



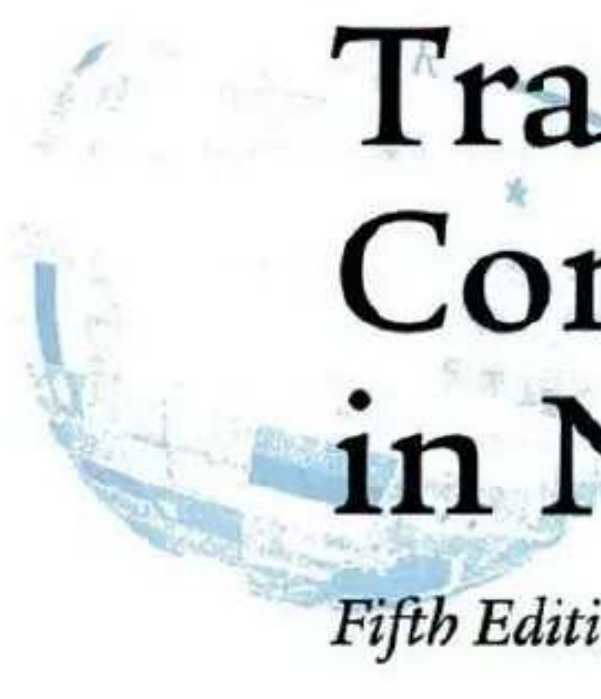
Transcultural Concepts in Nursing Care

Fifth Edition

Margaret M. Andrews and Joyceen S. Boyle



Wolters Kluwer | Lippincott
Health Williams & Wilkins



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Fifth Edition

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5th Edition

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HISTORICAL AND THEORETICAL FOUNDATIONS OF TRANSCULTURAL NURSING

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Theoretical Foundations of Transcultural Nursing

Margaret M. Andrews

KEY TERMS

Anthropology
Culture-specific nursing care
Culture-universal nursing care
Cultural competence

Cultural congruence
Culturally congruent care
Diversity
Ethnocentric
Leininger's Sunrise Model

Leininger's Theory of Culture
Care Diversity and Universality
Panethnic minority groups
Transcultural nursing

LEARNING OBJECTIVES

1. Examine the historical origins of transcultural nursing with special emphasis on its roots in anthropology.
2. Critically analyze the need for transcultural nursing in contemporary society.
3. Critically analyze prevailing nursing paradigms and nursing theories from a transcultural nursing perspective.
4. Identify resources available in transcultural nursing and health care.

During the past 6 decades, transcultural nursing's foundress Dr. Madeleine M. Leininger and thousands of other nurses from around the world have worked diligently to establish **transcultural nursing** as a formal area of academic study and practice. Since its initial conception in the 1950s to its formal creation as a specialty and new discipline within the profession in the 1960s and 1970s, a substantial and important body of transcultural theoretical, research-, and evidence-based knowledge has been generated by nurse scholars on every continent. In a historical and interpretive narrative highlighting the major features of the evolution of transcultural nursing as a specialty and discipline, Dr. Leininger describes her philosophical thoughts as she contemplated developing a new field of knowledge in nursing and health care: "It is amazing what some women

and men dare to do with their ideas over time and in many places in the world. Creative thinking and actions are often needed. Indeed, the nursing world needed transcultural nursing as essential to meet a changing world and changing health needs. . . . it is new ideas, education and practices that are essential to transform old practices and ideas into new ones" (Leininger, in press).

The term *transcultural nursing* is sometimes used interchangeably with *cross-cultural*, *intercultural*, or *multicultural* nursing. In analyzing the Latin derivations of the prefixes associated with these terms, you will notice that *trans* means *across*, *inter* means *between*, and *multi* means *many*. Given these derivations, it is understandable that various words have been used with similar connotative meaning (Andrews, 1992, 1995). Some

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people have used the term *ethnic nursing care* (Orque, Bloch, & Monroy, 1983) or have referred to *caring for people of color* (Branch & Paxton, 1976).

Approximately 30 years ago, nurse-anthropol-

team; the latter groups might be referred to as being members of occupational or professional cultures (Andrews & Boyle, 1997; Andrews & Boyle, 2002). There also are many other examples of *nonethnic cultures*, such as the culture of poverty

Approximately 50 years ago, nurse-anthropologists debated the conceptual differences between transcultural and cross-cultural nursing, and debate has continued. We have chosen to use transcultural nursing in this book in recognition of the historical and theoretical contributions of Dr. Madeleine M. Leininger, a nurse-anthropologist who, in the mid-1950s, envisioned transcultural nursing as a formal area of study and practice for nurses and coined the term *transcultural nursing* (Andrews & Boyle, 1997; Leininger, 1995, 1999; Leininger & McFarland, 2002; Leininger & McFarland, 2006). In her classic work, *Nursing and Anthropology: Two Worlds to Blend*, Dr. Leininger notes that “the fields of anthropology and nursing must be interdigitated so that each field will profit from the contribution of the other. . . . It is apparent that if these two fields were sharing their special knowledge and experiences, both would undoubtedly see new pathways in thinking and research” (Leininger, 1970).

As the name implies, transcultural nursing goes across cultural boundaries in a search for the essence of nursing. Transcultural nursing is the blending of anthropology and nursing in both theory and practice (Daugherty & Tripp-Reimer, 1985; Lipson & Bauwens, 1988; McKenna, 1984; Osborne, 1969). **Anthropology** refers to the study of humans and humankind, including their origins, behavior, social relationships, physical and mental characteristics, customs, and development through time and in all places in the world. Recognizing that nursing is an art and a science, transcultural nursing enables us to view our profession from a cultural perspective. Transcultural nursing is not just for immigrants, people of color, or members of the federally defined **panethnic minority groups**, i.e., Blacks, Hispanics, Asians/Pacific Islanders, and American Indians/Alaska Natives. Everyone has a cultural heritage, including nurses, patients, and other members of the health care

or *nonethnic cultures*, such as the culture of poverty or affluence, culture of the deaf or hearing impaired and the blind or visually impaired, and the gay, lesbian, and transgender cultures.

Transcultural nursing is a specialty within nursing focused on the comparative study and analysis of different cultures and subcultures. These groups are examined with respect to their caring behavior, nursing care, and health-illness values, beliefs, and patterns of behavior. The goal of transcultural nursing is to develop a scientific and humanistic body of knowledge in order to provide **culture-specific** and **culture-universal nursing care** practices to individuals, families, groups, and communities from diverse backgrounds. *Culture-specific* refers to particular values, beliefs, and patterns of behavior that tend to be special or unique to a group and that do not tend to be shared with members of other cultures. *Culture-universal* refers to the commonly shared values, norms of behavior, and life patterns that are similarly held among cultures about human behavior and lifestyles (Leininger, 1978, 1991, 1995; Leininger & McFarland, 2002).

Transcultural nursing requires sophisticated assessment and analytic skills and the ability to plan, design, implement, and evaluate nursing care for individuals, families, groups, and communities representing various cultures. You must also be able to apply knowledge related to the culture of organizations, institutions, and agencies, especially those concerned with health and nursing.

The Importance of Transcultural Nursing

Leininger (1995) cites eight factors that influenced her to establish transcultural nursing:

1. There was a marked increase in the migration of people within and between countries worldwide. Transcultural nursing is

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needed because of the growing diversity that characterizes our national and global populations. In its broadest sense, **diversity** refers to differences in race, ethnicity, national origin, religion, age, gender, sexual orientation, ability or disability, social and

nursing enables nurses to more accurately assess the cultural expression of pain and to provide culturally appropriate interventions to prevent or alleviate discomfort. Last, incidents have been reported in which parents have been arrested for child abuse because culturally based child-rearing practices were misunderstood. Trans-

economic status or class, education, and related attributes of groups of people in society.

2. There has been a rise in multicultural identities, with people expecting their cultural beliefs, values, and lifeways to be understood and respected by nurses and other health care providers.
3. The increased use of health care technology sometimes conflicts with cultural values of clients, such as Amish prohibitions against using certain apnea monitors, IV pumps, and other such health care technologic devices in the home.
4. Worldwide, there are cultural conflicts, clashes, and violence that have an impact health care as more cultures interact with one another.
5. There was an increase in the number of people traveling and working in many different parts of the world.
6. There was an increase in legal suits resulting from cultural conflict, negligence, ignorance, and imposition of health care practices.
7. There has been a rise in feminism and gender issues, with new demands on health care systems to meet the needs of women and children.
8. There has been an increased demand for community and culturally based health care services in diverse environmental contexts.

Let's examine a few clinical examples of ways in which transcultural nursing can be used in the care of people with diverse backgrounds. Transcultural nursing enables nurses to communicate more effectively with clients from diverse cultural and linguistic backgrounds and to assist those with mental health problems. Transcultural

rearing practices were poorly understood. Transcultural nursing is a vehicle for assessing the parent-child relationship and for encouraging forms of parental discipline that promote the health and well-being of children and prevent physical or emotional harm (Andrews, 1992, 1995; Flaskerud, 2000; Leininger, 1997; Leininger & McFarland, 2002, 2006; Mahoney & Engebretson, 2000).

