A Theoretical Review on Minorities’ Health Behavior in Individual and Social Contexts: Focusing on the Case of Korean American Women’s Mammogram Practice

Kim, Jun Hoe*

ABSTRACT

The purpose of this article was to review the current research theories and perspectives on minorities’ health behavior such as mammogram practice and discuss the relationships between social and individual components for that behavior through the case of the breast cancer screening among Korean American women (KAW) theoretically. Previous research studies on the issues of mammogram practice among minorities including KAW heavily rely on individual aspects such as the Health Belief Model (HBM), which limits diverse approaches on them. Hence, in this manuscript, the theoretical frame works on health behavior for mammograms of previous research studies, based on HBM mainly were reviewed and their limitations were discussed. At the same time, there was the effort to revise the theoretical frame work of HBM in the combination with social structural perspectives utilizing habitus, a concept of Pierre Bourdieu, to bridge the gap between both individual and social aspects. Especially, within the revised theoretical framework, the influence of social factors such as the information and service resource on individual’s behavior for mammogram practice is discussed. Furthermore, research with empirical data is suggested to verify the revised theoretical framework in practice fields of breast cancer screening for minority groups.

Key Words: Korean American women, health behavior, mammograms, health belief model, habitus

* Department of Social Welfare, Incheon National University
I. Introduction

Breast cancer is one of the major cancers causing mortality among women in the U.S., including Korean American Women (KAW) (McCracken, Olsen, Chen, Jemal, Thun, Cokkinides, Deapen, and Ward, 2007). Early detection is crucial to reducing the rate of mortality from breast cancer and previous research studies have confirmed that routine mammograms are the most significant factor in a general perspective of breast cancer early detection (Joun, Choi, Klassen, and Roter, 2006). Eventually, free mammograms have been available for the underserved women in the U.S. through The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) since the Breast and Cervical Cancer Mortality Prevention Act of 1990 (CDC, 2012).

Nevertheless, the rate of routine mammograms of Asian American women (including Korean Americans) over a two-year period was 64.1% in 2010, which is still low compared to other racial/ethnic groups: Black/African (73.2%), European (72.8%), and Hispanic (69.7%) (CDC, 2012). In fact, the mortality rate for European and African American women has declined slightly, whereas the mortality rate for Asian American women, including Korean Americans, has not changed significantly (CDC, 2013). Most of the research studies on breast cancer among Asian American women, including Korean Americans, indicated that the major reason for this phenomenon is the lack of success in breast cancer early detection and treatment (Kim and Sarna, 2004; Kim, Menon, Wang, and Szalacha, 2010; Maxwell, Bastani, and Warda, 1998).

Research is therefore needed on the issues related to breast cancer early detection among KAW, one of the major Asian minority groups in the U.S., in terms of a theoretical and practical approach (Hoeffel, Rastogi, Kim, and
A review of existing studies shows that their theoretical foundation is mainly based on the health belief model (HBM) and social support/network theory (Han, Lee, Kim, and Kim, 2009; Kim and Sarna, 2004; Lee, 2015; Maxwell et al., 1998). The studies concentrated on KAW’s personal factors such as negative attitude and cultural modesty toward breast cancer and early cancer detection, which might cause their limited practice of routine mammograms and health information navigation (Kim and Menon, 2009; Tang, Solomon, and McCracken, 2000). The authors of those research articles insisted that KAW’s negative attitudes toward mammography use could be changed through various forms of educational interventions (Champion, 1999; Kim and Menon, 2009; Kim and Sarna, 2004; Pasick and Burke, 2008). Their rationale on individuals’ behavior change seems clear and logical explaining less mammography usage among KAW.

However, their theoretical interest is excessively attached to individuals’ cognition and choice and dependence on outreach education intervention to increase KAW’s perceptions on breast cancer and screenings, based on the health belief model and social cognition theory (Champion, 1999; Glanz and Rimer, 1997; Kim and Menon, 2009; Pasick and Burke, 2008). The importance of accessible, selective, and structured resources of information and service to the underserved KAW has consistently been neglected. No study from any discipline looks at the relationships among KAW’s behaviors and social components of structured information and service resources for breast cancer screenings such as public or private institutions including non-profit organizations.

