focus of three studies, while Kentucky populations were the sole focus of two. Ohio and Tennessee populations each were the focus of one study, and North Carolina and Virginia populations were addressed through a handful of individual participants in one multi-population study.

***Population characteristics & health issues studied.*** Each study varied to the level of demographic and characteristics description given to their researched population. Authors commonly noted that populations under study were rural (three studies), low-income or impoverished (three), geographically isolated (two), aging population/ population declination (two), low educational attainment (two), and with limited healthcare access (two). Five studies addressed both males and females, while three studies were focused on sex-specific health concerns (two female-focused, one male).

Health concerns studied included diabetes (two studies), heart disease, depression, and tobacco use, all known epidemic issues in Appalachia, while three studies addressed general beliefs about healthcare and health treatment.

***Fields and methods.*** The field of study indicated by the authors and classified by the peer-reviewed periodicals were used to classify articles in the "Stated Field(s): Primary/ Secondary" category. Six of the eight articles explicitly situated the research in public health, while the remaining two were more specific to the expertise of their authors, nursing and orthopsychiatry. Within the public health arena, there were specializations evident in various sub-fields, including rural health, community health, health behavior, clinical psychology, and medicine.

Data collection methods used were largely qualitative and included individual interviews (five studies), focus groups (four), and surveys (three); while three studies used a combination of two methods, focus groups and individual interviews (two) and survey and individual interviews (one). Sampling was often directed by community members or health providers engaged with the population under study, and was "purposive" in nature. The personal interviews conducted were

"semi-structured," permitting the facilitators to guide and time questions as individuals became more comfortable and communicative.

*Table 4.2.d. Socio-cultural values and theoretical bases evident in studies addressing research question 2.*

| Author (Pub. Date) | Values Found/ Not Found | Socio/ Cultural Values - detail |
|---|---|---|
| Smith & Tessaro (2005) | found: traditions, hard work/work ethic, anti-government/ authority, self-reliance, aversion to new things<br>not found: fatalism | diabetes a relatively new disease because of change in modernity (shift away from traditional lifestyle and hard work), imposing role of government and social services, emphasis on self-reliance and value of traditional lifeways (herbs, home remedies and anti-prescriptions), belief that diabetes is caused by sugar and inactivity (and therefore self-induced, moral weakness, laziness and therefore high shame), self-management practices that are practical (yet "noncompliant technically) adaptations of clinical advice, challenge interpreting nutritional information, believed in foot care and vitamins/ herbs, while recognized exercise's place, very few applied this to their own circumstance, didn't like the foods on the diet (or diets not inclusive of foods they liked). Noted that fatalism not really found here, even though the belief that it existed was still high. Said very few empirical recent studies backed up fatalism. Also, found very little reference to God's doing but instead broadly linked to individual behavior. |
| Coyne (2006) | found: community & family ties, spirituality/ religiosity, rule-followers, hardworking, privacy<br>not found: fatalism, patriarchy | Sense of place, family ties, strong spiritual belief/ faith in god, pride. Fatalism and patriarchy were not strong.<br>Appalachian identity (not with that term per se): friendly, god-fearing, proud, law-abiding, hardworking, clannish, reluctant to share family problems. |
| Deskins (2006) | found: fear of new/ unknown, traditions, resistance to change, fatalism | Adults: fear of the unknown when receiving a diagnosis, fear of pain (needles), "traditional Appalachian beliefs" which included "resistance to change, denial, fatalism".<br>Children: fear of pain, fear of unknown (negative diagnosis), privacy among peers, not concerned about health aspect in general |
| Hayes (2006) | found: hard work, self-reliance, privacy, self-direction, hedonism, benevolence, religiosity (less so) | Informal care. 1. Doing what matters (would physically do whatever they needed to, belief that this and activity would keep them healthy), 2. Health and home as solitude (freedom in solitude, strong sense of place identity, nobody to boss them around, ability to focus on the things that they liked like gardening and quilting) 3. Living for the moment (don't want to focus on preventative care because it's in the future, living one day at a time), 4. Caring without asking (did not want to ask, sense that one should know to "care for your own"), 5. Wearing illness out (they could take care of things by "wearing out illness", did not find strong correlation with fatalism, the women wanted to take care o things themselves, like with eating honey and molasses to build blood count)<br>Formal care. 1. On my own (no need to see doctor unless there is an incident or illness of some sort, no partnership in prevention), 2. Relationships matter (wanted continuity of doctor, valued the long-term, thought they would know them best, transferred general feelings of relationships to doctors, but really they didn't know what the doctors wanted them to know like pill dosage or reasons for prescriptions; needed time, connectedness, active listening and dialogue to follow through), 3. Lack of fit (using services—like community center—didn't appeal to their lifestyles or timeline—like transportation services)<br>Religion important but didn't get indicated as theme. |
| Barish & Snyder (2008) | found: traditions, openness to new/ unknown, spirituality | preference for traditional medical professional; aversion to non-personalized care; willingness to try alternative treatments, specifically use of family/ community remedies and use of prayer (63%) |