Throughout this book, we shall examine various ways in which transcultural nursing facilitates nurses' knowledge and skill in caring for people from diverse backgrounds. Although much of the emphasis will be on diversity, we shall also explore the universal attributes that we have in common with other members of the human race, such as the need for food, sleep, shelter, safety, and human interaction. Let us now examine some key developments in transcultural nursing from a historical perspective.

History of Transcultural Nursing

In the 1950s, Dr. Madeleine M. Leininger noted cultural differences between patients and nurses while working with emotionally disturbed children. This clinical experience led her in 1954 to study cultural differences in the perceptions of care, and in 1965 she earned a doctorate in cultural anthropology from the University of Washington (Leininger, 1995; Leininger & McFarland, 2002, 2006; Reynolds & Leininger, 1993). Leininger recognized that one of anthropology's most important contributions to nursing was the realization that health and illness states are strongly influenced by culture. Table 1-1 gives a summary of Dr. Leininger's contributions to the development of transcultural nursing.

To help develop, test, and organize the emerging body of knowledge in transcultural nursing,

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TABLE 1-1 *Contributions of Madeleine Leininger to the Development of Transcultural Nursing*

Date	Achievement and Contribution
1954	Dr. Madeleine Leininger noticed and studied the cultural differences in the perception of care
1965	Leininger earned a doctorate in cultural anthropology (U. of Washington)
1965-1969	Leininger offered first courses and telelectures offered in transcultural nursing

	(U. of Colorado School of Nursing)
	Established first PhD nurse-scientist program combining anthropology and nursing (U. of Colorado School of Nursing)
1973	First academic department in transcultural nursing established (U. of Washington School of Nursing)
1974	Transcultural Nursing Society established as the official organization of transcultural nursing
1975	First national transcultural nursing conference, <i>Care of Infants and Children</i> , held at Snowbird, Utah; thereafter annual conferences held at various locations in the U.S., Canada, the Netherlands, Finland, Australia, Spain, and United Kingdom
1978	First advanced degree programs (master's and doctoral) established (U. of Utah School of Nursing)
1988	Transcultural Nursing Society initiated certification examinations: Certified Transcultural Nurse (CTN)
1989	Journal of Transcultural Nursing (JTN) first published as official publication of the Transcultural Nursing Society with Dr. Madeleine Leininger as founding editor. Goal of the JTN: to disseminate transcultural ideas, theories, research findings, and/or practice experiences
1991	Dr. Leininger published <i>Culture Care Diversity and Universality: A Theory of Nursing</i> , in which she outlined her theory (Culture Care Diversity and Universality and the Sunrise Model) and its research applications
1995	Dr. Leininger published <i>Transcultural Nursing: Concepts Theories, Research and Practices</i> (2nd edition)
2000	As part of a longstanding history of collaboration with Madonna University (Livonia, Michigan), Dr. Leininger negotiated to build the Transcultural Nursing Society's World Headquarters as part of a new wing of the building that houses the College of Nursing and Health
2002	Dr. Leininger (with co-author Dr. Marilyn McFarland) published <i>Transcultural Nursing: Concepts, Theories, Research, and Practices</i> (3rd edition)
2004	Installation of the Founder and Presidential Photos in the Global Transcultural Nursing Headquarters and induction as a charter member of the Transcultural Nursing Scholars (TNS)
2006	Dr. Leininger (with co-author Dr. Marilyn McFarland) published <i>Culture Care Diversity and Universality: A Worldwide Theory for Nursing</i>
2006	Dr. Leininger released a series of three DVDs: <i>The Life Career of Leininger</i> , <i>The Theory of Culture Care</i> , and <i>Conversation with a Legend</i>
2007 to present	A member of the Transcultural Nursing Society's Board of Directors and Professor Emerita at Wayne State University and the University of Nebraska, Dr. Leininger continues to be active as a transcultural nurse consultant, scholar, researcher, speaker, and leader in the field of transcultural nursing

Table based, in part, on Transcultural Nursing Society. (2007). Transcultural Nursing Society: Historical moments. Transcultural Nursing Society Newsletter, 16(1), 9.

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it is necessary to have a specific conceptual framework from which various theoretical statements can emerge. **Leininger's Sunrise Model** (Figure 1-1) is based on the concept of cultural

care and shows three major nursing modalities that guide nursing judgments and activities to provide **culturally congruent care**—that is, care that is beneficial and meaningful to the people



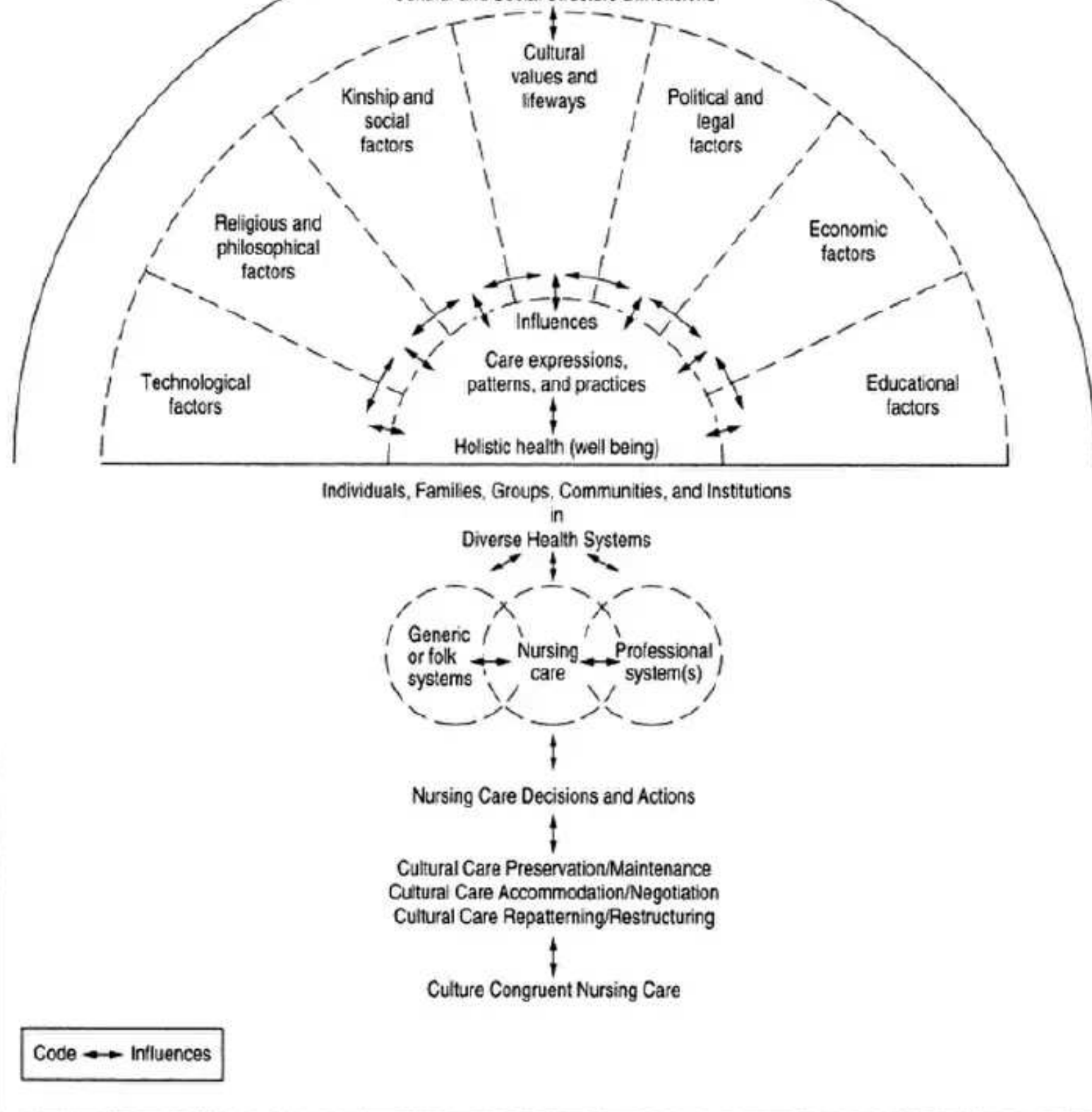


FIGURE 1-1. Leininger's Sunrise enabler to depict the Theory of Cultural Care Diversity and Universality. (Reprinted by permission from Leininger, M. M., & McFarland, M. R. [2006]. *Culture care diversity and universality: A worldwide theory for nursing* [2nd ed., p. 25]. Sudbury, MA: Jones & Bartlett, Publishers.)

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being served (Leininger, 1991, 1995; Leininger & McFarland, 2002).