Therefore, it is necessary to understand KAW’s unsuccessful breast cancer screening practices as the individual’s daily behavioral pattern within the social structure as well (Lindbladh, Lyttkens, Hanson, Ostergren,
Isacsson, and Lindgren, 1996). In other words, social structural chance and individual choice are very critical concepts in understanding human decision-making behaviors although the application and emphasis of each concept varies depending on perspectives or disciplines (Lindblandh and Lyttkens, 2002). These are not only conflicting concepts but their differences can be complementary to each other in understanding social phenomena such as breast cancer screening practice among KAW. Hence, the goal of this article is to explore the possibility of a new conceptual framework to understand minorities’ health behavior such as KAW’s mammogram practice through bridging the two different perspectives of social structure and individual choice by reviewing concepts, models, theories, and practical applications in previous research studies.

II. Method: Literature Review

The review of literature was conducted mainly through the GALILEO databases of the University of Georgia Libraries and Google search engine. Additional literature was found through the snowballing method, that is, finding relevant sources cited in the articles located in the initial search and then searching for those papers and repeating the process. The major literature review for this research study was performed between January 2014 and December 2015. For this review, only studies and articles about the issues of KAW’s breast cancer and screening conducted since the late 1990s were considered. Those research studies focused on KAW’s breast cancer prevalence and risk factors analysis and outreach education intervention development to promote routine mammogram usage among them for breast cancer early detection (Gonzalez et al., 2014; Joun et al.,

III. Korean American Women’s Risk Factors and Conceptual Issues

The previous research studies on breast cancer risk factors or issues among KAW can be classified into two main categories: biomedical and individual deficit aspects.

The studies in the biomedical category investigated the risk factors for breast cancer and more likely employed clinical approaches focusing on gender, age, family history, obesity, and ethnicity/race (Baum and Schipper, 2002; Bonadonna, Hortobagyi, and Gianni, 2001; Torosian, 2002).

Most of the research on breast cancer has focused on women because breast cancer has been found more often in women than men (American Cancer Society, 2014; Baum and Schipper, 2002). Such a difference between men and women in incidence rates of breast cancer can be explained by the traits of this hormone-related cancer such as estrogen level (Anderson, 1974; Bonadonna et al., 2001).

Age is another factor in determining susceptible breast cancer populations. Approximately 50% of breast cancer happens to women aged 50-64 years, and a further 30% occurs in women over the age of 70 years (Torosian, 2002). This radical change in breast cancer incidence rates for women aged 45-50 years suggests the involvement of reproductive hormones in the etiology of breast cancer such as menopause (Trichopoulos, Macmahon, and Cole, 1972).
Within populations, genetics plays a small role in determining the risk of breast cancer. However, heredity plays an important part among individuals with a strong family history or one of the genes associated with breast cancer (Baum and Schipper, 2002). The risk of breast cancer is increased 2-3 fold in women with a first-degree relative with breast cancer like a mother and daughter; the risk is also increased, but to a lesser extent, in women with a second-degree relative who is affected like an aunt and niece (Baum and Schipper, 2002).

Obesity is associated with an increased risk of breast cancer in postmenopausal women. This increased risk may be due to conversion of adrenal androgens to estrogens in adipose tissue. High consumption of animal fats has also been linked to breast cancer (Haagensen, Bodian, and Haagensen, 1981). However, there might be a misconception about the relation between and obesity and Asian population, which obesity has not been regarded as serious health problems among Asian and Korean people generally. This is one of the key points to consider for breast cancer prevention for Asian immigrants, including Korean, not only in the biomedical perspective but also others such as culture. Namely, when Asian people, including Koreans, immigrate to the U.S., they might experience an unbalanced acculturation process including diet (Kim and Menon, 2009; Unger, Reynolds, Shakib, Spruijt-Metz, Sun, and Johnson, 2004; Ziegler, Hoover, Pike, Hildesheim, Nomura, West, and Hyer, 1993). Eventually, the Asian immigrants might have more opportunity to be exposed to obesity in the U.S. than before immigrating to the U.S. which might cause breast cancer. (Kim and Menon, 2009; Unger et al., 2004; Ziegler et al., 1993). This is clear when the breast cancer incidence rates among the same ethnic groups in different geographical regions of residence are compared. According to Lee, Demissie, Lu, and Rhoads (2007), breast cancer incidence
rates are higher among Korean women in the U.S than those in S. Korea. In addition, the research study of Parkin (1997) showed that Chinese women living in Shanghai had two-thirds the risk of breast cancer compared with those in Hong Kong or Singapore, whereas the rates among Chinese women in San Francisco were more than twice as high. Similarly, Japanese women in Hawaii, San Francisco, and Los Angeles had rates double those in Japan. Namely, it might be determined that obesity might be one of the risk factors of breast cancer among KAW in relation with diet acculturation as well.

