



6

Consuming Research

In this chapter, *Consuming Research*, we discuss research from the perspective of professionals as critical consumers and provide tips and skills for assessing research quality and understanding the implications of findings for culturally safe professional practice. We discuss logic systems and worldviews as they relate to creating, developing, and interpreting research through the lens of cultural safety. Research methods and processes, including community-based participatory research, will be explored in relation to culturally safe principles. The role of unethical research in our past in contributing to distrust of health care is examined along with research ethics today.

Chapter Objectives

After completing this chapter, you should be able to:

- discuss different logic systems and worldviews that influence research
- describe some research methods commonly used in health research, including community-based participatory research

- discuss historical ethical issues in research and how that can contribute to current distrust in healthcare
- apply strategies for reading and assessing literature
- describe the ways professionals can be culturally safe consumers of research.

What Is Research?

What does it mean to ‘research’? Research is what we do to find answers or to increase our understanding. We do it all the time. We conduct research to help us better understand an issue or a topic or maybe we have a specific question for which we are seeking an answer. Most people understand or experience research through online search engines such as Google, and certainly, this can be a good place to start. But research, in an academic sense, is substantially more than a Google search.

Consuming research—that is reading it, critiquing it, and being able to apply what is learned, is a critically important skill to have as effective, culturally safe professionals. Very few health and human service professionals will conduct research, but all should understand how to be culturally safe consumers of research.

One way to think about what we are doing with research is with the parable of ‘the elephant’ (Daigneault, 2013). In this parable, a group of men, who had heard about elephants, wanted to understand what an elephant was like, but were only able to examine an elephant through touch. Each undertook their own examination. Standing around the elephant, they felt what was in front of them and then compared notes. The man who touched the tail said an elephant is like a rope. One man touched the side of the elephant and proclaimed that no, it was like a wall. The man who touched the tail said the elephant was like a spear and the one who touched the trunk said an elephant was like a hose. While none of these men were wrong from their perspective, for each man, his experience of the elephant was limited and incomplete.

How can we apply the parable of the elephant to our own research or the research and information that we search for, find, interpret and apply to our lives and our work? We must constantly ask ourselves if maybe,

what we think we know, or what we have learned, ‘could it be wrong or incomplete?’ Could there be another answer that I haven’t seen? Is there another way to look at this issue that I haven’t thought of? As we will see throughout this chapter, and in line with the principles of cultural safety, we always need to acknowledge that we could be wrong or there could be other equally valid viewpoints, which also means that someone else could be right or their perspective is just as acceptable as your own. Humility in research and knowledge is essential.

What has been taught in many health-related curricula in the U.S. is that ill-health and disease can be attributed to the spread of pathogens—germs. But Western medicine has not always believed in germs. Germ theory is a relatively modern-day belief that emerged out of experiments by Louis Pasteur in the 1860s (although like most things, this discovery is attributed to one individual, but others may argue its origins lay elsewhere). Yet, this theory of disease causation is so accepted today that public health and healthcare practices are based upon it.

Research in health and human services in this country has been dominated (or colonized we could say) by those with specific world-views. Clinical control trials, medical research and quantitative research have had a privileged place in determining what is evidence. But which cultural groups do not practice some kind of research, have not developed their own bodies of knowledge or examined evidence in some way? The problem has been in the narrow, ethnocentric view that has allowed only so-called ‘[Western] scientific research’ to dominate. Science is essential and highly valued, but it is not the domain of any single cultural group. There is an entire globe of knowledge beyond what is known as ‘Western Science’.

Even within the health and psychology fields there has been competition for research grants that don’t fit a narrow way of thinking. Nurses, social workers, psychologists, and others have had to push for recognition of qualitative research methodologies and to access academic journals to share findings. Qualitative research aligns more easily with Indigenous approaches, where story or narrative is valid evidence that adds more to the ‘elephant’ than a narrow perspective.

Reading

Smith, L. T. (2012). *Decolonizing methodologies: Research and indigenous peoples* (2nd ed.). London: Zed Books.

This book is a valuable contribution for researchers and students to understand what it means to decolonize research practice.

Washington, H. A. (2006). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. First Anchor Books.

Diunital Versus Dichotomous Logic and Worldviews

A very important part of research and understanding problems and issues is *how* we think about things, or our logical or cognitive processes, and how we view the world (i.e., our worldview). Even how we think and view the world is a part of how we ourselves are ‘colonized’ and requires being ‘decolonized’. A *worldview* is defined as ...

