Rethinking Consumer Acculturation, Privilege and Oppression

ABSTRACT

A paucity of studies have theorized acculturation outside of the home versus host relationships and concepts of privilege and oppression are undertheorized. This paper builds on the current literature by illustrating the fluidity of acculturation and re-acculturation through the lens of a service site (a popular multiethnic medical center).

STATEMENT OF KEY CONTRIBUTIONS – 300 words

This paper contributes to current consumer research debates by unpicking how consumers reacculturate and the findings also build on Veresiu and Giesler's (2018) work via the emergence of fifth strategy; that of 'emancipation'. By engaging with other service actors, identity positions are challenged and consumers feel emancipated because of the positive intercultural exchanges that take place. Second, feelings of emancipation help perpetuate re-acculturation by shaping consumer interaction with other service actors (or doctor-patient relationships in the context of this paper). Practically, healthcare and governments would benefit from this paper because there is a pressing need for institutionalized systems such as hospital service providers to put patients first and create an environment that resonates with the wider diversity of clients and not just the privileged majority, and also government to better appreciate the diversity of their local populations. Second, consumer researchers must recognize the importance of operationalizing privilege and oppression in perpetuating re-acculturation. Finally, the trajectory touchpoint technique used here can be applied in the context of other service providers to flesh out deeper insights into the consumer experience, especially those that advocate important life transitions such as motherhood, fatherhood, marriage and healthcare all need to ensure an inclusive consumer experience.

INTRODUCTION

Given the rise of globalization and migrating populations, few countries are ethnically homogeneous, and mass migration has rapidly contributed to the development of multi-cultural societies in many Western States (Demangeot, Broderick and Craig 2015). A plethora of studies have examined acculturation and built on John Berry's (a psychology academic) initial acculturation framework (first developed in 1989) and which is still widely

used today – (Chai and Dibb, 2014; Davis, Mohan, and Rayburn 2017; Kizgin, Jamal and Richard 2018). However, some scholars refute the outcomes of acculturation (Veresiu and Giesler, 2018; Jamal and Chapman, 2000; Peñaloza, 1994; 2018) and argue that there is no single fixed outcome of acculturation because individuals can be segregated from society in one instance and then assimilated in another. The effects of how consumers 're-acculturate' (i.e. the grounds to engage and attach new or extended identity positions to their own cultural heritage) are still poorly understood. In this paper, re-acculturation is viewed as the reverse of acculturation and it is an important concept for negotiating power struggles that exist within broader institutionalized systems. Kagawa-Singer, Dressler, and George (2016) note that acculturation is impeded by the emphasis on within-group variation, discrete cultural groups and dichotomous assumptions (e.g. moving from the home culture and acculturating within the host culture). To illustrate the fluidity of acculturation and re-acculturation, this paper examines the 'home culture' through the lens of a service site (a popular multiethnic medical center). Viewed from this perspective would seem to advocate a closer internalized system of acculturation rather than a holistic one as many studies have attended to.

The aims of this paper are to better understand the interplay between acculturation and re-acculturation agents and how consumers oscillate between different identity positions and also how concepts of privilege and oppression manifest within their re-acculturation journey. Veresiu and Giesler (2018) identify four consumer socialization strategies; namely 'envisioning', 'exemplifying', 'equipping' and 'embodying'. The first strategy involves institutional actors imagining the ethnic consumer as an ideal citizen type. The second involves meso level actors (e.g. market research agencies or health agencies such as Medicare in the USA or the NHS in the UK) profiling ethnic consumers based on primary and secondary research data. A third strategy entails liaising with market actors from the retail and service environments who equip the marketplace with a range of ethnic products,

services, or who advocate the inclusivity of ethnic minorities in their service offering. A final strategy sees ethnic minorities embody their consumption experiences by engaging in sharing with others (e.g. with other consumers or other actors such as healthcare professionals in this study context) and encouraging them to do the same. Sharing might include cultural awareness amongst various actors (e.g. other patients and/or doctors).