Leininger's Theory of Culture Care Diversity and Universality focuses on describing, explaining, and predicting nursing similarities and differences focused primarily on human care and caring in human cultures. Leininger uses worldview, social structure, language, ethnohistory, environmental context, and the generic (folk) and professional systems to provide a comprehensive and holistic view of influences in culture care. Culturally based care factors are

institutions in diverse health systems. Leininger's Sunrise Model depicts components of the Theory of Cultural Care Diversity and Universality, and it provides a visual schematic representation of the key components of the theory and the interrelationships among its parts. As the world of nursing and health care has become increasingly multicultural, the theory's relevance has increased as well. For further information about Dr. Leininger and her Theory of Culture Care Diversity and Universality, visit either Dr. Leininger's Web site (www.madelaine-leininger.com) or the

ture care. Culturally based care factors are recognized as major influences on human expressions and experiences related to health, illness, and well-being or on facing disabilities or death. The three modes of nursing decisions and actions—culture care preservation and/or maintenance, culture care accommodation and/or negotiation, and culture care repatterning and/or restructuring—are presented to demonstrate ways to provide culturally congruent nursing care (Leininger, 1991, 1995; Leininger & McFarland, 2002). Among the strengths of Leininger's theory is its flexibility for use with individuals, families, groups, communities, and

Leininger's web site (www.madeleine-leininger.com) or the Transcultural Nursing Society's Web site (www.tcns.org).

Critical Analysis of Transcultural Nursing

Transcultural nursing has been criticized for its definitional, theoretical, and practical limitations. You are encouraged to think critically as you examine some of the major criticisms of transcultural nursing. Recognizing that all nursing theories have limitations, you are urged to



FIGURE 1-2. Author Dr. Margaret Andrews (*left*) and Transcultural Nursing Foundress, and Dr. Madeleine Leininger (*right*), at a meeting of The American Academy of Nursing.

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critically reflect on ways in which the limitations can be addressed or overcome.

Major Criticisms

Let us begin by examining the criticism that transcultural nursing contains ambiguous terminology and lacks clarity in describing key concepts (Habayeb, 1995; Mulholland, 1995). For example, nurses have struggled to achieve clarity in concepts such as cultural awareness, cultural sensitivity, **cultural competence**, and **cultural congruence**. Color, religion, and geographic location are some of the factors that have been

commonly used to define cultural differences. However, these factors are often used interchangeably with *different*, *deviant*, *abnormal*, or *pathologic*. Problems are thought to be generated by customs or traditions deemed by the nurse to be “inappropriate,” a judgment that may be the result of personal bias, lack of knowledge concerning the cultural context in which these customs are practiced, the nurse's inexperience, or other factors. As a result, complex sociocultural phenomena are often reduced to overgeneralized stereotypes. For example, some North American nurses are critical of the role of women in traditional African and Middle Eastern cultures. In concentrating on culturally determined gender

location are most often used to narrowly define culture and highlight cultural diversity, which is often portrayed as a minority/majority issue. Discrepancies in definition arise when one fails to recognize that every person has a cultural heritage. Talabere (1996) suggests that cultural diversity is itself an **ethnocentric** term because it focuses on "how different the other person is from me" rather than "how different I am from the other." In using the term *cultural diversity*, the White panethnic group is frequently viewed as the norm against which the differences in everyone else (ethnocentrically referred to as non-Whites) are measured or compared.

Another criticism of transcultural nursing models is their failure to recognize the relationship between knowledge and power and their inattention to the complexities associated with prejudice, discrimination, and racism (cf. Gustafson, 1999; Price & Cortis, 2000). Although Leininger and other transcultural nurses address the need to consider the political, economic, and social dimensions in their theoretical formulations, transcultural nursing has been criticized for doing too little to encourage nurses to be actively involved in setting political, economic, and social policy agendas.

Culley (1996) criticizes transcultural nursing for failing to recognize the power relations that exist between groups. When clients from traditionally underrepresented groups fail to behave as a nurse expects, the behavior is sometimes referred to as *noncompliant*, a term with a negative connotation that is sometimes used synony-

ously, you might ignore or minimize the significance of power, inequality, and racism as embedded in structures or institutions (Gustafson, 1999; Price & Cortis, 2000), factors that fundamentally affect the health of cultural groups and their members' access to quality health care. The same criticism might be applied to nursing's failure to address other forms of bias, prejudice, discrimination, and social injustice.

Juntunen (2007) has criticized Leininger for generalizing her research by creating lists of the culture care values, meanings, and action modes of each of the cultures that she and her disciples have studied. These generalizations foster stereotyping and fail to consider the variations within cultures that influence the ways in which people express their cultural orientation. Lastly, every belief and practice has both cultural and individual or familial determinants.

Finally, transcultural nursing has been criticized for embracing models based on the assumption that understanding one's own culture and the culture of others creates tolerance and respect for people from diverse backgrounds. It has become apparent that the mere awareness of one's own culture and that of others is insufficient for the alleviation and potential eradication of prejudice, bigotry, racial, ethnic, or cultural conflicts, discrimination, or ethnic violence. Rather, nursing students, nurses, and other health care providers must have positive experiences with members of other cultures and learn to genuinely value the contributions all cultures make to our multicultural society.

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Response to Criticisms

In the remainder of this book, we, the authors, will attempt to address these criticisms of transcultural nursing through our approach to topics. It should be noted, however, that many of the issues raised by critics have deeply rooted historical, socioeconomic, religious, cultural, and political origins. Because the nursing profession is a microcosm of society, it mirrors the biases and prejudices found in the larger social order. It is unrealistic to expect that transcultural nursing can reverse all the inequalities cited by the critics. It is realistic, however, to expect more definitional, conceptual, and theoretical clarity. It also

nurses in key administrative positions can critically assess the organizational climate and culture for its encouragement of diversity, examine the organization's administrative hierarchy for the presence of diversity in leadership positions, evaluate its commitment to culturally sensitive and appropriate personnel policies, and foster an openness to different perspectives on leadership and management. The examples cited are intended to be illustrative, not exhaustive.

A variety of organizations, professional publications, and electronic resources support the development of transcultural nursing and health. With the proliferation of electronic resources available to search for subjects related

is realistic to expect nurses to become increasingly active in setting political, economic, and social policy agendas at the local, state/provincial, national, and international levels.

For example, you can empower yourself and your profession by running for elected offices; supporting candidates with health-related agendas congruent with your own; voting for candidates from diverse cultural backgrounds; using print, broadcast, and Web-based media to influence public opinion; and joining professional organizations or unions that employ professional lobbyists to represent them. You have the power to confront prejudice and discrimination by refusing to tolerate ethnic jokes and other expressions of prejudice in health care or educational settings. You can use peer pressure to change culturally insensitive or offensive behavior by others. You can also work with others to ensure that medical and surgical procedures, health-related appointments, and schedules are congruent with the religious and cultural calendars of clients, staff, and students.

Nurse educators can examine admission and recruitment policies, curricula, pedagogy, academic calendars, and teaching strategies from a transcultural nursing perspective. Nurse researchers need to ensure that diversity is represented in the population studied, that appropriate translation and interpretation have been used for non-English-speaking informants or subjects, and that research instruments are appropriate for use with diverse populations. Finally,

to transcultural nursing and health, it is important for you to keep abreast of computer-based tools that enable you to obtain the information you need on a wide variety of transcultural subjects. Andrews, Burr, & Janetos (2004) provide suggestions for narrowing and focusing your search using important research databases such as Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Educational Resources Information Center (ERIC), and Psychological Abstracts (PsycINFO). Selected Web sites for U.S. government agencies, organizations, and commercial groups that concern transcultural nursing and health care are also described in brief annotations. Table 1-2 provides some basic information on selected resources.