A way of describing the universe and life within it, both in terms of what is and what ought to be. A given worldview is a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or in principle), what objects or experiences are good or bad, and what objectives, behaviors, and relationships are desirable or undesirable. A worldview defines what can be known or done in the world, and how it can be known or done. In addition to defining what goals can be sought in life, a worldview defines what goals should be pursued. Worldviews include assumptions that may be unproven, and even unprovable, but these assumptions are superordinate, in that they provide the epistemic and ontological foundations for other beliefs within a belief system. (adapted from Koltko-Rivera, 2004, p. 2)

Researchers have long discussed variations in worldviews, philosophies, and values between groups of people such as those between

African and Euro-Americans (e.g., Bell, 1994; Carroll, 2010; Dixon, 1977; Myers, 1988). For the most part, the social sciences, and Western or Euro-American thinking in general, follow a dichotomous logic or worldview (see Table 6.1). For example, things are viewed as either good or bad, true or false, this or that, right or wrong, and even male or female and Black or White. This way of thinking is very much ingrained in Western or Euro-American culture, so much so that it can be incredibly difficult to see things in another way.

Diunital logic or worldview is another way to view things. This is an African logic system or worldview in which things can be seen as good AND bad simultaneously, or true AND false, this AND that, right AND wrong, good AND bad. The complexity and unifying aspects of

Table 6.1 A comparison of diunital and dichotomous logic or worldview with examples

Diunital (African) logic or worldview	Dichotomous (western) logic or worldview
<i>Both/and</i> Someone can be both a victim and perpetrator, such as with bullying and victims of bullying	<i>Either/or</i> Someone is either a bully, or a victim of bullying, but cannot be both
<i>Union of opposites</i> Trauma can have positive effects (such as in Post Traumatic Growth) as well as being extremely harmful (as in Post Traumatic Stress)	<i>Absolute answers</i> Trauma has absolute negative impacts and there is no point in looking for positive effects
<i>Something can be both A and not-A at the same time</i> Someone can be <i>ill</i> and <i>not ill</i> at the same time, such as having the flu but feeling spiritually well, or being fit and healthy but spiritually poor	<i>Discontinuity among things</i> Someone can only be sick or not sick, but not both
<i>Perceptual oneness or unity between the observer and the observed</i> Observation necessarily involves interactions and interpretation	<i>Perceptual distance or separation between the observer and the observed</i> Researchers can be objective in their observations of others and stand apart from the object of study
<i>Mind and body can be one, monism or nondualism or nonduality</i> Alcoholism can involve biology and genetics as well as spirituality, morals, and social influences	<i>Mind or body, Dualism</i> Alcoholism is a disease of the brain and genetically influenced and not a moral, social, or spiritual condition

a diunital worldview would also conceptualize the possibilities of male AND female in terms of gender identity and Black AND White in relation to race. This worldview allows for greater complexity as a way to view the world and can free us from forced dichotomous demands for strict mutually exclusive thinking.

One example of how dichotomous logic has infiltrated psychology is in the debates around nature or nurture. You will likely have been introduced to the ideas of nature and nurture in introductory psychology and maybe even in most psychology and other social science courses. Briefly, this debate concerns whether behavior is attributed to our biology and genetic makeup (nature), or our environments and upbringing (nurture). How do the diunital and dichotomous worldviews apply to this debate? As we think about health through this book, we might explore topics such as alcoholism and drug addiction, chronic illnesses, mental health and social and emotional well-being, heart conditions, and cancer and how they are understood through the lenses of nature and nurture and within the dichotomous and diunital worldviews.

As we think about the differences between diunital and dichotomous logic and worldviews, we also need to keep in mind to not make these perspectives dichotomous! While we have presented these perspectives as two very different ways to think about and view the world, the reality is that most of us may use both of these ways of thinking, depending on the situation or context. From your own experience or culture, can you identify a particular way of understanding and thinking about things that fit into these categories? Perhaps you can identify another worldview or perspective?

Activity

Looking at Table 6.1 and thinking about these two different ways of seeing the world, can you already come up with some examples that illustrate these perspectives? Look at some recent headlines or current events relevant to health and social issues. Identify how these worldviews influence how events or issues are viewed and understood. Can you reinterpret events or issues from the other perspective?