This paper firstly contributes to current consumer research debates by unpicking how consumers reacculturate and the findings also build on Veresiu and Giesler's (2018) work via the emergence of fifth strategy; that of 'emancipation'. By engaging with other service actors, identity positions are challenged and consumers feel emancipated because of the positive intercultural exchanges that take place. Second, feelings of emancipation help perpetuate re-acculturation by shaping consumer interaction with other service actors (or doctor-patient relationships in the context of this paper).

THEORETICAL BACKGROUND

Acculturation

As a term, acculturation is considered to be where intercultural exchanges take place between individuals and one which includes the assimilation of a new culture, maintenance of the old culture and also resistance to both old and new cultures (Peñaloza, 2018). Based on John Berry's 1989 conceptualization of acculturation and later work (Berry, 2005, 2008), there are four dimensions of acculturation: integration, assimilation, separation and marginalization. Integration implies a desire of minority groups to maintain original cultural integrity as well as attempts to integrate into wider society. Assimilation relates to the extent to which minority groups surrender their own cultural identity and shift more towards the norms of mass society. Separation suggests a move away from mainstream society and a focus on traditional values whilst marginalization infers an objection to mainstream society as well as

any identification with traditional values. Studies have also argued that second-generation citizens better identify with acculturation (Khan, Lindridge and Pusaksrikit, 2018; Sekhon and Szmigin, 2011; Üstüner and Holt, 2007).

Privilege and Oppression

In Allan Johnson's (2006) seminal work on privilege, power and difference, he defines privilege as any advantage that is unearned, exclusive and bestowed upon an individual. Privilege, as Johnson notes, is "one of those loaded words we need to reclaim so that we can use it to name and illuminate the truth" (21). Johnson gives the example of people with disabilities for instance, and notes how nondisabled people may assume (whether consciously or subconsciously) that people with disabilities lack intelligence or cannot take care of themselves and their success in life rests on their physical or mental conditions. Johnson terms this crude outlook toward privilege as "the luxury of obliviousness" (22). That is, individuals abuse their own privileges without consciously realizing they are doing so.

Privilege does not always guarantee good outcomes for the privileged group or negative ones for everyone else. A problem with privilege is that like acculturation theory, it loads a sense of bias and the pendulum of 'unearned privileges' goes against the minority, who subsequently feel oppressed. Privilege is rampant everywhere, it is intangible and bears no geographical boundaries in the sense that it cannot be physically possessed. Privilege and oppression concepts would seem to impact the extent to which consumers re-acculturate because at the nexus of discussions surrounding equal access to goods and services is the premise that it should be available and accessible to everyone.

METHOD

Semi-structured interviews were carried out with twenty-five inpatient participants from a large Medical center (based in New York) which provides patient care services to a

multi-ethnic (predominantly immigrants) including Chinese; Mexicans; Middle Easterners; Pakistanis; Italians; Russians; Syrian; Haitians, Mixed Caribbean nationalities and Mixed European nationalities. The Medical center offers a range of services including over seventy primary care and other specialist programs. The MedSurg (medical/surgical) unit was selected as this unit cares for patients undergoing major surgical procedures and patients hospitalized for illnesses, diseases and injuries.

An adaptation of the seven point Touchpoint Trajectory Technique (TTT), developed by Sudbury-Riley et al. (2020) (a methodology for mapping out the consumer journey which has previously applied within palliative and end-of-life care environments) was used. These touchpoints consisted of the following stages: Pre-arrival to the MedSurg Unit; arrival, reception and patient admission; faculty/clinical care; ancillary services; family members' shared areas; feel at home services (chapel, internet, Wi-Fi, Etc.); discharge process and post discharge support. The TTT affords patients the opportunity to tell their (untainted) story from their own perspective and permits the researcher to gain more rich and in depth qualitative insights.

Sample size was determined through historic and trend analyses of discharges within the MedSurg Unit. Participants were invited to share stories of their service experiences at the Medical center, using key touchpoints as a guide.