| | | |
|---|---|---|
| Della (2011) | found: self-reliance, privacy, self-direction, benevolence | Diabetes can be managed by the individual, reluctance to involve other community members, even family (self-management specifically through diet). Shows conservative, individualistic culture. Did not adequately assess their own risk (although women more so than men), and thought they were all in generally good health. Recognized that risk was inherited and that being overweight was a risk factor.<br>Individuals were not concerned with social stigma, but author thought that perhaps this would change should they use a population already saddled with diabetes.<br>For men, a personal experience with diabetes (even someone close to them) was educational and influenced their belief that the community should be involved (collectivist).<br>People understood risk factors but did not internalize them or self-apply. |
| Nemeth et al. (2012) | found: masculinity, achievement | Smokeless tobacco use is both: 1. a part of Appalachian identity and 2. a masculine act. |
| Snell-Rood et al. (2016) | found: distrust of authority, self-reliance, privacy, conformity, religiosity | 1. Doubts about treatment necessity/ efficacy, 2. Self and external stigma against depressive symptoms, 3. Efforts to cope without treatment. Women's desires to control their worries, think positively, and endure hardship with evangelical ideas about wellbeing described by other researchers. Some voiced this in explicitly religious terms, while others secular. Took pride in coping mechanisms, socially pressured to see through lens of faith, fear of being misunderstood, struggle to be positive, and frustration with waiting for change. Stressed individual responsibility even though recognized poverty. Thought depression was an individual struggle rather than an illness. Must "keep going". |

### *Prominent socio-cultural values found*

*Theme 1. Self-reliance.* This value was expressed in several ways, and often overlapped with the idea of hard work, represented as a different theme (below) when the meaning was geared more toward "effort". Some studies alluded to a general sense of work ethic, while others indicated that self-reliance manifested as a desire to amend one's health issues without assistance from others, or independence. In some instances, there was a corresponding allusion to self-direction, whereby study participants were averse to outside input, even from close family members, instead preferring to make decisions about their health in isolation.

Smith and Tessaro (2005), studying beliefs about diabetes in West Virginia, found that self-reliance was a historically linked value: "In the past, people depended on themselves for the necessities of life in an unstable local economy. This attitude of self-reliance continues to be embedded in the culture. A major concern among participants both with and without the disease was losing independence and becoming a "burden" on others if complications should result in

blindness or amputation. Consistent with this idea of self-reliance was the belief that managing diabetes is the sole responsibility of the patient. (p. 294)" In studying attitudes toward diabetes self-care, Della's (2005) findings concurred: "When asked whether they thought diabetes was something that individuals living with the disease should be responsible for managing by themselves or whether others in the family and/ or community should help, most respondents expressed a strong belief in self-management. (p. 7-8)" This emphasis on independence is a noteworthy contrast to the community-focused assumptions about Appalachian people in the public consciousness. Hayes' work focused on gerontology and perceptions of elder health care in Central Appalachian Tennessee, but expressions of self-reliance as rooted in tradition were similar to the findings of Smith and Tessaro: "For these Appalachian women, physical activity was a part of their traditions, and despite limitations brought about by aging, they believed remaining physically activity would enable them to keep "doing those things that really matter," which were remaining active, maintaining their health, and living alone. (p. 286)" Outside expertise was largely unneeded and unwelcomed, with a strong preference for self-direction: "All study participants perceived themselves as experts in their own health and illness care, and they expressed confidence in their abilities and resources to cure themselves when ill. (p. 286)"

Snell-Rood (2016) also identified self-reliance as a theme, but its manifestation was necessitated by privacy and a strong work ethic. The authors noted that "'Keep going,' Was the mantra of many who tried to take each day at a time by taking care of family members and cleaning. (p. 6)" and that "If women expressed their depressed feelings, they had to contend with others' reactions. In some cases, women explained that family members who heard their feelings might intervene in situations that they wanted to handle independently. (p. 5)" Independent decision-making was a key factor for women choosing to self-manage their health care.