Assessing Information

Let's say we want to find something out. For example, we had a conversation the other day in our house about the race and ethnicity of people who have been shot and killed by police. The question emerged, what are the rates of death from shootings by police for different race and ethnic groups in the U.S.? Where do you look? As most people do, we started with Google.

As we looked for an answer, it was not surprising to find that question and the factors or variables we need to consider are much more complicated than originally thought. For example, who determines the race or ethnicity of these shooting victims? Who reports these incidents? Are they all reported in the same way? Does everyone have to report this information? Why or why not? What other variables or factors should we be thinking about or looking at when we try to understand what is going on? For example, does it matter if the shooting victim was carrying a firearm at the time of the shooting? Does gender matter? What about mental illness? Who is reporting the information and where did they get it from? Are they a reliable source? How would we know? What we will likely find in our search is that there is no easy answer. Indeed, we might even consider that if we think we found an answer, we very likely might be wrong, or, at least, our 'answer', is only part of the story, as with the elephant.

However, we need to start somewhere. Let's consider where we might look for information and explore some information to help us understand what we are finding.

When doing a basic internet search, you will be directed to a variety of websites. Use the CRAAP test to assess the information you find. First, is the information *Current*? Check the dates of the material you are looking at. Is the information or source *Relevant*? Who is the author of the information? Did anyone pay for or sponsor the information or the website? What are the credentials or affiliations of the author or the website? Check the domain name. If the website ends in .gov, it is a government site and .edu is an educational institution, for example.

Read the 'about' section of the website to assess who the website belongs to. Is there an author for the information you are looking for?

Can you find out any information about that author? These items all relate to the *Authority* of the source of the information. What is the *Accuracy* of the information presented? Are there sources cited and are they credible? Is the material reliable and truthful? According to whom? Was the material reviewed or refereed? This is not always easy to find out but may require further investigation. Finally, what is the *Purpose* of the information? Why is it being written or published? Are there advertisements or something being sold? Are there religious, political, or other biases evident?

Starting with a general internet search can be useful in gaining a current perspective on a topic and helping to inform your further questions and terms that you might need to know and understand before searching further. Government documents and reports can also be very useful to inform our understanding about a topic. Government departments are also required to report on their work and to make their information accessible to the public. Government departments such as the Department of Health and Human Services and the Centers for Disease Control can be good places to get an understanding of the current mainstream views on a wide range of topics.

Check the website you are looking at on a media bias chart. There are a number of media bias charts currently available that depict media and news sources and their rankings in terms of political leanings (left, right, or centrist) as well as their reliability in reporting factual information. Certainly, just because a website or news source is found to be biased in one way or the other does not mean that you need to completely discount the information. Be a 'critical consumer' of information and add it to your information to take into consideration.

Website

Use the Media Bias Chart at this website as a tool to help assess the political leanings of web-sourced information: <https://www.adfontesmedia.com/>

Google Scholar is a specific search engine that focuses on scholarly work. Scholarly work can include reports published through academic institutions, masters and doctoral theses, as well as peer-reviewed journal articles and other papers published in academic journals and books. After you have done an initial internet search on a topic, it's a good idea to then take your search to scholarly sources. Google Scholar can be a good first place to look for scholarly work in the field, to help narrow your search terms, and to get an idea of the broad scope of work that has been done on a topic or a research area.

Books can be good sources for detailed information about a specific topic. They can be popular or academic in nature. Edited academic books often involve researchers with a great deal of expertise and knowledge in a particular field. The authors might collate, or review, much of the research in particular fields or subject areas. A limitation of books is that they are typically not peer-reviewed, though this does not necessarily reduce the value of the material.

Theses and dissertations can be useful sources for cutting edge thinking about a topic and can provide a wide range of sources relevant to a particular field. Academic publications often emerge from theses and dissertations.

Scholarly journal articles or academic publications might include systematic reviews, research reports, opinions, rapid reports, and first-person accounts. Peer-reviewed journal articles often have strict word limits requiring researchers to summarize their work very concisely. These publications undergo a review process where other experts in the field anonymously scrutinize the work. This process can be time-consuming, sometimes taking years to complete. It is not unusual for a research project to be published five years or more after the study was conducted.

Gray literature is other information that can be very useful but not published in the other forms mentioned. This literature might include reports from non-profit organizations, educational institutions, or other agencies who work closely with communities but do not have the capacity or resources (or even interest) to elevate information to a form such as an academic publication or book.