Standards for Transcultural Nursing

Under the leadership of the Minnesota Chapter of the Transcultural Nursing Society, standards for transcultural nursing have been developed based on Leininger's Theory of Culture Care Diversity and Universality (Leininger, 1991, 1995, 1998; Leininger & McFarland, 2002) and Campinha-Bacote's Model of Cultural Competence (Campinha-Bacote, 2002). The Standards for Transcultural Nursing were developed to foster excellence in transcultural nursing practice, provide criteria for the evaluation of transcultural nursing, create a tool for teaching and learning,

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TABLE 1-2 *Selected Resources for Transcultural Nursing*

Professional Resources

Professional Organizations

Description

Council on Nursing and Anthropology Association (CONAA) (1968)

Transcultural Nursing Society (TNS) (1974)

Council on Cultural Diversity of the American Nurses' Association (ANA, 1978)

International Association of Human Caring (1987)

Description and Purpose

Organization for nurse-anthropologists, transcultural nurses, and anthropologists
Purpose: promotes interdisciplinary research exchange

Organization of transcultural nurses
Purpose: to promote transcultural nursing knowledge and competencies globally through education, research, consultation, and clinical services

ANA Council of transcultural nurses
Purpose: to focus on diversity issues in clinical practice

Organization of qualitative researchers, some of whom are nurses

	Human Caring (1987)	or whom are nurses
	Committee on Cultural Diversity	Purpose: to explore the cultural similarities and differences in expressions of human care Committee established by the American Academy of Nursing Purpose: to develop guidelines for culturally competent nursing
Refereed Printed Materials on Transcultural Nursing and Health	<i>Journal of Transcultural Nursing</i> <i>Journal of Multicultural Nursing and Health</i> (JMCNH) <i>Journal of Cultural Diversity</i> <i>Association of Black Nursing Faculty</i> (ABNF) <i>Journal</i> <i>International Nursing Review</i> <i>International Journal of Nursing Studies</i>	Only publication focused on transcultural nursing theory, research methods, consultation, teaching, and clinical community practices Interdisciplinary; addresses multiculturalism in nursing education and/or health Focuses on cultural diversity theory and principles from a variety of perspectives Documents the distinct nature and health care needs of the Black patient Both published by the International Council of Nurses
Nonrefereed Print Materials	<i>Minority Nurse Newsletter</i> <i>Closing the Gap</i> (newsletter) <i>IHS Primary Care Provider</i> (newsletter)	Examines minority issues affecting patient care and nursing education Published by the Federal Office of Minority Health; focuses on federal interventions aimed at improving the health of panethnic groups Published by the Federal Indian Health Service; free to nursing and medical students and health care providers

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TABLE 1-2 *Selected Resources for Transcultural Nursing (continued)*

Professional Resources

Electronic Resources

Description

www.tcns.org

Description and Purpose

Official Web site for the Transcultural Nursing Society, provides information about membership in the organization, conferences, regional workshops, transcultural nursing certification, and the *Journal of Transcultural Nursing*; useful links to other Web sites of relevance to transcultural nursing

increase the public's confidence in the nursing profession, and advance the field of transcultural nursing. The general membership of the Transcultural Nursing Society subsequently reviewed and approved the standards, which, effective fall

gum, Wieger, & McCullough-Zander, 2002; Transcultural Nursing Certification Committee, 2007).

2008, will form the foundation for the Transcultural Nursing Certification Exam. Each of the eight transcultural nursing standards is accompanied by rationale, process criteria, and outcome criteria. The eight standards are (1) Theoretical Foundations of Transcultural Nursing, (2) Cultural Information Gathering, (3) Caring and Healing Systems, (4) Cultural Health Patterns and Caring Practices, (5) Health Care Planning, (6) Evaluation, (7) Research, and (8) Professional Development. These eight standards were developed to assist nurses in providing culturally competent and culturally congruent care, a topic that will be discussed in more depth in Chapter 2. Standards provide clarity in direction for nursing practice, reflect values and priorities in professional practice, define accountability to the public, and provide a clear framework for evaluation of transcultural nursing practice (Leuning, Swig-

Summary

In this introductory chapter, we have examined the historical origins of transcultural nursing as a blending of two fields: anthropology and nursing. Founded by nurse-anthropologist Dr. Madeleine M. Leininger, transcultural nursing has provided a theoretical foundation to guide nurses in the provision of culturally congruent and competent care for individual clients and patients of all ages, families, groups, and communities. Transcultural nursing also enables nurses to examine the cultural dimensions of health and nursing organizations, institutions, and agencies. Leininger's Theory of Culture Care Diversity and Universality and her Sunrise Model were introduced. Finally, selected resources in transcultural nursing and health care were identified.

REVIEW QUESTIONS

1. Conceived in the early 1950s by nurse-anthropologist Dr. Madeleine M. Leininger, the term *transcultural nursing* was coined in 1970 with her seminal work *Nursing and Anthropology: Two Worlds to Blend*. Define transcultural nursing in your own words.
2. Summarize the historical development of transcultural nursing since its founding by Dr. Madeleine Leininger.

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3. Review the limitations of transcultural nursing cited by critics. What can be done to address the criticisms?
4. Identify electronic and print resources in transcultural nursing and health.

CRITICAL THINKING ACTIVITIES

1. Visit the Transcultural Nursing Society's official Web site (www.tcns.org).
 - a. Briefly summarize the information you found at the Web site.
 - b. Critically evaluate the strengths and limitations of this information source and the data available.
 - c. What clinical relevance does the electronic information on transcultural nursing have for you as a nurse?
 - d. Visit links to other related Web sites on transcultural nursing.
2. Using CINAHL, enter the words *transcultural nursing* and search for references cited during the past year. How many references are identified? What are the subcategories under which you can narrow your search? If you want information about a specific cultural, ethnic, or minority group, what keywords will help you to narrow the search? Consult a reference librarian for assistance if you need help.

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CHAPTER 2



Culturally Competent Nursing Care

Margaret M. Andrews

KEY TERMS

Collateral relationships	Distance	Nonverbal communication
Cross-cultural communication	Environmental context	Proxemics
Cultural code	Eye contact	Sick role behavior
Cultural competence	Individual cultural competence	Silence
Culturally congruent care	Linguistic competence	Space
Cultural self-assessment		Touch

LEARNING OBJECTIVES

1. Analyze the complex integration of knowledge, attitudes, and skills needed for cultural competence.

1. Analyze the components, integration of knowledge, attitudes, and skills needed for cultural competence.
2. Explore cross-cultural communication as the foundation for the provision of culturally competent nursing care.
3. Identify strategies for promoting effective cross-cultural communication in multicultural health care settings.

When the author recently conducted an Internet search for **cultural competence**, using the popular search engine Google, more than 27,700,000 “hits” resulted. These fell into two major categories: (1) *organizational cultural competence* and (2) *individual cultural competence*, usually in reference to nurses, physicians, social workers, or others in health care, education, or social services professionals.

According to the National Center for Cultural Competence (Georgetown University Center for Child and Human Development, n.d.), cultural competence requires that *organizations* have the following characteristics:

- A defined set of values and principles and demonstration of behaviors, attitudes, poli-

cies, and structures that enable them to work effectively cross-culturally.

- The capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporation of the previously mentioned items in all aspects of policy making, administration, practice, and service delivery, and systematic involvement of consumers, key stakeholders, and communities.

Individual cultural competence refers to a complex integration of knowledge, attitudes, beliefs, skills, and encounters with those from

cultures different from one's own that enhances cross-cultural communication and appropriate and effective interactions with others (American Academy of Nursing, 1992, 1993; Campinha-Bacote, 2000, 2003; Geron, 2002). Cultural competence has been defined as a process, as opposed to an end point, in which the nurse continuously strives to work effectively within the cultural context of an individual, family, or community from a diverse cultural background (Andrews & Boyle, 1997; Campinha-Bacote, 2000, 2003; Campinha-Bacote & Munoz, 2001; Wells, 2000; Smith, 1998). Campinha-Bacote (2003) defines cultural competence as “the ongoing process in which the healthcare professional continuously strives to seek the ability and availability to work effectively within the cultural context of the client (individual, family, community). This process involves the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters” (Campinha-Bacote, 2003, p. 14).

In addition to cultural competence, some experts have noted the considerable impact that **linguistic competence** by health care providers has on clients' access and response to health care services. Cultural and linguistic competence

meaningful and fits with cultural beliefs and lifeways. Leininger's definition of culturally congruent care is holistic and focuses on the complex interrelationship of lifeways, religion, kinship, politics, law, education, technology, language, **environmental context**, and worldview—all factors that contribute to culturally congruent care.

Because you may encounter clients from literally hundreds of cultures in your professional career and clients of mixed cultural heritage, it is virtually impossible to know about the culturally based, health-related beliefs and practices of them all. It is, however, possible to master the knowledge and skills associated with cultural assessment and learn about some of the cultural dimensions of care for clients representing the groups most frequently encountered. In-depth knowledge of several cultures is often a reasonable goal if you live in a large urban center characterized by a high degree of diversity.

services. Cultural and linguistic competence refers to an ability by health care providers and health care organizations to understand and effectively respond to the cultural and linguistic needs brought by clients to the health care encounter. Summarized in Box 2-1 are the 14 recommended standards for culturally and linguistically appropriate health care services proposed by the U.S. Department of Health and Human Services, Office of Minority Health (2000). These standards identify the 14 standards and include a definition of culturally competent care, as well as standards concerning language access, required organizational supports, implementation guidelines, the relationship between the standards and existing laws, diverse and culturally competent staff, data collection, and information dissemination.

Instead of using the term *cultural competence*, Leininger (1991, 1995, 1999; Leininger & McFarland, 2005) prefers *culturally congruent care*, which she defines as the provision of care that is

Before you can provide culturally competent care for people from diverse backgrounds, it's important to engage in a **cultural self-assessment**. When interacting with clients from various cultural backgrounds, you must be aware of your own cultural values, attitudes, beliefs, and practices. To gain insight into the way that you relate to various groups of people in society, describe your level of response to the groups identified in Box 2-2.