As a result, based on the bio-medical risk factors above and the prevalence of research studies on breast cancer among Korea American women, KAW age 40 and over were determined as one of the populations vulnerable to breast cancer. Nevertheless, the routine mammogram rates among KAW are still low although mammograms are considered the most effective way to decrease mortality by that disease (Kim and Sarna, 2004; Lee et al., 2006; Maxwell et al., 1998).

In the individual deficit perspective, the issue of less breast cancer screening among KAW has been approached in relation to their perceptions and self-efficacy of breast cancer and mammogram utilization as individual determinants for their mammogram rate (Kim and Sarna, 2004; Pasick and Burke, 2007; Kim and Menon, 2009; Maxwell et al., 1998). In fact, the concept of deficit in the article was adapted from the deficit model of the special education field for the current study (Brown, 2008). In this model, the issues of a student were analyzed only in terms of the individual’s incapability (Brown, 2008). This trend was found in research studies on KAW’s breast cancer issues as well. These studies attempted to determine the risk factors or barriers within KAW’s individual context, focusing on their low confidence and awareness on breast cancer and the significant role of routine screenings (Kim and Menon, 2009; Kim and Sarna, 2004). It was
expected that their perceptions and self-efficacy could be increased through educational processes about breast cancer and screenings (Kim and Sarna, 2004; Kim, Menon, Wang, and Szalacha, 2010).

The health belief model (HBM) has been the most frequently used theory in the individual deficit perspective since the late 1980s in the health education and health promotion fields (Glanz and Rimer, 1997; Pasick and Burke, 2008). Especially, HBM with its culturally sensitive instruments, developed by Champion (1999), is the most commonly used or adopted model in breast cancer screening studies for underserved women including KAW (Juon, Kim, Shankar, and Han, 2004; Pasick and Burke, 2008; Kim and Menon, 2009). The core concept of the health belief model is that personal beliefs or perceptions on a disease and strategies are determinants to preventing the disease (Kim and Sarna, 2004; Kim et al., 2010).

The construct of perceived seriousness concerns the individual’s belief regarding the severity of a disease and it is grounded on medical information and experience in general (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). As mentioned above, there are complicated risks for the breast cancer incidence by gender, age, family history, obesity, and race/ethnicity. However, due to KAW’s various barriers, from language to access of information on breast cancer and screenings, it may be difficult for KAW to have sufficient knowledge or awareness about breast cancer and understanding about the role of mammograms for breast cancer early detection (Eun, Lee, Kim, and Fogg, 2009; Juon et al., 2004; Kim and Sarna, 2004; Kim and Menon, 2009; Kim et al., 2010). In other words, KAW’s low seriousness concerning breast cancer and screenings, caused by the lack of information about them could have a significant correlation with their limited mammogram practice.

Secondly, personal susceptibility, which refers to the risk perception on a
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Disease, could be one of the key cognitions to influence people’s behavior modification for their healthier lives (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). If KAW have high perceived susceptibility to breast cancer, they might be motivated to seek methods to decrease the mortality rate by that disease, such as routine mammograms.

Thirdly, the perceived benefit is the personal assessment of new behavior in disease risk reduction (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). KAW’s awareness of the significant role of a screening for breast cancer early detection and mortality reduction can affect their mammography usage.

Lastly, the construct of perceived barriers is a personal evaluation of obstructions to changing to new healthier behavior (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). These perceived barriers could play a significant role in KAW’s new behavior adoption and maintenance for breast cancer screenings because these obstacles may limit KAW’s reception of information on breast cancer and screenings, linked to their perceived seriousness, susceptibility, and benefit (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). Eventually, KAW could be discouraged by the barriers, such as language seeking breast cancer screenings.

Besides, according to HBM, personal behavior can be affected by cues to action, which are things or events to lead people to change their behavior for a healthy life (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). Hence, there are many different types of cues to action such as breast cancer cases of family or peers, media documentary reports about breast cancer, and advice from health care providers. According to Park and Park (2014), due to the recent advanced communication technologies, the Internet has become one of the primary resources for information and cues.
to action in breast cancer early detection.