Reading

Nicholas, G. (2018). When scientists ‘discover’ what Indigenous people have known for centuries: When it supports their claims, Western scientists value what Traditional Knowledge has to offer. If not, they dismiss it. *Smithsonian Magazine*. <https://www.smithsonianmag.com/science-nature/why-science-takes-so-long-catch-up-traditional-knowledge-180968216/>

Research Methods

Research methods are what we do to collect information or data. These are the ways that we set out to test our ideas, theories, or assumptions about the world, events, behaviors, and such. Overall, research in the social and health sciences involves being a good observer, whether that involves observing people and their behaviors or the ways that they interact, or observing results or research findings through numbers, graphs, figures, or patterns in conversations. Our methods might include interviews, sending out a survey, or collecting a variety of biological information, such as blood tests, urine samples, blood pressure, or body weight. The kinds of information we collect can be in the form of numbers (often called quantitative data) or words (qualitative data). We might describe our observations in a variety of ways to show how they relate to one another or to our ideas.

Randomized Controlled Trials

We often find in health and social sciences that the randomized controlled trial is viewed as the ‘gold standard’ of research methods and is the ultimate method to determine causality. Causality is the idea or principle that everything has a cause and that, through rigorous research methods, we can determine cause and effect. This information constitutes much of what is deemed ‘evidence’ and, in theory, guides the work

that health and human services professionals do. ‘Evidence-based practice’ is applying ‘scientific evidence’ to our work and to the decisions we make. Some have gone so far as to say that *only* work or practice that has been proven or supported by rigorous, scientific evidence should be implemented. Read the following abstract from researchers skeptical of the strict requirement for ‘evidence’ based wholly on randomized controlled trials:

Objectives: To determine whether parachutes are effective in preventing major trauma related to gravitational challenge.

Design: Systematic review of randomised controlled trials.

Data sources: Medline, Web of Science, Embase, and the Cochrane Library databases; appropriate internet sites and citation lists.

Study selection: Studies showing the effects of using a parachute during free fall.

Main outcome measure: Death or major trauma, defined as an injury severity score > 15.

Results: We were unable to identify any randomised controlled trials of parachute intervention.

Conclusions: As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomised controlled trials. Advocates of evidence-based medicine have criticised the adoption of interventions evaluated by using only observational data. We think that everyone might benefit if the most radical protagonists of evidence-based medicine organised and participated in a double blind, randomised, placebo controlled, crossover trial of the parachute. (Smith & Pell, 2003)

Overall, there are many methods that can be used in research to help us better understand our clients, their situations, and how we can best serve them. Some methods will be more successful in some contexts and not successful in other contexts. And sometimes, like in the parachute example, we just need to think carefully and critically and use our experiences, knowledge, and communication with our clients to determine what might be the best course of action.

Ethics and Research

Health services and medical care are overwhelmingly viewed or believed to be part of the solution to health problems and concerns, and most of the time this is true. Indeed, medical professionals take the Hippocratic Oath to ‘do no harm’. But what about when health care is the problem? Researchers from Johns Hopkins University found that medical errors are the third leading cause of death in the U.S., with about 250,000 deaths from medical errors occurring every year (Makary & Daniel, 2016). Certainly, mistakes are bound to happen, but we are also justified in being cautious about the care we receive and perhaps seeking a second opinion. In addition to general mistakes that can happen in the course of our health care, there are unfortunately numerous examples of harm inflicted through medical care and unethical research practices.

The Tuskegee Study of Untreated Syphilis in the Negro Male was a study conducted between 1932 and 1972 in Alabama. This is probably the most well-known study of medical racism and unethical research practices in the U.S., but unfortunately, it is not the only case. In the Tuskegee study, treatment was withheld from around 200 participants. While there were no proven treatments for syphilis when the study began, the use of penicillin to treat syphilis was the standard treatment in 1947.

As part of a blinding control procedure, the men in the study who were in the control group were told that they were being treated when they were not. Blinding in a research study means that the research participants do not know what treatment condition they are in. When a study has an experimental group and a control group, the control group typically does not receive the treatment but may receive a placebo, or a substance that does not have an effect. Not only did the research participants continue to get sick and even die, but also had infected others in the community.

Researchers did not tell the men in the study the true title of the study or the nature of their illness (they were only told that they had ‘bad blood’). Despite concerns being raised about the ethics of the study as early as 1968, it wasn’t until 1972 when news articles condemned the study and it was eventually ended. Hearings and a class-action lawsuit

began in 1973 and in 1997 President Clinton apologized to study participants and their families.