Through self-assessment, it is possible to gain insights into the health-related values, attitudes, beliefs, and practices that have been transmitted to you by your own family. These insights also enable you to overcome ethnocentric tendencies and cultural stereotypes, which are vehicles for perpetuating prejudice and discrimination against members of certain groups.

After you have engaged in a cultural self-assessment, it is possible to conduct a cultural assessment of others.

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BOX 2-1

Office of Minority Health Standards for Culturally and Linguistically Appropriate Health Care by Health Care Organizations

- Promote and support attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment
- Have a comprehensive management strategy, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation
- Utilize formal mechanisms of community and consumer involvement in the development and execution of service delivery
- Develop and implement a strategy to recruit, retain, and promote qualified diverse and culturally competent administrative, clinical, and support staff who are trained to address the needs of racial and ethnic communities
- Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent delivery of service
- Provide all clients having limited English proficiency with access to bilingual interpretation services
- Provide oral and written notices, including translated signage at key points of entry, to clients in their primary language, informing them of their right to receive interpreter services
- Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting
- Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's information system
- Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community
- Undertake ongoing organizational self-assessments of cultural and linguistic competence and measure for access, satisfaction, quality, and outcome using internal audits and performance improvement programs
- Develop structures and procedures to address cross-cultural ethical and legal issues in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services, or denial of services

- Translate and make available signage and commonly used written patient educational materials in the predominant language(s) in the service area

- Prepare an annual progress report documenting progress in implementing these standards, including information on programs, staffing, and resources

Source: Office of Minority Health (2000). National standards on culturally linguistically appropriate services (CLAS). *Federal Register* 65(247), 80865–80879. Department of Health and Human Services, U.S. Public Health Service, Washington, D.C. www.omhrc.gov/clas/ds.htm

Cultural Assessment

The author believes that cultural assessment is the foundation for culturally competent and culturally congruent nursing care. Appendix A contains the Andrews/Boyle Transcultural Nursing Assessment Guide for Individuals and Families, an instrument that is intended to help you to ask key questions during your assessment interview. Please refer to Chapter 3, Cultural Competence in the Health History and Physical

Examination, for a complete discussion of cultural assessment.

Skills Needed for Cultural Competence

The term *cultural competence* implies that you have developed certain psychomotor or behavioral skills. Box 2–3 contains selected examples of these skills, and others will be presented throughout the text. It should be noted that mastery of some skills, such as the assessment of

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BOX 2-2

How Do You Relate to Various Groups of People in the Society?

Described below are different levels of response you might have toward a person.

Levels of Response

1. *Greet*: I feel I can *greet* this person warmly and welcome him or her sincerely.
2. *Accept*: I feel I can honestly *accept* this person as he or she is and be comfortable enough to listen to his or her problems.
3. *Help*: I feel I would genuinely try to *help* this person with his or her problems as they might relate to or arise from the label-stereotype given to him or her.
4. *Background*: I feel I have the *background* of knowledge and/or experience to be able to help this person.
5. *Advocate*: I feel I could honestly be an *advocate* for this person.

The following is a list of individuals. Read down the list and place a checkmark next to anyone you would *not* “greet” or would hesitate to “greet.” Then move to response level 2, “accept,” and follow the same procedure. Try to respond honestly, not as you think might be socially or professionally desirable. Your answers are only for your personal use in clarifying your initial reactions to different people.

Level of Response

	1	2	3	4	5
Individual	Greet	Accept	Help	Background	Advocate
1. Haitian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Child abuser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Jew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Person with hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Neo-Nazi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Mexican American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. IV drug user	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. IV drug user	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Catholic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Senile, elderly person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Teamster Union member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Prostitute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Jehovah's Witness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Cerebral palsied person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. ERA proponent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Vietnamese American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Gay/lesbian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Atheist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Person with AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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BOX 2-2 (continued)

How Do You Relate to Various Groups of People in the Society?

	Level of Response				
	1	2	3	4	5
Individual	Greet	Accept	Help	Background	Advocate
<i>Physically/mentally handicapped</i>					
4. Person with hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Senile elderly person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Cerebral palsied person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Person with AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Amputee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Person with cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Political</i>					
5. Neo-Nazi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Teamster Union member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. ERA proponent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Communist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Ku Klux Klansman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Nuclear armament proponent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reproduced with permission of the Association for the Care of Children's Health, 7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814, from E. Randall-David (1989). *Strategies for Working with Culturally Diverse Communities and Clients*, pp. 7-9.

cyanosis in people with darkly pigmented skin, might be critical for a patient's survival. Other skills may be helpful in promoting hygiene or comfort, but they do not have such dire consequences. Because communication is a skill found

include differences in language, worldview, and values. It is estimated that up to 90% of all difficulties in nurse-client interactions have resulted from miscommunication.

To begin the discussion on cross-cultural

quences. Because communication is a skill foundational to all nursing interactions, the remainder of this chapter will focus on this important topic.

Cross-Cultural Communication

Communication is an organized, patterned system of behavior that regulates and makes possible all nurse-client interactions. It is the exchange of messages and the creation of meaning. Because communication and culture are acquired simultaneously, they are integrally linked. In effective communication there is mutual understanding of the meaning attached to the messages. Barriers to communication

To begin the discussion on cross-cultural communication, it is necessary to examine the ways in which people from various cultural backgrounds communicate with one another. In addition to oral and written communication, messages are conveyed nonverbally through gestures, body movements, posture, tone of voice, and facial expressions (Figure 2-1).

Frequently overlooked is the context in which communication occurs. The environmental context imparts its own message and is influenced by the setting, the purposes of the communication, and the perceptions of the nurse and client concerning time, space, distance, touch, modesty, and other factors. For example, let us imagine you know that a Mexican-American patient is extremely anxious about having a mammogram.

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BOX 2-3

Selected Examples of Psychomotor Skills Useful in Transcultural Nursing

Assessment

- Techniques for assessing biocultural variations in health and illness, e.g., assessing cyanosis, jaundice, anemia, and related clinical manifestations of disease in darkly pigmented clients; differentiating between mongolian spots and ecchymoses (bruises)
- Measurement of head circumference and fontanelles in infants using techniques not in violation of taboos for selected cultural groups
- Growth and development monitoring for children of Asian heritage, using culturally appropriate growth grids
- Cultural modification of the Denver II and other developmental tests used for children
- Conducting culturally appropriate obstetric and gynecologic examinations of women from various cultural backgrounds

Communication

- Speaking and writing the language(s) used by clients
- Using alternative methods of communicating with non-English-speaking clients and families when no interpreter is available (e.g., pantomime)

Hygiene

- Skin care for clients of various racial/ethnic backgrounds
- Hair care for clients of various ethnic/racial backgrounds, e.g., care of African-American clients' hair

Activities of Daily Living

- Assisting Chinese-American clients to regain use of chopsticks as part of rehabilitation regimen after a stroke
- Assisting paralyzed Amish client with dressing when buttons and pins are used
- Assisting West African client who uses "chewing stick" with oral hygiene

Religion

- Emergency baptism and anointing of the sick for Catholics
- Care before and after ritual circumcision by *mohel* (performed 8 days after the birth of a male Jewish infant)



After the procedure, you intend to send an empathetic, caring message by remarking, "It's all over, Señora Garcia." Señora Garcia bursts into tears because she believes she has been diagnosed with terminal breast cancer. Needless to say, even communication between individuals having the same



FIGURE 2-1. Effective cross-cultural communication is vital to the establishment of a strong nurse-patient relationship. It is important to understand both verbal and nonverbal cues when communicating with people from various cultural backgrounds. (© Copyright M. Andrews)

munication between individuals having the same cultural background may be fraught with pitfalls. When you communicate with others from cultural backgrounds unlike your own and with those for whom English is a second language, the probability of miscommunication increases significantly. In promoting effective cross-cultural communication, you should avoid technical jargon, slang, colloquial expressions, abbreviations, and excessive use of medical terminology.

Lipson and Steiger (1996) suggest affective, cognitive, and behavioral strategies for effective cross-cultural communication. In the affective domain, they suggest respect for, appreciation of, and comfort with cultural differences; enjoyment

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within the household. It is necessary to identify the significant others whom clients perceive to be important in their care and who may be responsible for decision making that affects their health care. For example, for many clients, familism—which emphasizes interdependence over independence, affiliation over confrontation, and cooperation over competition—may dictate that important decisions affecting the client be made by the family, not the individual alone. When you work with clients from cultural groups that value cohesion, interdependence, and collectivism, you may perceive the family as being overly involved and usurping the autonomy of the client. Clients are likely to perceive the involvement with family as a source of mutual support, security, and fulfillment.