Self-efficacy was not an original construct of HBM (Champion, Skinner, and Menon, 2005). It was included in the model later and became a very significant predictor for action in HBM (Rosenstock, Strecher, and Becker, 1988). In fact, self-efficacy was a core concept of social cognitive theory, which reverberates the strength of individuals’ beliefs on their accomplishing a certain task (Bandura, 1997, 2012). A person with greater self-efficacy has greater confidence in their capability for success compared to people with low self-efficacy (Champion et al., 2005; Bandura, 1997). Namely, self-efficacy is a significant factor to explain KAW’s motivation and achievement for their goals: Breast cancer screenings are regarded as a product that individuals experienced through observation and interaction with others in the past (Champion et al., 2005). However, these experiences and information do not affect the self-efficacy for breast cancer screenings immediately. As a learning process, all of the resources for experiences and information on breast cancer screenings are screened and weighed through cognitive assessment procedures (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2008). Essentially, self-efficacy is important in HBM but also in several behavior theories and intervention models, based on social cognitive theory (Bandura, 1997, 2012; Glanz and Rimer, 1997; Champion, 1999; Pasick and Burke, 2008).

This concept of self-efficacy can be applicable to social network/social support theory as well because self-efficacy can be enhanced through a strong social network and support, and the interaction of social relations and individual behavior may occur in various ways (Baker et al., 1997; Bandura, 1997, 2012; Glanz and Rimer, 1997; Israel, 1985; Pasick and Burke, 2008). KAW might receive information on breast cancer, screenings, and other women’s cancer cases through their social network and then their perceived
seriousness, susceptibility, and benefit can be affected through those processes. In addition to that, when KAW have social support including formalized outreach education for breast cancer screenings, their perception on barriers would be changed significantly (Kim and Sarna, 2004; Kim and Menon, 2009).

In addition, some research studies tried to include other factors such as modesty, fear, anxiety, fatalism, and acculturation in analyzing KAW’s perceptual transition processes for accessing breast cancer screenings as mediator or moderator (Champion, Skinner, Menon, Rawl, Giesler, Monahan, and Daggy, 2004; Kim and Menon, 2009; Lee, Chen, Jung, Baezconde-Garbanati, and Juon, 2014). There may be controversy about the ambiguity about the concepts of fear, anxiety, and fatalism and the significant effectiveness of modesty and acculturation rather than just language on breast cancer screening among women, currently emigrated from South Korea, where free or affordable mammograms are common. Nevertheless, those constructs may provide more detailed explanation of the transition process between the individual’s perceptions and actual behavior of breast cancer screenings, and the discussion on acculturation can lead to considering the influence of environment or social structure on breast cancer screening among KAW.

Finally, those research studies provide an important theoretical and practical foundation for discussing the outreach education intervention model such as the lay health advisor (LHA) model.

IV. Outreach Education Intervention and Lay Health Advisor Model
Based on the theoretical foundation discussed above, community-based intervention research studies have focused on outreach education intervention in different forms to increase the awareness of breast cancer early detection or to promote routine mammograms in quantitative ways, mainly based on HBM (Kim and Menon, 2009). The discussion about the intervention to promote routine mammograms among KAW was initiated in the mid-2000s.

In 2004, Kim and Sarna implemented quasi-experimental research on 141 KAW in Southern California to evaluate the group education intervention to improve attitude and knowledge about breast cancer screening, proving the significant effectiveness of that intervention. Juon, Choi, Klassen and Roter (2006) conducted another quasi-experimental study on 200 KAW in Maryland to assess the impact of community-based breast cancer education. In 2008, a different type of intervention—a print intervention to promote routine mammograms of KAW—was addressed by Maxwell, Jo, Chin, Lee and Bastani (2008). Finally, Han, Lee, Kim and Kim (2009) adapted the lay health advisor model into an intervention study to promote annual breast cancer screening.

The lay health advisor model was introduced into the breast cancer screening field in 1995 (Earp, Altpeter, Mayne, Viadro, and O'Malley, 1995) and has become the major intervention tool to increase annual mammography use of minority groups. The definition and role of the lay health advisor (LHA) can be diversely conceptualized and described. According to Israel (1985), LHAs are lay people to whom others normally turn for advice, emotional support, and tangible aid. LHAs may serve any number of functions, including linking and negotiating agency services for people in need. Sometimes, LHAs counsel people and design the mission of health professionals, while they assist in bridging the cultural and linguistic
gaps between health and human service providers and the community (Baker, Bouldin, Durham, and Lowell, 1997).