As a health or human services professional, it is important to understand the history and contemporary possibilities for mistakes and unethical practices. It is also important to understand that there are guidelines and codes for the conduct of research to help prevent problematic practices from occurring. For example, the Nuremberg Code of 1947 required that research participants voluntarily consent to participate in research. The Nuremberg Code, a set of ten ethical principles for research, resulted from the trials following WWII of doctors who had conducted cruel medical experiments in concentration camps in Nazi Germany. The following are the ten principles:

1. Voluntary, informed consent is essential
2. The results of any experiment must be for the greater good of society and not random or unnecessary
3. Human experiments should be based on previous animal experimentation
4. Experiments should be conducted in a way that avoids physical and mental suffering and injury
5. No experiments should be conducted if it is believed to cause death or disability
6. The risks should never exceed the benefits of the research
7. Adequate facilities should be used to protect subjects from injury, disability, or death
8. Experiments should be conducted only by scientifically qualified persons
9. Subjects should be able to end their participation at any time
10. The scientist in charge must be prepared to terminate the experiment when injury, disability, or death is likely to occur.

Other recommended sources

Declaration of Helsinki (2000), originally World Medical Association in 1964. These are principles that are directed toward physicians, but are relevant to medical research

<https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>

Belmont Report (1979)

<https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html>

CIOMS (2002): Council for International Organizations of Medical Sciences: International Ethical Guidelines for Biomedical Research Involving Human Subjects 2016: International Ethical Guidelines for Health-Related Research Involving Humans

<https://cioms.ch/wp-content/uploads/2017/01/WEB-CIOMS-EthicalGuidelines.pdf>

National Institutes of Health: Patient Recruitment: Ethics in Clinical Research: Ethical Guidelines <https://clinicalcenter.nih.gov/recruit/ethics.html>

National Institutes of Health: Guiding Principles for Ethical Research: <https://www.nih.gov/health-information/nih-clinical-research-trials-you/guiding-principles-ethical-research>

Community-Based Participatory Research

Community-based participatory research and other similar research approaches such as participatory action research are research processes that have been shown to address some of the concerns with other research practices. Hartwig et al. (2006) suggest community-based participatory research as a method can be useful particularly because traditional research has failed to solve complex health disparities and many communities and groups are burned out. Also, research design and results can be improved when community members are actively involved in all stages of the research process. Research findings can be applied more effectively

when communities are involved as equal partners. Overall, when relationships are an integral part of the entire research process, research and health outcomes are improved.

Community-based participatory research provides a research process that fits well with the principles of cultural safety. When community members are active and equal partners throughout the research process, this can be decolonizing and address power imbalances. Communication throughout the research process, in the determination of the need for research, the development of the research protocols and methods, the interpretation of findings, and finally, the application of those findings, improves the quality of the research and benefits all who are involved.

Special Topic: Culture and Population Migration: Female Circumcision

In this next section, we will look at a special topic and see how we can apply a culturally safe, critical analysis. Many people are familiar with the practice of male circumcision, but most will not have heard that there is also a tradition of female circumcision in many countries around the world. Greater awareness of female circumcision emerged when practicing communities migrated to western countries and western health professionals found themselves ill-equipped and ill-informed. We can learn a lot about culturally safe (and unsafe) healthcare and human services practices by exploring this particular practice and how, when very different cultural practices come together through population migration patterns, misunderstandings can lead to quick decisions with severe consequences for communities. We will see how we can apply a decolonizing and culturally safe lens through which to interpret research and policy. The practice of female circumcision also provides us with a good example for understanding diunital and dichotomous logic.

As a start to our discussion of this cultural practice, let's first look at the terms that are used to describe it. The World Health Organization calls the practice 'Female Genital Mutilation' (FGM), as does most mainstream media. But if we were to ask women in communities who

engage in this practice, we would find a range of other labels or descriptions such as cutting, sunna, or circumcision. Understandably, many find the label Female Genital Mutilation offensive and hypocritical. As we think about cultural safety, imagine your own cultural traditional practice being given the label of ‘mutilation’. A range of emotions, images, and potential misunderstandings have been created before we even start the conversation.