*Theme 2. Privacy.*

The need or desire for privacy was mentioned in several articles, although the definition of privacy varied between self-contained information and information kept within the family. Coyne (2005) studied attitudes about health in coal-industry-heavy areas of West Virginia and found that privacy, and the relegation of health issues and decisions, was an affair for immediate family only in most cases: "Participants reported that family members usually deal with family problems internally and that sometimes second-degree relatives, such as aunts, uncles, or grand-parents are included in the process. Although family problems are considered private and not to be shared with the community, an exception is sometimes made by involving the church. (p. 5)" Snell-Rood's participants detailed a more specific anxiety in terms of privacy, explicitly the fear that others might come to know their troubles: "Women described a fraught process between what they knew of their own feelings and what others might come to know of them. (p. 5)" Perception of others outside themselves or their immediate family was of primary concern, and often prohibited the sharing of health situations or medical needs, especially when related to mental health. Coyne continued: "Families often do not allow their children to know about problems families face. When they do know about problems, children are told not to discuss them beyond the family circle. (p. 5)"

*Theme 3. Spirituality/ religiosity.*

Religion was identified as both important in the consideration of health care decisions and key to the community identity. Faith was considered an inherited lifestyle or tactic, an approach to life made relevant because of its longevity and persistence within the community. Coyne relayed that "Religion, family cohesion, friendship, health, and integrity are important values according to participants. Faith appears to be a traditional value that has been carefully

passed down from one generation to another… Many participants believe that deep religious faith has its origins in the early years when West Virginia was settled. Life was hard, and people sought relief in religious faith. Spiritual beliefs offered emotional and spiritual support, and churches served as a bonding element in communities. (p. 4)" Religious faith and the resultant community formed around it, or the institution of the church, functioned as both outlet and support, tactic and identity. Barish and Snyder (2008), in studying attitudes toward alternative forms of health care, found that "The majority of respondents expressed the importance that their religious beliefs have in healthcare practices. (p. 225)" While independence and self-reliance were recurrent themes, trust in a higher power in regards to decision-making was largely exempted from or external to those preferences.

Comments about faith and spirituality and their direct influence on health were centered on the impact of prayer and trust in God as a form of healing. Snell-Rood explained: "A number of women felt that through reflection and prayer, they could endure the problems that were at the root of their depressive symptoms. (p. 6)" Trust in god was paramount to retaining a sense of security and often prohibited women from seeking outside help: "For some women, the desire to suppress depressive feelings emerged from religious faith. 'I try not to worry,' noted one woman. 'The Lord tells you not to worry but sometimes it's hard not to worry.' (Snell-Rood, p. 5)"

*Theme 4. Tradition/s.*

References to tradition surfaced as both culture-specific lifestyle traditions (home remedies and ways of tackling everyday life situations) and beliefs, broadly. Smith and Tessaro noted that there had been a "shift away from traditional subsistence lifestyles on family farms and the decline of the once prosperous coal economy in West Virginia. This divergence from the old way of life is characterized by the decline of 'hard work,' decreased activity, and the addition

of daily stress. (p. 294).” Here, tradition is connected to industry, with the community impacted by the departure from historic economies. With the hard work required by coal mine employment came certain necessities that are no longer valued or embodied as deeply, in the participant’s views. The coal industry, generally, was viewed favorably because of the steady income and activity that it brought to the surrounding communities. Left without these endeavors, individuals had less opportunity for activity and income, more time for negative behaviors, and thus additional stressors.