The family is the basic social unit in which children are raised and learn culturally based values, beliefs, and practices about health and illnesses. The essence of family consists of living together as a unit. Relationships that may seem obvious sometimes warrant further exploration when the nurse interacts with clients from culturally diverse backgrounds. For example, most European Americans define siblings as two persons with either the same mother, the same father, the same mother and father, or the same adoptive parents. In some Asian cultures, a sibling relationship is defined as any infants breast-fed by the same woman. In other cultures, certain kinship patterns, such as maternal first cousins, are defined as sibling relationships. In some African cultures, anyone from the same village

to identify the primary provider of care and the key decision maker who acts on behalf of the child. In some instances, this person may not be the biologic parent. Among some Hispanic groups, for example, female members of the nuclear or extended family such as sisters and aunts are primary providers of care for infants and children. In some African-American families, the grandmother may be the decision maker and primary caretaker of children. To provide culturally congruent care, you must be certain that you are effectively communicating with the appropriate decision maker(s).

When making health-related decisions, some members of culturally diverse backgrounds in which lineal relationships predominate may seek assistance from other members of the family. It is sometimes culturally expected that a relative (e.g., parent, grandparent, eldest son, or eldest brother) will make decisions about important health-related matters. For example, in many Asian cultures, it is the obligation and duty of the eldest son to assume primary responsibility for his aging parents and to make health care decisions for them. If **collateral relationships** are valued, decisions about the client may be interrelated with the impact of illness on the entire family or group. For example, among the Amish, the entire community is affected by the illness of a member because the community pays for health care from a common fund, members join together to meet the needs of both the sick person and his or her family throughout the illness, and the roles of dozens of people in the commu-

rituals, and those from the same village may be called brother or sister.

Members of some ethnoreligious groups (e.g., Roman Catholics of Italian, Polish, Spanish, or Mexican descent) recognize relationships such as godmother or godfather, in which an individual who is not the biologic parent promises to assist with the moral or spiritual development of an infant and agrees to care for the child in the event of parental death. The godparent makes these promises during the religious ceremony of baptism.

In communicating with the parent or parent surrogate of infants and children, it is important

and the role of decisions of people in the community are likely to be affected by the illness of a single member. The individual values orientation concerning relationships is predominant among the dominant cultural majority in North America. Although members of the nuclear family may participate to varying degrees, decision making about health and illness is often an individual matter.

Cultural Perspectives on Intimacy

Interactions between you and your client are influenced by the degree of intimacy desired,

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which may range from very formal interactions to close personal relationships. For example, some clients of Asian origin expect you and other health care providers to be authoritarian, directive, and detached. In seeking health care, some clients of Chinese descent may expect you to know intuitively what is wrong with them, and you may actually lose some credibility by asking a fairly standard interview question such as, "What brings you here?" The Asian-American patient may be thinking, "Don't you know why I'm here? You're supposed to be the one with all the answers." The reserved interpersonal behavior characteristics of many Asian Americans may leave you with the impression that the client agrees with or understands your explanation. Nodding or smiling by Asians may simply reflect their cultural value for interpersonal harmony, not agreement with what you have said. The emphasis on social harmony among Asian-North American clients may prevent their full expression of concerns or feelings.

In Thai culture, a high value is placed on *kreengcaj*, or awareness and anticipation of the feelings of others by kindness and the avoidance of interpersonal conflict. By obtaining validation of assumptions, you may distinguish between genuine concurrent and socially compliant client responses aimed at maintaining harmony. This may be accomplished by inviting the client to respond frankly to suggestions or by giving the client "permission" to disagree.

By contrast, Appalachian clients often have close family interaction patterns that lead them to expect close personal relationships with health

courtesy, respect, and the absence of critical or confrontational behavior. The concept of *personalismo* emphasizes intimate personal relationships. Persons of Latin American or Mediterranean origins often expect a high degree of intimacy and may attempt to involve you in their family system by expecting you to participate in personal activities and social functions. These individuals may come to expect personal favors that extend beyond the scope of what you believe to be professional practice, and they may feel it is their privilege to contact you at home during any time of the day or night for care. If your cultural value system emphasizes a high level of personal privacy, you may choose to give clients the agency's phone number and address rather than disclose information about your personal residence.

Because initial impressions are so important in all human relationships, cross-cultural considerations concerning introductions warrant a few brief remarks. To ensure that a mutually respectful relationship is established, you should introduce yourself and indicate to the client how you prefer to be called: by first name, last name, and/or title. You should elicit the same information from the client because this enables you to address the person in a manner that is culturally appropriate.

Nonverbal Communication

Because **nonverbal communication** patterns vary widely across cultures, nurses must be alert for cues that convey cultural differences

care providers. The Appalachian client may evaluate your effectiveness on the basis of interpersonal skills rather than professional competencies. Some Appalachian clients may be uncomfortable with the impersonal orientation of most health care institutions.

Among some Hispanic groups, such as Mexican Americans and Cuban Americans, *simpatia* and *personalismo* should be considered. *Simpatia* refers to the need for smooth or harmonious interpersonal relationships, characterized by

client for cues that convey cultural differences in the use of silence, eye contact, touch, space, distance, and facial expressions. Cultural influences on appropriate communication between individuals of different genders also need to be considered.

Silence

Wide cultural variation exists in the interpretation of **silence**. Some individuals find silence extremely uncomfortable and make every effort

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to fill conversational lags with words. By contrast, many Native North Americans consider silence essential to understanding and respecting the other person. A pause following your question signifies that what has been asked is important enough to be given thoughtful consideration. In traditional Chinese and Japanese cultures, silence may mean that the speaker wishes the listener to consider the content of what has been said before continuing. Other cultural meanings of silence may be found. English persons and Arabs may use silence out of respect for another's privacy, whereas French, Spanish, and Russian persons may interpret it as a sign of agreement. Asian cultures often use silence to demonstrate respect for elders. Among some African Americans, silence is used in response to a question perceived as inappropriate.

Eye Contact

The use of **eye contact** is among the most culturally variable nonverbal behaviors that clients will use to communicate with you. Although most nurses have been taught to maintain eye contact when speaking with clients, individuals from culturally diverse backgrounds may attribute other culturally based meanings to this behavior. Asian, Native North American, Indochinese, Arab, and Appalachian clients may consider direct eye contact impolite or aggressive, and they may avert their own eyes when talking with you. Native North Americans often stare at the floor during conversations—a culturally appropriate behavior indicating that the listener is paying close attention to the speaker. Some African Americans use oculistics (eye rolling) in response to what is perceived to be an inappro-

expected of you but will not necessarily be reciprocated by the client.

In some cultures, including Arab, Latino, and African-American groups, modesty for both women and men is interrelated with eye contact. Muslim-Arab women achieve modesty, in part, by avoiding eye contact with males (except for one's husband) and keeping the eyes downcast when encountering members of the opposite sex in public situations. In many cultures, the only woman who smiles and establishes eye contact with men in public is a prostitute. Hasidic Jewish males also have culturally based norms concerning eye contact with females; you may observe a Hasidic Jewish man avoiding direct eye contact and turning his head in the opposite direction when walking past or speaking to a woman. The preceding examples are intended to be illustrative, not exhaustive.

Touch

You are urged to give careful consideration to issues concerning **touch**. While we recognize the often-reported benefits in establishing rapport with clients through touch, including the promotion of healing through therapeutic touch, physical contact with clients conveys various meanings cross-culturally. In many Arab and Hispanic cultures, male health care providers may be prohibited from touching or examining part or all of the female body. Adolescent girls may prefer female health care providers or may refuse to be examined by a male. You should be aware that the client's significant others also may exert pressure by enforcing these culturally meaningful norms in the health care setting.

In some cultures, there are strict norms

priate question. Among Hispanic clients, respect dictates appropriate deferential behavior in the form of downcast eyes toward others on the basis of age, sex, social position, economic status, and position of authority. Elders expect respect from younger individuals, adults from children, men from women, teachers from students, and employers from employees. In the nurse-client relationship with Hispanic clients, eye contact is

related to touching children. Many Asians believe that touching the head is a sign of disrespect because it is thought to be the source of a person's strength. You need to be aware that patting a child on the head or examining the fontanelles of a Southeast Asian infant should be avoided or done only with parental permission. Whenever possible, you should explore alternative ways to express affection or to obtain information

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necessary for assessment of the client's condition. For example, you might ask the mother to hold the child on her lap while you observe for other manifestations of increased intracranial pressure or signs of premature fontanelle closure. You might also try placing your hand over the mother's while asking for a description of what she feels.

Space and Distance

The concepts of **space** and **distance** are significant in cross-cultural communication. The perception of appropriate distance zones varies widely among cultural groups. Although there are individual variations in spatial requirements, people of the same culture tend to act in similar ways. For example, if you are of European North American heritage, you may find yourself backing away from clients of Hispanic, East Indian, or Middle Eastern origins who frequently seem to invade your personal space. Such behavior by these clients is probably an attempt to bring you closer into the space that is comfortable to them. Although you may be uncomfortable with close physical proximity to these clients, they are perplexed by your distancing behavior and may perceive you as aloof and unfriendly.