Remember earlier we talked about cultural safety as involving a cycle of awareness, sensitivity, and safety? Think about how someone who is new to learning about this cultural practice, and therefore developing an awareness, may be biased when the topic itself is initially presented as ‘mutilation’. To become aware of a cultural practice, it is important to be introduced to the topic without layers of stigma, bias, and discrimination that will now need to be unpacked and destigmatized. In this spirit, let’s take a look at some of the basics of this practice and consider how we might move toward cultural safety.

The WHO (2020) recognizes four categories of the practice, aptly called Type I, Type II, Type III, and Type IV. Type I, also sometimes called Sunna in Muslim practicing communities, is the ‘partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans)’. Type III, also called infibulation or pharaonic circumcision, has attracted the most attention because of the severity of the practice. It is defined by the WHO as ‘the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I)’.

Given the definitions of Type I and Type III circumcisions, do you think that health effects of these two very different procedures might also be very different? Can you think of any practices or traditions in Western cultures that may be similar to these procedures? While a very different body part (or is it?), some have compared the practice to various body piercing practices, which in some communities is done with newborns or very young children.

The practices of female circumcision vary widely both within and between communities and families. The age of circumcision ranges from girls who are very young, as young as two (although this is unusual), and into adulthood. Female circumcision is practiced by a wide range of religious groups including Christians, Muslims, Jewish, and Animists. Female circumcisions are more common in African, Middle Eastern, and Asian countries, but due to migration, including forced migration, the practice is now seen globally. Circumcision may be performed under medical conditions or by a midwife or woman who has been trained or selected by the community. When circumcision is performed by untrained people and in unsanitary conditions, unsurprisingly, infections and problems can arise. Additionally, childbirth can be complicated for women who are infibulated especially when they are being treated by healthcare professionals unfamiliar with the practice and with deinfibulation procedures. It is these cases, particularly with Type III circumcision, when infections, botched procedures, and other complications can arise, as well as ethnocentrism (applying one's own cultural perspectives onto another culture or practice), that have attracted so much attention. While some researchers and professionals have argued that medicalization of the practice would reduce harm and problems, the WHO is opposed to medicalization.

Let's explore how diunital and dichotomous logic apply to the case of female circumcision. Calling the practice Female Genital Mutilation creates a dichotomous perspective in that the practice has been put into a box of 'bad' and any attempts to talk about the practice in a less-stigmatized way may lead to being labelled as condoning the practice and potentially in support of child abuse and violence against women. The naming of the practice, in and of itself, potentially prevents conversations and inhibits research, understanding and community engagement. For example, the WHO states that there are no benefits to the practice. But could there be? For example, we know that male circumcision can have health benefits for both males and their female partners (Eisenberg et al., 2018). We can't even begin to explore the possibilities with female circumcision due to the heated context surrounding the practice. How does this relate to diunital and dichotomous logic? Thinking about the different models of health that we explored earlier, what might be

some of the questions we could ask regarding 'benefits' of a cultural practice? Are benefits only understood in terms of biology? Or should we consider social and relational, religious or spiritual, emotional, or any other outcomes?

Within the framework of cultural safety, it is important to look at history and how it is related and to look at oneself critically. For female circumcision, with the outrage that we see from U.S. academics, advocacy groups, and health professionals, one would think that no one in the U.S. ever engaged in any sort of manipulation of the female genitalia. However, there is a long history and current practices that often fail to be acknowledged.

Rodriguez (2014) explores the history of female circumcision and clitorrectomy in the U.S., showing an extensive history as well as an increase in current 'female genital cosmetic surgeries'. For example, 'following liposuction, breast augmentation and rhinoplasty, labiaplasty was reported to be the fourth most common cosmetic surgical procedure according to U.S. statistics in 2013, rising by 44% in 2013 alone' (Simonis et al., 2016). Labiaplasty, vulvoplasty, and other female genital cosmetic surgeries include trimming of the labia minora and less commonly labia majora, hymenoplasty, vaginal reconstruction, mons pubis liposuction, vaginal 'rejuvenation' or laser 'rejuvenation', G-spot augmentation, and Orgasm-shot. Revisit the description of Type III 'FGM'. Do you see any similarities?

If we broaden our scope, we might also look at other body modification practices such as tattooing, piercing, and scarification and ask ourselves if the extreme response to female genital circumcisions is warranted. Indeed, even Healthline, a well-known source for medical and health information, has a special section on their website for 'clitoris piercing'. Moulton and Jernigan (2017) found that women are increasingly having genital piercings and suggest an increase in complications.