The data was analyzed using thematic analysis where patterns in the data were identified and then categorized into themes. These themes included 'patient's expectation(s)' prior to hospital admittance' and 'patient's hospitalization experience'. Sub themes included 'ethnicity informing expectation(s)'; 'generalized expectation(s)'; 'was I seen/recognized and heard – communication and interpersonal relationship(s)'; 'typecast response' and 'expectation versus experience'.

ANALYSIS AND DISCUSSION

Patient's expectations (prior to hospital admittance)

Prior to arriving at the medical center, several participants ascribed their cultural heritage to the context of the medical center. As told by a Hasidic Jew inpatient:

"I expected a Jewish person to call me. It is a Jewish hospital, isn't it?"

This comment is typical of many others as patients appeared to find familiar solace in referring to their own cultural heritage. This identity negotiation enabled patients to oscillate between assimilation and integration. Perceptions of feeling integrated with hospital individuals of a similar ethnicity pointed in the direction of privilege; that is the medical center was a Jewish hospital and therefore there was an expectation that patients would be seen by fellow Jewish healthcare professionals.

For other participants, for example Mexicans, comparisons were made to their home country. As one Mexican patient tells:

"I knew the hospital would call me. This is America."

This quote denotes a sense of alleviating possible oppression referent to past experiences in a Mexican hospital and the Mexican participant equates hospitals in America with a sense of prestige. It also suggests a move away from marginalization and a move toward assimilation in the American context. Table 1 below displays the eight touchpoints and illustrates key patient indicative quotes.