Because individuals are usually not consciously aware of their personal space requirements, they frequently have difficulty understanding a different cultural pattern. For example, sitting in close proximity to another person may be perceived by one client as an expression of warmth and friendliness but by another as a threatening invasion of personal space. According to Watson (1980), Americans, Canadians, and British require the most personal space, whereas Latin Americans, Japanese, and Arabs need the least.

other's odor, heat, and touch. Personal distance varies from 1.5 to 4 feet, the usual space within which communication between friends and acquaintances occurs. Nurses frequently interact with clients in the intimate or personal distance zones. Social distance refers to 4 to 12 feet, whereas anything greater than 12 is considered public distance (Hall, 1963).

Sex and Gender

Nonverbal behaviors are culturally significant, and failure to adhere to the **cultural code** (set of rules or norms of behavior used by a cultural group to guide behavior and to interpret situations) is viewed as a serious transgression. Violating norms related to appropriate male-female relationships among various cultures might jeopardize your therapeutic relationship with clients and their families. Among Arab Americans, you may find that adult males avoid being alone with members of the opposite sex (except for their wives) and are generally accompanied by one or more male companions when interacting with females. The presence of the companion(s) conveys that the purpose of the interaction is honorable and that no sexual impropriety will occur. Some women of Middle Eastern origin do not shake hands with men, nor do men and women touch each other outside the marital relationship. Given that clients who have recently immigrated are in various stages of assimilation, traditional customs such as these may or may not be practiced. If in doubt, you should ask the client or observe the client's behaviors, preferably at the time of admission.

A brief comment about same-sex relationships is warranted. In some cultures, it is considered an acceptable expression of friendship and affection to openly and publicly hold hands with or

In the early 1960s, Edward T. Hall pioneered the study of **proxemics**, which focuses on how people in various cultures relate to their physical space. Although there are intercultural variations, the intimate distance in interpersonal interactions ranges from 0 to 18 inches. At this distance, people experience visual detail and each

embrace members of the same sex without any sexual connotation being associated with the behavior. For example, you may note that although a Nigerian-American woman may not demonstrate overt affection for her husband or other male family members, she will hold hands with female relatives and friends while walking or

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USE OF INTERPRETERS

One of the greatest challenges in cross-cultural communication occurs when you and your client speak different languages. After assessing the language skills of non-English-speaking clients, you may find yourself in one of two situations: either struggling to communicate effectively through an interpreter or communicating effectively when there is no interpreter. See Box 2-4.

NON-ENGLISH-SPEAKING PATIENTS AND INTERPRETERS

Interviewing the non-English-speaking person requires a bilingual interpreter for full communication. Even a person from another culture or country who has a basic command of English (someone for whom English is a second language) may need an interpreter when faced with the anxiety-provoking situation of entering a hospital, encountering a strange symptom, or discussing a sensitive topic such as birth control or gynecologic or urologic concerns. Ideally, a trained medical interpreter should be used. This person knows interpreting techniques, has a health care background, and understands patients' rights. The trained interpreter is also knowledgeable about cultural beliefs and health practices. This person can help you to bridge the cultural gap and can give advice concerning the cultural appropriateness of your recommendations.

Although you will be in charge of the focus and flow of the interview, the interpreter should be viewed as an important member of the health care team. It is tempting to ask a relative, a friend, or even another client to interpret because this person is readily available and likely is anxious to help. However, this violates confidentiality for the client, who may not want personal information shared. Furthermore, the friend or relative, though fluent in ordinary language usage, is likely to be unfamiliar with medical terminology,

obtain basic descriptive information about the client such as age, occupation, educational level, and attitude toward health care. This eases the interpreter into the relationship and allows the client to talk about aspects of his or her life that are relatively nonthreatening.

When using an interpreter, you should expect that the interaction with the client will require more time than is needed in the care of English-speaking clients. It will be necessary to organize nursing care so that the most important interactions or procedures are accomplished first before any of the parties (including yourself) becomes fatigued.

Both you and the client should speak only a sentence or two and then allow the interpreter time to translate. You should use simple language, not medical jargon that the interpreter must simplify before it can be translated. Summary translation—allowing a person to speak in his or her native language and then having an interpreter summarize what was said—goes faster and is useful for teaching relatively simple health techniques with which the interpreter is already familiar. Be alert for nonverbal cues as the client talks; he or she can give valuable data. A skilled interpreter also will note nonverbal messages and pass them on to you (Nailon, 2004, 2006). Evidence-based Practice Box 2-1 examines nurses' concerns and practices using interpreters in the care of Latino patients in the emergency department.

The Joint Commission on Accreditation of Healthcare Organizations and the American Hospital Association both require that accommodations be made for patients who lack proficiency in English, and some states have passed laws requiring health care organizations to provide interpreters for their non-English-speaking patients. Box 2-5 provides a summary of sugges-

hospital or clinic procedures, and health care ethics.

Whenever possible, work with a bilingual member of the health care team. In ideal circumstances, you should ask the interpreter to meet the client beforehand to establish rapport and to

tions for the selection and use of an interpreter and for overcoming language barriers when an interpreter is unavailable. Although the use of an interpreter is ideal, you will need a strategy for promoting effective communication when none is present.

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BOX 2-4

Overcoming Language Barriers

Use of an Interpreter

- Before locating an interpreter, be sure that the language the client speaks at home is known, considering it may be different from the language spoken publicly (e.g., French is sometimes spoken by well-educated and upper-class members of certain Asian or Middle Eastern cultures).
- Avoid interpreters from a rival tribe, state, region, or nation (e.g., a Palestinian who knows Hebrew may not be the best interpreter for a Jewish client).
- Be aware of gender differences between interpreter and client. In general, same gender is preferred.
- Be aware of age differences between interpreter and client. In general, an older, more mature interpreter is preferred to a younger, less experienced one.
- Be aware of socioeconomic differences between interpreter and client.
- Ask the interpreter to translate as closely to verbatim as possible.
- Expect an interpreter who is not a relative to seek compensation for services rendered.

Recommendations for Institutions

- Maintain a computerized list of interpreters who may be contacted as needed.
- Network with area hospitals, colleges, universities, and other organizations that may serve as resources.
- Utilize the translation services provided by telephone companies (e.g., American Telephone and Telegraph Company).

What to Do When There Is No Interpreter

- Be polite and formal.
- Greet the person using the last or complete name. Gesture to yourself and say your name. Offer a handshake or nod. Smile.
- Proceed in an unhurried manner. Pay attention to any effort by the patient or family to communicate.

- Speak in a low, moderate voice. Avoid talking loudly. Remember that there is a tendency to raise the volume and pitch of your voice when the listener appears not to understand. The listener may perceive that the nurse is shouting and/or angry.
- Use any words known in the patient's language. This indicates that the nurse is aware of and respects the client's culture.
- Use simple words, such as *pain* instead of *discomfort*. Avoid medical jargon, idioms, and slang. Avoid using contractions. Use nouns repeatedly instead of pronouns. Example: Do *not* say, "He has been taking his medicine, hasn't he?" Do say, "Does Juan take medicine?"
- Pantomime words and simple actions while verbalizing them.
- Give instructions in the proper sequence. Example: Do *not* say, "Before you rinse the bottle, sterilize it." Do say, "First, wash the bottle. Second, rinse the bottle."
- Discuss one topic at a time. Avoid using conjunctions. Example: Do *not* say, "Are you cold and in pain?" Do say, "Are you cold [while pantomiming]?" "Are you in pain?"
- Validate whether the client understands by having him or her repeat instructions, demonstrate the procedure, or act out the meaning.
- Write out several short sentences in English, and determine the person's ability to read them.
- Try a third language. Many Indochinese speak French. Europeans often know three or four languages. Try Latin words or phrases, if the nurse is familiar with that language.
- Ask who among the client's family and friends could serve as an interpreter.
- Obtain phrase books from a library or bookstore, make or purchase flash cards, contact hospitals for a list of interpreters, and use both formal and informal networking to locate a suitable interpreter.

Evidence-Based Practice 2-1:

Use of Interpreters in the Care of Latino Patients in the Emergency Department

Nearly one-fourth of Latinos residing in the United States live in *linguistically isolated* households, which means that all household members age 14 and older have at least some difficulty speaking and understanding English. When these individuals visit the emergency department, they may fail to receive care in a timely and culturally appropriate manner because a medically trained interpreter is unavailable. Nurses are cognizant of the need for accurate communication in meeting the nursing care needs of their Spanish-speaking patients/clients and sometimes turn to family members or untrained interpreters due to the urgency of the patient's medical situation.