Thus, the LHA model, which is holistically and ecologically grounded on local needs and resources through the input of local community members, has considerable potential for a positive impact. Especially, the importance of social support and networks emerged in this intervention model as well. However, like other interventions, there may still be criticisms about the LHA model, based on an individual deficit context perspective such as health belief for lack of considering the concrete relations between individual perceptions and social factors for KAW’s consistent behavioral pattern change.

V. Habitus and Extension of Health Belief Model

In this section, the status of KAW’s breast cancer screenings is reviewed through the theoretical framework, extended from the health belief model with social information and service resource components overcoming the limitations of that model. Individual attitude, including perceptions, self-efficacy, and knowledge, and behavior patterns of mammogram practice are conceptualized with habitus (Grenfell, 2008). The nature of information and service resources was analyzed as a part of a social system or structure, which could influence individual habitus and dynamics among their components as well.

In the perspective of habitus, individuals’ health-related behavior might be a product of interaction between social structure and personal psychological structure (Lindbladh et al., 1996; Lindbladh and Lyttkens, 2002). In other words, the information and service resource structure of KAW’s breast
cancer screenings might be regarded as one of the major social determinants for their awareness of and confidence about mammogram practice and the significant role of routine screenings or willingness for the mammograms. This is quite similar to the theoretical approach of information and experience on perceptual constructs of the health belief model. HBM focused on the individuals’ perceptions, influenced by receiving information including experience from outside (Champion, 1999; Glanz and Rimer, 1997; Pasick and Burke, 2007), whereas in the perspective of habitus, the resources of information and service and their structure are included in the theoretical framework of HBM with perceptions and behavior expansively. Habitus, a concept developed by French sociologist Pierre Bourdieu, is useful in understanding KAW’s low breast cancer screening rate within social structures (Grenfell, 2008). Habitus has been defined as follows:

The concept of habitus begins from both an experiential and a sociological conundrum. Formally, Bourdieu defined habitus as a property of social agents (whether individuals, groups, or institutions) that comprise a structured and structuring structure. It is structured by one’s past and present circumstances, such as family upbringing and educational experiences. It is a structure in that it is systematically ordered rather than random or unpatented. (Grenfell, 2008, pp. 50-51)

Bourdieu’s concept of habitus is formed and exists through the interaction of individuals’ capital and field with multiple dimensional structures such as their environments, and those relations and processes are understood in association with symbols or culture, based on dualism or pluralism (Grenfell, 2008). In this context, it could be explained that KAW’s habitus as a perceptual and behavioral pattern may have reformed and been reformed in diverse interactions with diverse individual and social
components such as resocialization in a breast cancer screening field since they immigrated to new places and stayed in the U.S. This process might be complicated and implemented in mutual directions instead of one way because of the dual characteristics of habitus, which might be not dominated or influenced only by internal (personal) or external (social) components instead of both (see Figure 1).

KAW’s habitus on breast cancer screenings might be regarded as a construct of attitude, including perceptions, self-efficacy, and knowledge of breast cancer and routine mammography practice, which are interacted with their socio-economic and cultural capital such as income, resource, language, and culture in breast cancer screening fields. Eventually the social accessibility and individual selectivity of information and service sources for breast cancer screenings might be very significant in transforming KAW’s habitus of breast cancer screenings.

Lee, Fogg, and Sadler (2006) found that the status of health insurance possession was not significantly related to the breast cancer screening practice of KAW; however, they reported a strong relationship between the usual source of care and mammography usage. Meanwhile, a research study on the effectiveness of access and acculturation on cancer screening practice among Asian American women showed that access indicators such as health insurance and service providers were more significant as predictors than acculturation (Pourat, Kagawa-Singer, Breen, and Sriipipatana, 2010).

The outcomes might be explained by linguistic and geographical factors to influence KAW’s access to information and services for breast cancer screenings despite the number of free mammogram programs through National Breast Cervical Cancer Early Detection Program services in the U.S. (Juon, Choi, and Kim, 2000; Korean American Community Services, 2012). For example, Korean American Community Services of Chicago
served about 350 KAW without health insurance for free mammograms through their navigation program including free language and escort services at the clinical sites (Korean American Community Services, 2012). More than 89% of the participants in the program resided in the Chicago suburbs but most of the free mammogram providers working closely with Korean American Community Services, such as Presence Saints Mary and Elizabeth Medical Center and Swedish Covenant Hospital, were close to or in downtown Chicago.