Consider other practices such as abortion that continue to be a contentious topic in the U.S. as it relates to legality and the implications of that for health care and outcomes. Making abortion illegal potentially forces the practice underground, and thereby with no protections to prevent unhealthy and unsafe procedures. Women have historically engaged in a wide range of practices when faced with an unwanted or

forced pregnancy that have led to complications and even death. While it has taken decades to legalize safe abortions under medical conditions in the U.S., it continues to be a contentious and politically heated topic. Despite the politics, the benefits of abortions in medical settings as opposed to non-medical settings are unquestionable.

But it seems there is no possibility of medicalization and harm minimization for female circumcision, at least for African and other women who practice this culturally. Thirty-nine states have laws against the practice of 'FGM' and in 2021, the STOP FGM Act of 2020 was signed into law. This law gives federal authorities the power to prosecute those who carry out or conspire to carry out FGM, as well as increasing the maximum prison sentence from five to ten years. It also requires government agencies to report to Congress about the estimated number of females who are at risk of or have had FGM, and on efforts to prevent FGM (Stop FGM Act of 2020). This may be understandable to protect those under the age of consent for medical procedures, but why is the same protection not given to young boys in response to the still common practice of circumcision? Just to be clear, we are not advocating for these practices. We are asking professionals who may encounter cultural practices at odds with their own worldview, to critically analyze your responses, assumptions, and judgments in your professional practice. This includes asking hard and unpopular questions with curiosity and a desire to understand and learn.

The Somali community has attracted a lot of attention in relation to the practice because many of the women have experienced the Type III circumcision and it is still practiced although there is evidence that this is changing (Guerin et al., 2006). The Somali diaspora (or the dispersion of a people) grew dramatically since the 1990s with the Somali Civil War. Somali people had long been travelers as merchants and perhaps had been coming to North America since the 1850s. Through the United Nations High Commissioner for Refugees program, many Somali were relocated to the U.S., New Zealand, Australia, Canada, and throughout Europe. There are currently around 150,000 Somali living in the U.S. (Connor & Krogstad, 2016).

Given what we have learned in this brief review of female circumcision, how might women in a community like the Somali community

be affected by legislation against the practice and the ways in which the practice is framed or discussed?

Critical thinking

Are genital cosmetic surgeries or genital piercings considered FGM? If they are not, why not? And, if they are not, then is the FGM law inherently racist?

What do you do when your own values and beliefs are in conflict with those of your clients? How do you navigate your professional practice?

How do these words, such as ‘mutilated’ or ‘cosmetic surgery’ reflect or influence your worldview?

Reading

Below is an excellent review that applies cultural safety to the healthcare experiences of those who have experienced female circumcision.

Evans, C., Tweheyo, R., McGarry, J., et al. (2019). Seeking culturally safe care: A qualitative systematic review of the healthcare experiences of women and girls who have undergone female genital mutilation/cutting. *BMJ Open*, 9, e027452. <https://doi.org/10.1136/bmjopen-2018-027452>.

Making it local

Using Google Scholar, type in key words for your state or local community, including the words **health psychology** or **health services**. Find an article that relates to your area or region. Ideally, look at research from the last five years for this activity. For example, a search including the key terms above and Oklahoma brought up a number of articles including:

Currin, J. M., Hubach, R., Crethar, H., Hammer, T. R., Lee, H., & Larson, M. (2018). Barriers to accessing mental healthcare for gay and

bisexual men living in Oklahoma. *Sexuality Research and Social Policy*, 15, 483–496.

The same search using Hawaii, elicited this article:

Lim, E., Gandhi, K., Siriwardhana, C., Davis, J., & Chen, J. J. (2019). Racial and ethnic differences in mental health service utilization among the Hawaii medicaid population. *Journal of Mental Health*, 28(5), 536–545. <https://doi.org/10.1080/09638237.2018.1521917>

Sometimes the articles are restricted for purchase, but often they are free access. Read the abstract to determine if this would be a useful article to learn more about what research has been conducted in your local area. Do these research studies reflect any cultural safety principles in their processes? If not, why not? What would need to happen to make them culturally safe?

Conclusion

Research is a valuable tool for understanding the world, but as with the perspectives of those investigating the elephant by feel only, it can be limited and unsafe if it only takes into consideration a narrow perspective. Research that contributes to greater understanding will be culturally safe, decolonized in methods and methodology, ethical, and not privilege certain worldviews over others.