Tradition also extended beyond employment to lifestyle. Barish and Snyder found that home remedies were preferred as a first line of action against health issues: “The majority of those interviewed reported previous or current use of the family- and community-taught remedies… Respondents did not view any family-taught remedies as a form of CAM (Complementary Alternative Medicine). (p. 225)” Participants did not view their traditional methods of non-medically advocated treatment as alternative, rather there was a normalization of these methods. Deskins (2006), in researching acceptance of heart disease prevention-methods, found that traditional beliefs often served as a barrier: “The primary attitudinal barriers to participation in health screenings were traditional cultural beliefs. For example, beliefs such as resistance to a preventative approach to health, resistance to new people and ideas, using denial as a coping strategy, and having a fatalistic view toward health were predominant sentiments attributed to their communities by participants. (p. 370-371)” Hayes (2006) researched elderly female populations and found that individuals were more likely to try their own remedies before seeking professional medical assistance: “The words of one woman reflected a common traditional home remedy… solstice and other “rub ons” were described as often as home

remedies that were useful in wearing out illness. (p. 289)" This sentiment, that illness or disease could be treated, or "worn out", through traditional methods, was common.

*Theme 5: Hard work*

Hard-work was intertwined with the concept of self-reliance. Hayes found that the women in her study found both solace and sense of purpose in the rigors of everyday living. Chores and the routine of work created a supportive foundation for a healthy, meaningful life: "For these Appalachian women, home was a place for cooking, cleaning, exercise, reading, creative expression, and connection to the natural world in solitude… these everyday activities were ways in which they maintained their health. (p. 286)" In several studies, hard work resonated with the participants. Through hard work, individuals could avoid laziness and sloth, and found pride, purpose, and healthfulness through activity.

***Less prominent socio-cultural values found.***

*Distrust of authority/ government.*

Distrust of authority/ government, although a common theme in stereotypical representations of Appalachian people, was less evident in this collection of studies. Smith and Tessaro did locate some resistance to dependence on outside benefactors as related to self-reliance: "Economic decline has resulted in a consciousness of the growing, imposing role of government agencies and services such as Medicare, Medicaid, and Social Security Insurance. Governmental assistance is not usually regarded favorably and is associated with decreased self-reliance. (p. 294)" In addition, governments, and by extension medical facilities, were also regarded relatively unfavorably to some when used as a replacement for independent or familial decision-making. Coyne (2006) found that "Agencies are regarded as replacements for parental authority or family decision making. (p. 5)" Outsiders were also viewed with distrust, although

this was specifically aimed at non-American-born individuals: “Some participants expressed concern about a lack of American-born physicians in their geographic area and seemed disgruntled about having to see a foreign-born physician for medical care. (p. 5)” Coyne elaborated that distrust of medical professionals often was the result of fear around substance-abuse— “There is distrust of specialists because people fear they will prescribe medicine that could cause addiction, and there is concern that family problems will become public knowledge. (p. 5)”—and lack of personal care: “Depending on personal experiences with the medical system, participants reported that some southern West Virginians distrust physicians or question the quality of care they receive. (p. 5)”

*Fatalism:*

Fatalism, or the belief that all events are predetermined and therefore inevitable, was found in one study (Deskins) but found to not occur in another (Hayes). In Deskins study, participants felt that there was little they could do to affect their health outcomes: “thematic analysis identified a fatalistic view of life, confirming previous views attributed to some Appalachians… Another parent remarked, ‘They just feel it’s [heart disease] going to get them no matter what. It doesn’t make any difference. That’s pretty much the whole attitude.’ (p. 371)” However, Hayes did not find evidence of fatalism often attributed to Appalachian culture: “Previous studies often associate the Appalachian culture with fatalism, a belief that illness cannot be prevented, rather only coped with. This belief was not consistent with the findings of this study. (p. 289)”

*Fear of Unknown*

Deskins noted a very slight incidence of fear of the unknown: “While some concern was linked to fear and anxiety about the test results (eg, “I’m afraid of what might be found”), the

majority of adults specified environmental barriers such as the cost of *additional* testing as the reason screenings might be avoided. (p. 370)"

*Moral Character*

Smith and Tessaro noted that health issues such as diabetes were within an afflicted individual's control and therefore were indicative of moral character: "Because of the primary beliefs related to causation, diabetes is perceived as a self-induced disease…. Having diabetes is viewed as a moral weakness among participants. The diagnosis leads to blame and feelings of guilt. (p. 295)"