Namely, as shown in Figure 1, within the information and service structure with no language and navigation support and low geographical accessibility for routine mammograms, KAW with limited capital in English fluency and personal resources might constantly experience information and service asymmetry in breast cancer and routine mammograms. In the end, KAW’s negative habitus of breast cancer screenings such as their perceptual and behavior pattern due to the social structural barriers might lead to their low screening rate and form a part of their culture against routine mammograms. On the other hand, within the information and service structure with language and navigation support and geographical accessibility for routine mammogram practice, KAW could develop their positive habitus on breast cancer and routine screenings through obtaining equivalent information and service empowering themselves and their habitus could structure a part of their culture in favor of routine breast cancer screenings. KAW’s positive habitus on mammography use would generate an active pattern for a routine mammograms.

In sum, the personal capital status might be different and limited among KAW, as well as the differences and limitations could affect individual’s access and selection of information and services for mammograms. Eventually, the accessibility and selectivity of information and service
sources for breast cancer screenings might be very significant in transforming KAW’s habitus of mammogram practices.

<Figure 1> Interaction between Social Factors and KAW’s Habitus of Routine Mammograms

VI. Discussion

In this article, KAW’s breast cancer issues and theoretical approaches and application were explored through a review of the literature. The conceptual framework on KAW’s information and service asymmetry on breast cancer and mammograms and their perceptions and screening practice for routine
mammograms were redesigned through bridging concepts of the health belief model and habitus theory for this study. The HBM model of linear relations between factors such as perceptions and breast cancer screening practice in the individual context was extended to the theoretical framework considering the multi-dimensional interactions between social factors such as information and service resources and individual habitus, composed of the components of the HBM model in a social structural context (see Figure 1). In addition to that, the extended framework was examined theoretically considering the relations among the diverse social components and individual perceptions and behavior in terms of accessibility and selectivity.

As a result, this raises the need for further theoretical and practical investigation on the structure of information and service resources and its components to understand the effect of KAW’s habitus of breast cancer screenings. It is essential to understand the nature of information and service resources of breast cancer and free mammograms including support services as (quasi-)public goods and the roles of major providers such as public agencies and non-profit organizations (McGinnis, 1999). Especially, due to their non-rivalry and non-excludability as free and public information and services among the characteristics of free information and service resources as (quasi-) public goods, non-motivation and inefficiency could occur between production and distribution (Anheier and Ben-Ner, 2003). In other words, the underserved KAW with diverse barriers may not have accurate and enough access to information and services for breast cancer screenings or screening providers may not be able to distribute such information and services efficiently because the appropriate and exact level of demand and provision of goods cannot be estimated and determined through the market. The problems of unequal accessibility and selectivity on information and service for having routine mammograms among KAW would be generated.
In this context, the role of the government can be emphasized to intervene with direct or indirect alternatives working with entities in different sectors such as non-profit or for-profit as shown in Figure 2.

Hence, it is critical to analyze the composition of information and service resources and the dynamics among major entities of the structure for free breast cancer screenings in the community setting. The task would be essential in understanding the overall status and issues of the underserved KAW with the extended health belief model discussed above, especially after the Affordable Care Act initiative in 2014.

Finally, in order to verify the theoretical modification and extension of HBM on KAW’s breast cancer screening, mentioned in this article, and to
apply that to the practical field, further examination through empirical inquiries is required. A research study with mixed methods such as survey and interview will be appropriate to cover diverse issues, related to KAW’s breast cancer screening in multidimensional perspectives.

VII. Limitations

As stated at the beginning of this article, this was the first effort to bridge the gap between social structural and individual deficit perspectives approaching the issues of KAW’s breast cancer screening. Especially, due to theoretical bias or dependency on HBM of limited academic disciplines such as the Nursing and Public Health fields, it was difficult to discover and discuss comprehensively the diverse issues and perspectives associated with KAW’s mammography usage. However, through extending the theoretical frame of HBM, the theory and model of Public Health and Psychology with habitus, the concept of Sociology, it was possible to explain the individual’s behavior for breast cancer screening in theoretical continuity between social and individual contexts. In addition to that, through defining information and service for routine mammograms including support services as (quasi-) public goods, a concept of Economics, it was possible to understand the nature of information and service asymmetry for breast cancer screening among KAW.