Table 1: showing key patient quotes Participants	Pre Arrival	Arrival, Reception and Patient Admission	Faculty/Clinical care	Ancillary Services	Family Members Shared Areas	Feel at Home Services (chapel, Wi-Fi, Etc.)	Discharge Process	Post Discharge Support
Hasidic Jews: (N=5) *Age:* 18-34 (0), 35-49 (2), 50-65 (1), 65-80 (1), 81+ (1), *Gender:* (2 Male, 3 Female), *Length of Stay:* 6-9 days (2), 10 days+ (3)	"I expected a Jewish person to call me. It is a Jewish hospital, isn't it?"	"I wanted to see a familiar face (Jewish). I was told the hospital do have Jewish employees."	"My doctor is Jewish and he knew best. I trusted him and his team […]."	"This is my first hospitalization experience. I hoped to share my room with another Hasidic Jew like myself."	"I thought my family may wander around a little, but I know that they would want to stay in my room so that we can catch up."	"Even though there is a chapel, it would not be the same as a synagogue. I expected to worship mostly in my room."	"They always want more information at the last minute. Last time, they kept coming back for more information."	"Apparently the supervisor called me. She was cordial but very professional."
Anglo Americans: (N=5), *Age:* 18-34 (2), 35-49 (2), 50-65 (1), 65-80 (0), 81+ (0), *Gender:* (3 Male, 2 Female), *Length of Stay:* 3-5 days (1), 6-9 days (3), 10 days+ (1)	"This is my second time around. I know what to expect. I would get a call, then surgery. No big deal."	"I anticipated a speedy admission. My surgery was the first scheduled, so I expected little or no waiting time."	"I expected the medical staff to listen to me. I may not understand everything, but I do know myself."	"I expected to be treated with respect […] the person who came in to change the sheets on the bed was very rude […]"	My dad would prefer to go to the waiting room and watch television. He would just want to spend a very short time with me."	"I really don't care much about the chapel […] I am not very religious. Good Wi-Fi service is important."	"Let them take their time and do it right. I can wait for a while"	"On the third day while I was in the washroom I got a call from the hospital…"
Chinese: (N=5), *Age:* 18-34 (0), 35-49 (1), 50-65 (3), 65-80 (1), 81+ (0), *Gender:* (1 Male, 4 Female), *Length of Stay*: 6-9 days (3), 10 days+ (2)	"My granddaughter was in that hospital. She told me many Chinese are patients there."	"I told my daughter that there is no need to worry. The people will take good care of me."	"I expect the clinical staff to see me as part of the solution. I hope there are Chinese doctors and nurses to look after me."	"I really do not care about the food. I knew my family and friends will bring in my oriental food. I just expected a clean room."	"I knew that my family really does not care for the waiting room. They would prefer to stay with me and cheer me up"	"I am second generation Chinese […] I expected good internet access and being able to use my Wi-Fi."	"Why this long, drawn out process? We are not going anywhere. They should get the information ahead of time."	"My mother speaks English very slowly and the caller was very rude [and] was completing her sentences"
Mexican: (N=5), *Age*: 18-34 (3), 35-49 (2), 50-65 (0), 65-80 (0), 81+ (0), *Gender*: (3 Male, 2 Female), *Length of Stay*: 3-5 days (1), 6-9 days (4)	"I am a second generation Mexican. Most likely, I would have received a polite follow-up call from the hospital."	"Who cares? In my country (Mexico) I had to wait forever. I know that here it not be so long."	"I trust the doctors and nurses to do their best for me. If there are any questions, I hoped they would listen to my daughter."	"The last time I was in a hospital, I was treated like a second class citizen [...] the workers saw me as a Mexican and thought I was an illegal immigrant."	My parents would by very uncomfortable in the waiting room. They prefer to chat in Spanish. Their English is not so good."	"I hoped that the TV shows good Latin channels. I like to keep up with what is happening with my home country."	"Who cares about the waiting? As long as feel better, I do not mind waiting."	"Someone called and was very abrupt with me. Honestly, I felt like a second class citizen."
West Indians: (N=5), *Age*: 18-34 (3), 35-49 (2), 50-65 (0), 65-80 (0), 81+ (0), *Gender*: (1 Male, 4 Female), *Length of Stay*: 6-9 days (2), 10+ (3)	"Who cares whether the hospital calls or not. It is in my interest, so I called first."	"I came from Jamaica. Waiting for a long time before I am looked after is fine with me."	"West Indian doctors and nurses understand me best. I am more comfortable among my own people."	"I expected West Indian food and West Indian music…"	"My family and friends would come to visit me to catch up on their day time soap operas in the waiting room."	"I do not care much for television. I just hoped that their Wi-Fi service is great."	"Waiting a long time to be discharged is so third world."	"Three days after my discharge someone from the hospital called to find out how I was doing."

Patient's hospitalization experience

Enmeshed in the narratives of the patients during the course of their hospitalization experience is where re-acculturation is most potent. As one Chinese participant notes:

> "The doctor always had to remind me to raise my head and look at him whenever he spoke to me. When my husband was with me, I felt no pressure because he would discuss my treatment with the doctor. The nurses just did their jobs with little or no zest."

This comment refers to Chinese culture where as a mark of respect, Chinese women (and even men) do not look directly in the faces of those thought to be their superiors. Worryingly, some participants signaled feelings of marginalization and oppression and felt culturally torn when it came to assimilation attempts. Examples included:

> "While my relatives and friends are mostly second generation Mexicans and know English well, they still enjoy Spanish programing. Every time they went in the waiting room, the Television station is always set on an English (American) channel…" (Mexican)

And comments also related to spiritual devotion and religion:

> "We are devout Muslims. There is no private room to pray. Sometimes my family was forced to spread their praying mats around my bedside and pray." (West Indian) and "Even though there is a chapel, it would not be the same as a synagogue. I expected to worship mostly in my room" (Hasidic Jew).