*Gender Norms*

Both Coyne and Nemeth reviewed gender norms within the context of their studies. While Coyne's results disputed commonly held beliefs about masculinity and patriarchal familial structure in Appalachia, Nemeth's research confirmed stereotypical definitions of masculinity. Coyne relayed that "The traditional family structure that includes a wife who stays home to rear children and a husband who is head of the household has changed in many Appalachian families. Both parents typically work outside the home and share decision making." Most men thought this had changed since older times, and women concurred that more patriarchal roles and decision-making responsibilities were being shared by women. Nemeth found that certain behaviors, namely use of smokeless tobacco products, was tied to a specifically Appalachian conception of masculinity and that to use such products would be anti-feminine: "Though spoken by an adult user, 'You know you got to be a man to rub snuff' was a common sentiment across adolescent and adult [tobacco] users and non-users… For this adult user, the very sight of young girls using defied expectations…" (p. 1210)" Nemeth also described that the masculine associations of smokeless tobacco usage were known to marketers in the area: "Cultural norms

are reinforced through ST [smokeless tobacco] products and their packaging. Participants perceived advertisements as reflecting masculine cultural standards valued in Appalachia. (p. 1211)"

### Theoretical Backgrounds

Most the studies presented did not specify a worldview or theory based understanding of cultural values. Those that did indicated clear theoretical backgrounds pulled from psychology (Deskins and the theory of planned behavior), gerontological studies (Hayes and hierarchical-compensatory models), and health behaviors (Nemeth and social-contextual models of behavioral change) Some studies did not specify a worldview or theoretical perspective outright, but did reference "commonly known" Appalachian attributes or values, presumably from experience and/ or anecdote when prior literary evidence was not noted. Where theoretical basis for socio-cultural values was unspecified, it unfortunately rendered indication of the basis by which they coded cultural values unspecified as well.

# CHAPTER 5

# DISCUSSION AND FURTHER STUDIES

## 5.1. Discussion

This study describes the results of two meta-syntheses of data pertaining to the research questions: 1) what are models of cultural value identification applicable to discourses of nutrition (food and health), and 2) what social and cultural values around nutrition (food and health) are apparent/ evident in research about Appalachia? For discussion, and with the goal of offering a model—framework, analysis methods, and tools—for identifying values embedded in nutrition-focused communications in Appalachia, we present here commonalities in method, discourse type, theoretical backgrounds, and data results from RQ1 and RQ2 that inform that goal.

None of the articles produced from the search addressed nutrition outright, therefore there were no direct links made between nutrition, or food and health, and theoretical models of socio-cultural values. Ultimately we must assess whether the theories and methods used in these studies can be extrapolated to apply to a future study pertaining to discourses of nutrition in a specific population or culture.

### Discourse Types

Nutrition information is disseminated to targeted populations in various formats and through multiple channels on a macro-level (pharmaceutical advertisements, internet-based "advice" columns and articles, and WebMD for instance) and micro-level (patient-provider interpersonal communications). The studies produced from RQ1 indicated applicability of using value theory to identify values in nutrition discourses, as the nine studies in the data set analyzed websites, television commercials, newsprint, advertisements, speeches, and doctor-patient

communications. Studies produced from RQ2 largely utilized content analysis, but the content analyzed was largely transcripts from interviews and focus groups. This was expected as prior searches for value identification studies specific to Appalachia and/ or nutrition communications did not produce adequate results and inspired this study.

## Theoretical Models of Values

Expressly stated models of cultural values were incorporated and used as a basis for content analysis in six of the nine studies produced through the literature search for Research Question 1: four to Hofstede and two to Schwartz. The three other studies utilized theories of cross-cultural communication, culturally-sensitive communication, and behavior change theory. These three studies, while not utilizing specific models of socio-cultural values for their data analysis, did produce some value results that fit either directly or indirectly within the value models of Schwartz, Hofstede and Inglehart (as will be enumerated below).

## Values Present in Research about Appalachia

There were a number of values present in the literature produced from the search for RQ2 that aligned with Schwartz's Theory of Basic Values and/ or Hofstede's Cultural Values, some directly on a one-one basis and others indirectly, or as a combination of values. The coincidence of these values and their theoretical counterparts helps structure our value identification model. This is key as these alignments provide the ability to test for specific values within a discourse and the ability to tailor culturally-sensitive communications to a target population or cultural group using the value as an underlying theme.