Nevertheless, there are still theoretical limitations of the extended HBM with habitus. First of all, the concept of “habitus” was adapted to the theoretical framework of this article instrumentally to reconcile the influences of social structure and individual perceptions on breast cancer screening practice. Originally, the concept of “habitus” was introduced with
other concepts such as “capital” and “field” by Bourdieu and they are connected to one another conceptually (Grenfell, 2008). Besides, those concepts are based on culture and cultural production (Grenfell, 2008). However, only the concept of habitus was stressed without conceptual clear explanation about capital and field in this article such as the relation between capital and social demographic factors. Especially, culture was a very important factor in understanding the concept of habitus as one of the major components of socialization, but it seemed that the conceptual framework of the extended HBM with habitus did not include the concept of culture or acculturation with clear explanations about the relations between habitus and culture.

Secondly, there is the lack or limitation of generalization in the extended frame of HBM with habitus. All of the discussions in this article focused on KAW’s breast cancer screening only. Hence, there would be questions about whether the conceptual framework in this article could be applied only to KAW’s breast cancer screening or also to other health behavioral issues of other minority groups. If the extended framework of HBM with habitus would be applicable only to KAW’s routine mammograms, the theoretical utility of the framework should be limited. Hence, through empirical research studies on diverse populations with other types of health behavior, the extended framework should be tested in diverse dimensions.

Finally, the characteristics of habitus were still ambiguous in this article. As stated before, habitus was defined as structuring structure and structured structure by Bourdieu (Grenfell, 2008). Hence, habitus has both active and passive characteristics of the external environment but in the scheme of the conceptual framework of Figure 1, it seemed that the individual’s habitus was composed of HBM components including screening behavior and described as passive internal structure, influenced by social structural
components. In that framework, self-efficacy could be one of the key concepts to determine the activity or passivity of habitus in relation to accessibility and selectivity of information and service resources. There should be further discussion about the relationship between the concepts of HBM and habitus.

Through the brief overview of this article, three limitations of the extended HBM framework with habitus were discussed. Those issues should be further explored through empirical research studies in the future. In spite of those theoretical problems or limitations, the implications of this article reconciling the two contradictory perspectives in social or individual contexts on social phenomenon are significant in terms of the direction of research studies about health behavior including breast cancer screening practice for theoretical development.
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Barriers to Mammography, Clinical Breast Exam and Breast Self-exam among Chinese-American Women 60 and Older.”
개인적/사회적 맥락에서의 소수 집단의 건강행태에 대한 이론적 고찰: 미국 거주 한인여성들의 유방암 검사 실천 사례를 중심으로

김준희
인천대학교 사회복지학과

요 약
본 연구의 목적은 미국 한인 여성들의 사례를 통해, 미국 소수인종집단들의 유방암검사 실천과 같은 건강관련 행태에 대한 최근 연구들을 살펴보고 이에 대한 사회적 그리고 개인적 요인간의 관계를 이론적으로 탐색하고 논의하는 것이다. 한인 여성들을 포함하여 미국 여성들의 유방암 검사 이슈들과 관련하여 진행된 기존의 연구들은 건강신념모델(Health Belief model)과 같은 개인적 관점에 과도하게 집중하고 있어, 이는 특히, 여전히 높은 유방암 조기 발견의 실패율과 같은 소수집단의 건강행태 관련 문제들에 대한 다양한 학문적 그리고 실천적 접근을 제한시켜왔다. 따라서, 본 연구 논문에서 유방암 검사의 행태에 대한 기존 연구들의 이론적 특성을 살펴보고 그들의 한계를 논하였으며 더 나아가, 개인적 그리고 사회적 관련간의 간극을 잇기 위해 부르디에의 아비투스(habitus) 개념의 개인/사회구조적 관점을 적용하여 건강신념모델을 수정하고 이에 대해 논하였다. 특히, 이 수정된 이론적 틀 안에서 사회적 요인으로의 유방암 검사 관련 정보와 서비스 자원들의 개인의 유방암 검사 실천에 미치는 영향도 논하였다. 그러나 이와 같은 인간 건강 행태를 개인적 및 사회적 관점으로 같이 포괄적으로 이해하려는 본 연구의 함의에도 불구하고 존재하는 이론적 한계가 존재하며 이를 극복하고 검증하기 위한 경험적 연구가 지속적으로 진행되어야 할 것이다.

주제어: 미국한인여성, 건강행태, 유방암검사, 건강신념모델, 아비투스