Such comments indicated a sense of separation, marginalization and feelings of oppression because although there was a chapel (which advocates multi-faith use), several participants felt this was still insufficient. Overall, participants' experiences with respect to faculty/clinical care were very similar irrespective of ethnic groups. These experiences can be classified into two main categories. The first category was an exhibition of paternalistic care by the clinical staff where patients are relegated to a passive position regarding their care:

> "No one listened to me. Several times I told the doctor and nurses about the pain I feel. I had to use my buzzer many times before I get any attention" (Chinese) and "I felt as though my doctors and nurses were either ignoring me or didn't understand me because of my West Indian accent. My English is good, but […] no one listened. I felt pushed away and had no say in my treatment and care" (West Indian).

Such paternalistic care made the participants feel marginalized in their care-plan and prevented fluid re-acculturation. The second category experienced by the participants was patient-centered care which permitted greater re-acculturation. Here the partnerships among the clinical staff and the patients are engendered:

> "Just as I expected. I insisted in being included in all aspects of my care and the doctors and nurses did exactly that" (Anglo American), "My doctors really listened to my concerns. We even became friends' (Mexican) and "My Jewish doctor and the nurses who attended to my care included my husband and me in all aspect regarding my care" (Hasidic Jew).

The findings therefore indicate that when paternalistic care is experienced, patients feel more oppressed and by contrast, more privileged when patient-centered care is experienced and therefore more emancipated in their overall experience. The latter thus functions as a positive catalyst for re-acculturation in the broader patient experience story.

GENERAL DISCUSSION AND IMPLICATIONS

The aims of this paper were to better understand the interplay between acculturation and re-acculturation agents and how consumers oscillate between different identity positions and also how concepts of privilege and oppression manifest within their re-acculturation journey. Anchored in the work of acculturation, privilege and oppression, the findings demonstrate the complex nature of how acculturation evolves over a temporal period (in this case- patients in a medical center). As Giesler and Veresiu (2014, 854) note, researchers should "shift their analytical focus from asking how cultural value systems structure consumers identities and experiences to asking how family, religion, ethnicity, activism, and other institutions are rearticulated as market and consumption systems". The insights in this paper suggest that the aforementioned factors are at play in the narratives of the participants. The medical center is not just a site for receiving care but also one for identity negotiation that does not follow a linear progression of acculturation as some previous studies have

denoted (Chai and Dibb, 2014; Davis et al., 2017; Kizgin et al., 2018). Rather, concepts of privilege and oppression must be taken into account as they have shown to influence the iterative nature of acculturation and re-acculturation. This paper therefore contributes to the existing acculturation debate and by illustrating how privilege and oppression manifest with each other, hedges a step further to understanding the cultural contextualized consumer subject (Askegaard and Linnet, 2011).

In addition, this paper extends Veresiu and Giesler's (2018) identification of four consumer socialization strategies (envisioning, exemplifying, equipping and emobodying by recognizing a fifth strategy; *emancipation*. Here, emancipation subsumes positive consumer experiences (in this case patient-centered care) and instances where consumers feel a sense of liberation and are devoid of contemporary worries. Examples included experiencing local ethnic cuisine, similar ethnic doctors to the participants, being viewed as a patient and not as 'the other' (immigrant- e.g. Mexican) and having amenities to support collectivist cultural closeness (e.g. having friends and family in the same room or in a designated space).

This paper suggests several implications: first, there is a pressing need for institutionalized systems such as hospital service providers to put patients first and create an environment that resonates with the wider diversity of clients and not just the privileged majority. Second, consumer researchers must recognise the importance of operationalizing privilege and oppression in perpetuating re-acculturation. Finally, the trajectory touchpoint technique used here can be applied in the context of other service providers to flesh out deeper insights into the consumer experience, especially those that advocate important life transitions such as motherhood, fatherhood, marriage and healthcare all need to ensure an inclusive consumer experience.

LIMITATIONS AND FUTURE RESEARCH

These findings can be used to inform future studies examining the how re-acculturation manifests within a given scenario or temporal period. Equally, future studies could explore in more depth, the interplay between consumer based privilege and oppression to see if the two concepts can be sub segmented further. In this paper, they have been treated as a dichotomy and so it would be useful to see if there is scope to develop a more detailed privilege and oppression continuum.

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