### *Self-reliance*

Self-reliance, connoting either hard work or independence depending on the study, was a pervasive theme within the data set. Schwartz's basic value of "self-direction" deals with the

ability of an individual to both make their own choices, and the capacity to act on those choices—both in terms of empowerment and physical and mental faculty. This value was also present in Hofstede's model as "indulgence vs. self-restraint," indicating the ability to influence life outcomes through intentional acts.

***Privacy***

Privacy, too, was a prominent theme in the study set. Individuals in Appalachia were often reluctant to share their health outside of a certain closed group of family members. There are no values offered by either Hofstede or Schwartz that mean "privacy", although it functions as the converse of Schwartz's "achievement" in that health issues are taken as signs of deficiency according to social standards in some cases. Similarly, Hofstede's "long-term orientation" deals with an individual's "face" and personal dignity perceived by the external world.

***Spirituality/ religiosity***

This value was highly apparent in the studies included, and is indicated by both Schwartz and Inglehart's models. In Inglehart's World Values model, the tendency toward spirituality or religiosity would indicate a higher score on the "traditional" (as opposed to the "secular-rational" value) scale. Schwartz included religion as related to "traditions" of a culture. Here the idea of "faith" could be directly correlated tied to Schwartz's concept of "self-direction", or the ability of an individual to control their life circumstances (through free will, etc.).

***Tradition(s)***

Tradition was a major value found within the study set. Hofstede's "individual-collectivism" continuum explores the relationship between group and individual, and is intimately tied to the accepted traditions, customs, and other social norms of a group versus an individual's potentially deviant path. Inglehart's World Values Survey set up "traditional vs.

secular-rational" as one of its two major dichotomies. Schwartz, too, finds adherence or non-adherence to tradition as key to a culture's identity.

***Hard work***

This value was not readily evident within the studied cultural values theories.

***Distrust of authority/ government***

Distrust of authority is indicated within the framework of Inglehart's "Survival vs. Self-expression" aspect: Individuals scoring high on in "survival" tended towards both ethnocentrism and wariness of either outsiders or those in power. Hofstede's "power distance" situated an individual's relationship with authority, and their feelings of power in terms of other's power. Schwartz's "universalism" speaks to tolerance and acceptance of outsiders or the "other", in this case potentially referring to those who would be in positions to mandate or regulate nutrition or health choices or who advocate for different lifestyles.

***Fatalism***

While fatalism is not a directly evident among the cultural values models, both Hofstede's "Indulgence vs. Self-restraint" spectrum and Schwartz's "self-direction" invoke themes relevant to a fatalistic view—empowerment, choice, and ability to influence life outcomes through actions and behaviors.

***Fear of the unknown***

While fear of the unknown was not prominent across the board in the studies produced from RQ2, it was somewhat evident. Hofstede's conception of "uncertainty avoidance" speaks directly to this value. According to Hofstede's model, cultures that score high in uncertainty avoidance also tend to be more close-minded, adhering to single "truth" and heavy rules and regulations. While the fear of the unknown in our data set was a reason given for unwillingness

to be tested for diabetes and heart disease in Appalachian populations, the presence of this value might lead the health communications professional to tailor communications according to the tendencies aligned with fear of the unknown according to Hofstede.

**Proposed Model of Value Identification**

The apparent cross-connection between fields (public health, health communications, public policy, and advertising for example), theoretical models, and research data indicates the need for further exploratory research linking the theories of Schwartz, Hofstede, and Inglehart (or other emergent models of cultural values) with current communications theory and practice, and the valuableness of this work. This meta-synthesis does not attempt to make a final determination about which theoretical model of values is more accurate or useful than another. As such, without further research rooted in value theory (outside of the scope of this communications-focused work) it is ultimately impossible to choose the "perfect" model from which to base a model of values identification for discourses of nutrition. Given that many values evident in the studies on Appalachian health align with those proposed in Schwartz, Hofstede, and Inglehart, it appears that any of these models could be potentially useful, providing a theoretical structure and/ or schema to assessments of discourses of nutrition targeted to specific populations or cultures such as those of Appalachia. Further research should be done to differentiate applicability of these models to health communications, likely by conducting comparison testing. Further research must specifically gauge the values of both Appalachians and the entities crafting the discourse targeted to them (providers, insurers, public health advocates, etc.), using these models, in order to provide a baseline for tailoring effective and resonant nutrition communications.