References

- Bell, Y. R. (1994). A culturally sensitive analysis of black learning style. *Journal of Black Psychology*, 20(1), 47–61. <https://doi.org/10.1177/00957984940201005>.
- Carroll, K. K. (2010). A genealogical review of the worldview framework in African-centered psychology. *The Journal of Pan African Studies*, 3(8), 109–134.

- Connor, P., & Krogstad, J. M. (2016, June 1). *5 facts about the global Somali diaspora*. Pew Research Centre. <https://www.pewresearch.org/fact-tank/2016/06/01/5-facts-about-the-global-somali-diaspora/>.
- Daigneault, P.M. (2013). The blind men and the elephant: A metaphor to illuminate the role of researchers and reviewers in social science. *Methodological Innovations Online*, 8(2), 82–89. <https://doi.org/10.4256/mio.2013.015>.
- Dixon, V. J. (1977). African-oriented and Euro-American-oriented world views: Research methodologies and economics. *The Review of Black Political Economy*, 7, 119–156.
- Eisenberg, M. L., Galusha, D., Kennedy, W. A., & Cullen, M. R. (2018). The relationship between neonatal circumcision, urinary tract infection, and health. *The World Journal of Men's Health*, 36(3), 176–182. <https://doi.org/10.5534/wjmh.180006>.
- Guerin, P. B., Allotey, P., Hussein Elmi, F., & Baho, S. (2006). Advocacy as a means to an end: Assisting refugee women to take control of their reproductive health needs. *Women Health*, 43(4), 7–25. https://doi.org/10.1300/J013v43n04_02. PMID: 17135086.
- Hartwig, K., Calleson, D., & Williams, M. (2006). Unit 1: Community-based participatory research: Getting grounded. In: The Examining Community-Institutional Partnerships for Prevention Research Group. *Developing and Sustaining Community-Based Participatory Research Partnerships: A Skill-Building Curriculum*. www.cbprcurriculum.info.
- Koltko-Rivera, M. E. (2004). The psychology of worldviews. *Review of General Psychology*, 8(1), 3–58.
- Kelley, A., Belcourt-Dittloff, A., Belcourt, C., & Belcourt, G. (2013, December). Research ethics and Indigenous communities. *American Journal of Public Health*, 103(12), 2146–2152. <https://doi.org/10.2105/AJPH.2013.301522>. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3828983/>.
- Makary, M. A., & Daniel, M. (2016). Medical error—The third leading cause of death in the U.S. *British Medical Journal*, 353, i2139. <https://doi.org/10.1136/bmj.i2139>.
- Moulton, L. J., & Jernigan, A. M. (2017). Management of retained genital piercings: A case report and review. *Case Reports in Obstetrics and Gynecology*, 2402145. <https://doi.org/10.1155/2017/2402145>.
- Myers, L. (1988). *Understanding an Afrocentric worldview: Introduction to an optimal psychology*. Kendall/Hunt.
- Rich, K., & Breunig, M. (2020). Cultural safety: A lens to consider leisure provision in cross-cultural contexts. *Managing Sport and Leisure*. <https://doi.org/10.1080/17447359.2020.1811111>.

- [org/10.1080/23750472.2020.1800506](https://doi.org/10.1080/23750472.2020.1800506). <https://www.tandfonline.com/doi/abs/10.1080/23750472.2020.1800506>.
- Rodriguez, S. B. (2014). *Female circumcision and clitoridectomy in the United States: A history of a medical treatment*. University of Rochester Press.
- Simonis, M., Manocha, R., & Ong, J. J. (2016). Female genital cosmetic surgery: A cross-sectional survey exploring knowledge, attitude and practice of general practitioners. *BMJ Open*, 6(9), e013010. <https://doi.org/10.1136/bmjopen-2016-013010>.
- Smith, G. C. S., & Pell, J. P. (2003). Parachute use to prevent death and major trauma related to gravitational challenge: Systematic review of randomised controlled trials. *British Medical Journal*, 327, 1459. <https://doi.org/10.1136/bmj.327.7429.1459>.
- Stop FGM Act of 2020. H. R. 6100. 116th Congress (2019–2020). Public Law No. 116-309. <https://www.congress.gov/bill/116th-congress/house-bill/6100/text>.
- WHO. (2020). *Female genital mutilation fact sheet*. <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>.