## 5.2. Proposed Further Studies: Phase I Survey

The purpose of this second phase of this research study is to discover the apparent values at the intersection of food, cooking, and health 1) communicated by Southern Appalachian health intervention providers and 2) held by the people they serve by sampling and surveying those two distinct populations. Values for our purposes will be defined by Shalom Schwartz in his *Value Theory* (Schwartz; 1992, 2006, 2012), as there is precedent within the marketing and communications field for doing so. The study will ultimately address one primary research question: what do practitioners of nutrition in Southern Appalachia understand about the values of health, food, and nutrition held by those they intend to serve?

### 5.2.1. Proposed Approach and Methodology

Communication materials are designed by individuals who must make assumptions about their audience, and in the case of health communication, in often highly sensitive situations. This study will address to what extent those value assumptions are revealed in communication. The manifestation of cultural values and understanding of audience in materials designed to educate or persuade is an issue that could be applicable to many genres of professional and technical communication, not just health communication. Therefore it is imperative that the values of the audience are clearly understood.

#### Participants

Four categories of nutritional information providers will be surveyed in the first phase of the survey distribution: 1) wellness program administrators within rural Appalachian health systems, 2) health educators in those systems, 3) health practitioners who work in Appalachian health

clinics, and 4) food bank administrators/ educators. The second phase of the survey distribution will record the responses of Appalachian individuals who are served by the above institutions.

Organizational and practitioner participants will be recruited individually by the primary researcher; chosen among 50 Southern Appalachian organizations, including rural health clinics, hospital systems with rural health programs, food banks, and other miscellaneous nutrition-related organizations within the geographic boundaries of Southern Appalachia.

**Design**

The questions in the Survey—designed to ascertain cultural values—are all based on the Schwartz *Survey of Basic Values* and *Portrait Values Questionnaire*. Individuals, organizational representatives, and practitioners will be asked to consider their clients and the populations that they serve when answering questions. The code in parenthesis will not be visible to the participant, and the pronouns will be adjusted for sex of participant.

1. Power (PO): Social status and prestige, control or dominance over people and resources. (social power, authority, wealth, preserving my public image)
2. Achievement (AC): Personal success through demonstrating competence according to social standards. (successful, capable, ambitious, influential)
3. Hedonism (HE): Pleasure and sensuous gratification for oneself. (pleasure, enjoying life, self-indulgence)
4. Stimulation (ST): Excitement, novelty, and challenge in life. (daring, a varied life, an exciting life)
5. Self-direction (SD): Independent thought and action-choosing, creating, exploring. (creativity, freedom, independent, curious, choosing own goals)

6. Universalism (UN): Understanding, appreciation, tolerance and protection for the welfare of all people and for nature. (broadminded, wisdom, social justice, equality, a world at peace, a world of beauty, unity with nature, protecting the environment)
7. Benevolence (BE): Preservation and enhancement of the welfare of people with whom one is in frequent personal contact. (helpful, honest, forgiving, loyal, responsible)
8. Tradition (TR): Respect, commitment and acceptance of the customs and ideas that traditional culture or religion provide the self. (humble, accepting my portion in life, devout, respect for tradition, moderate)
9. Conformity (CO): Restraint of actions, inclinations, and impulses likely to upset or harm others and violate social expectations or norms. (politeness, obedient, self-discipline, honoring parents and elders)
10. Security (SE): Safety, harmony and stability of society, of relationships, and of self. (family security, national security, social order, clean, reciprocation of favors)

Survey data will assess the assumption of values that nutrition program providers have about Southern Appalachian individuals that they serve or intend to serve.

**Procedure**

The survey will be administered via Qualtrics. It will compile data with a foundation in the Schwartz Value Theory, Participants in the first group will answer with their patients or their audience in mind; questions will be oriented around their perceptions of the people that they serve. The second group of Appalachian health service clients will answer for themselves.

Responses will be solicited over a period of one month. Data will be compiled by Qualtrics, with each value code (CO, SE, and TR for example) grouped and analyzed.

### 5.2.2. Proposed Survey Instrument

**Section I**

5 = very much like me, 4 = Like me, 3 = Somewhat or a little like me, 2 = Not like me, 1 = Not like me at all.

**Instructions**: Please answer the questions on a scale of 1 – 5, with 1 being "not like me at all," and 5 being "very much like me." If you do not know or don't understand the question, enter 0.

How much like you is this person?

1. It is important to her/ him to be rich. She/ he wants to have money and lots of expensive things. (PO)
2. It is important to her/ him to show her ability to make healthy foods. She/ he wants people to admire what she cooks for attention to health. (AC)
3. Having a good time with food is important to her/ him. She/ he likes to "spoil" him/ herself with treat or cheat foods. (HE)
4. She/ he likes to experiment and is always looking for new ways to prepare foods. She/ he thinks it is important to try lots of different cuisines in life. (ST)
5. Thinking up new ideas and being creative is important to her/ him. She/ he likes to put their own spin on recipes and dishes instead of preparing it the same way everyone else does (SD)
6. She/ he thinks it is important that every person in the community or school should have the same access to the same foods. They believe everyone should have equal opportunities to eat nutritiously. (UN)
7. It's very important to him/ her to help the people around them get healthy. She/ he wants to care for their health and wellness. (BE)
8. It is important to her to not eat a lot of fancy food. She/ he tries to draw attention to their food choices. (TR)
9. She/ he believes people should always do what they're doctor or nutritionist advises—when choosing foods. She thinks people should follow the nutrition rules their doctor sets, even when no one will know. (CO)
10. It is important to her/ him to live the healthiest they can to avoid illness. She/ he avoids anything that might endanger his/ her health. (SE)
11. It is important to him/ her to make her own decisions about what she/ he eats. She/ he likes to be free and not depend on others for food, recipes, or cooking tips. (SD)
12. It is important to him/ her to listen to health advisors who are different from her/ him or who are not from their area. Even when she/ he disagrees with them, she/ he still wants to understand them. (UN)

13. Showing other his/ her health achievements is important to him/ her. She/ he hopes people will recognize his/ her achievements. (AC)
14. It is important that the government insure her well-being by researching the latest health threats. She wants the state to stay up on the latest health and nutrition research so he/ she can always be healthy. (SE)
15. She/ he looks for new food adventures and new foods to try, and likes to take risks with flavors and textures. She/ he wants to have an exciting cooking and eating life. (ST)
16. It is important to her to behave properly and follow health professional's guidance. She/ he wants to avoid doing something wrong. (CO)
17. It is important to get respect from community members for her/ his ability to prepare meals. She/ he wants people to listen to her cooking and food advice. (PO)
18. It is important to her to do right by the people around her. She wants to do everything she/ he can to help them be healthy individuals. (BE)
19. She/ he strongly believes that people should eat foods from places that practice sustainable farming methods. Looking after the earth is important to her/ him. (UN)
20. Tradition, especially around meals and celebrations, is important to him/ her. She/ he tries to follow the meals and recipes handed down by her religion or family. (TR)
21. She/ he seeks every chance to have fun with food. It is important to do things that make eating a pleasure. (HE)

**Section II**

**Questions to establish sample characteristics (individual respondents only) will come at the end of the survey:**

A. Please select your sex:
B. Please select your age group:
C. Please select the race you identify with most: African American or Black, American Indian or Alaska Native, Asian, Caucasian or White, Hawaiian or Pacific Islander
D. Please select your ethnicity: Hispanic or Latino, Not Hispanic or Latino
E. Please indicate the city and state where you reside most of the time:
F. Please indicate the city and state which you consider your "hometown" of childhood:
G. Please indicate the number of individuals who live in your home at least 9 months per year.
H. Please indicate the average number of hours per week that you work for a paying employer. If you are self-employed please indicate the average number of hours that you work per week for yourself.
I. Select the range that reflects your annual income before taxes:
J. Please indicate your education status: Some High School, High School graduate, Some College, Associates Degree (A.A. or A.S.), Bachelor's Degree, Post-Bachelor's/ Professional Degree (R.N., etc.), Master's Degree, Ph.D. or Doctorate.

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