This phenomenological study focuses on the nursing care of Latinos in the emergency department and the manner in which nurses from four hospitals in the Northwest approached the cultural and language needs of their Latino patients. Using unstructured interviews and participant observation, the researcher studied 22 nurse-patient encounters, 16 of which involved the use of an interpreter. The majority of the 15 nurses who participated in the study had minimal to limited Spanish-speaking ability and required the assistance of an interpreter.

Clinical Applications

The findings from the study include the following clinical implications:

- Lack of interpreter availability impedes nurses' involvement with non-English-speaking patients and reduces the amount of time nurses spend with them.
- Nurses' skills relative to work with interpreters, interpreter availability, engagement, and accuracy enhance or impede effective care.
- Nurses and interpreters should receive training to prepare them to work effectively with each other so that meaningful, accurate, and culturally appropriate communication results with non-English-speaking Latino patients and their families.
- Linguistic differences challenge effective care provision by nurses, including the tendency to defer valuable and expensive time involving an interpreter to the physician.
- Nurses tend to take shortcuts when assessing non-English-speaking Latino patients in the emergency department by relying too much on vital signs and observation of patients rather than gathering firsthand information from the patient.
- If interpreters are used, nurses tend to involve them for discharge teaching but not always during the assessment or provision of care.
- Culturally competent care requires accurate communication.
- Strong administrative support is necessary for cultural competence, including funding to train interpreters and nurses to facilitate effective nurse-patient communication for non-English-speaking patients.

BOX 2-5**National Council for Interpreters in Health Care**

The National Council on Interpreting in Health Care (2006) has developed the first set of national standards for medical interpreting professionals in the United States. The 32 national standards provide guidelines on the following nine issues:

- **Accuracy:** To enable other parties to know precisely what each speaker has said.
- **Confidentiality:** To honor the private and personal nature of the health care interaction and maintain trust among all parties.
- **Impartiality:** To eliminate the effect of interpreter bias or preference.
- **Respect:** To acknowledge the inherent dignity of all parties in the interpreted encounter.
- **Cultural Awareness:** To facilitate communication across cultural differences.
- **Role Boundaries:** To clarify the scope and limits of the interpreting role to avoid conflicts of interest.
- **Professionalism:** To uphold the public's trust in the interpreting profession.
- **Professional Development:** To attain the highest possible level of competence and service.
- **Advocacy:** To prevent harm to parties whom the interpreter serves.

Sick Role Behaviors

If you find yourself feeling uncomfortable because a client is asking too many questions, assuming a defensive posture, or otherwise showing discomfort, it might be appropriate to pause for a moment to examine the source of the conflict from a transcultural perspective. During ill-

ness, culturally acceptable **sick role behavior** may range from aggressive, demanding behavior to silent passivity. Researchers have found that complaining, demanding behavior during illness is often rewarded with attention among Jewish and Italian groups. Because Asian and Native North American patients are likely to be quiet and compliant during illness, they may not receive the attention they need. Children are socialized into culturally acceptable sick role behaviors at an early age.

Clients of Asian heritage may provide you with the answers that they think are expected. This behavior is consistent with the dominant cultural value for harmonious relationships with others. Thus, you should attempt to phrase questions or statements in a neutral manner that avoids foreshadowing an expected response.

Summary

In this chapter we have explored culturally competent and culturally congruent nursing care as well as the importance of linguistic competence. We have discussed cultural self-assessment and encouraged you to gain insights into your own attitudes and beliefs about different ethnic, religious, and social groups.

Most of the chapter has focused on the complex, multifaceted topic of cross-cultural communication, including aspects of verbal and nonverbal communication that enable nurses to provide culturally competent and culturally congruent nursing care.

REVIEW QUESTIONS

1. Summarize the key standards for culturally and linguistically competent health care recommended by the Office of Minority Health, U.S. Department of Health and Human Services.
2. Critically examine the strategies for pro-
- cation between nurses and clients. Identify actions that you can take to overcome communication barriers when caring for non-English-speaking clients.
3. What are the major languages spoken in households in the United States and

CRITICAL THINKING ACTIVITIES

1. After critically analyzing the definitions of cultural competence presented in the chapter, craft a definition of the term in your own words.
 2. To provide culturally competent nursing care, you should engage in a cultural self-assessment. Answer the questions in Box 2-2, *How Do You Relate to Various Groups of People in the Society?*, and score your answers using the guide provided. What did you learn about yourself? How would you learn more about the background of those groups mentioned, including information about their health-related beliefs and practices? What resources might you use in your search for information?
 3. At the request of the Bureau of Primary Health Care, Health Resources and Services Administration, in the U.S. Department of Health and Human Services, staff at the National Center for Cultural Competence (NCCC) developed the *Cultural Competence Health Practitioner Assessment* which is available online. Visit the Web site at <http://www11.Georgetown.edu/research/gucchd/nccc/features/CCHPA.html> and complete this assessment.
 4. After identifying someone for whom English is a second language, ask the person what he or she believes (a) promotes effective communication and (b) sets up barriers to effective communication. What has the person found to be most challenging in communicating health-related needs to physicians, nurses, and other health care providers?
 5. Interview a nurse with experience in caring for clients whose primary language is not English. What challenges does the nurse report in communicating with these clients? What strategies does the nurse use to promote effective cross-cultural communication? How effective does the nurse believe these strategies have been in the care of these clients?
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on the physical examination. Ideally, the cultural assessment should be integrated into the overall assessment of the client, family, group, and/or community. It is usually impractical to expect that nurses will have the time to conduct a separate cultural assessment, so questions aimed at gathering cultural data should be integrated into the overall assessment.

In Appendix A you will find the Andrews and Boyle **Transcultural Nursing Assessment Guide for Individuals and Families**. The major categories in this guide include cultural affiliations, values orientation, communication, health-related beliefs and practices, nutrition, socioeconomic considerations, organizations providing cultural support, education, religion, cultural aspects of disease incidence, biocultural variations, and developmental considerations across the life span.

Transcultural Perspectives on the Health History

The purpose of the health history is to gather *subjective data*—a term that refers to things that people say about themselves. The health history provides a comprehensive overview of a client's past and present health, and it examines the manner in which the person interacts with the environment. The health history enables the nurse to assess health strengths, including cultural beliefs and practices that might influence the nurse's ability to provide culturally competent nursing care. The history is combined with the *objective data* from the physical examination and the laboratory results to form a diagnosis about the health status of a person (Jarvis, 2004).

For the well client, the history is used to assess lifestyle, which includes activity, exercise, diet, and related personal choices that enable you to identify potential risk factors for disease. For the ill client, the health history includes a chronologic record of the health problem(s). For both well and ill clients, the health history is a screening tool for abnormal symptoms, health problems, and concerns. The health history also

provides you with valuable information about the coping strategies used previously by clients (Jarvis, 2004).

In many health care settings, the client is expected to fill out a printed history form or checklist. From a transcultural perspective, this approach has both positive and negative aspects. On the positive side, this approach provides the client with ample time to recall details such as relevant family history and the dates of health-related events such as surgical procedures and illnesses. It is expedient for nurses because it takes less time to review a form than to elicit the information in a face-to-face or telephone interview.

However, this approach has limitations. First, the form is likely to be in English. Those whose primary language is not English might find the form difficult or impossible to complete accurately. Although some health care facilities provide forms translated into Spanish, French, or other languages known to be spoken by relatively large numbers of people who use the facility, it is costly to translate forms into multiple languages. In some instances, the literal translation of medical terms isn't possible. In other instances, the symptom or disease is not recognized in the culture with which the client identifies. For example, in asking about symptoms of depression, there might be many cultural factors that influence the client's interpretation of the question. In Chinese languages, there is no literal translation for the word *depression*. In Chinese culture it is more acceptable to somaticize emotional pain with expressions of physical discomfort such as chest pain or "heaviness of the heart." If health care providers fail to understand the cultural meaning of the symptom "heaviness of the heart," unnecessary, invasive, and costly tests might be performed to rule out cardiovascular disease. In some instances, clients might be unable to read or write in any language; thus, an assessment of the client's literacy level should precede the use of printed history forms or checklists.

Although there is wide variation in health history formats, most contain the following cate-

gories: *biographic data, reason for seeking care, present health or history of present illness, past history, family and social history, and review of systems*. This chapter will not cover a comprehensive overview of all data categories in a health history; it will present only those relative to the provision of culturally congruent and culturally competent nursing care.

Biographic Data and Source of History

In addition to the standard descriptive information about clients (name, address, phone, age, gender, and so forth), it is necessary to record who has furnished the data. Whereas this is usually the client, the source might be a relative or friend. Note whether an interpreter is used and indicate his or her relationship to the client. Be sure to document the *specific language* spoken by the client, e.g., Mandarin Chinese (compared with Cantonese Chinese or other dialects).

Although the biographic information might seem straightforward, several cultural variations in recording age are important to note. In some Asian cultures, an infant is considered to be one year old at birth. Among some South Vietnamese immigrants who migrated to the United States during the Vietnam War, there might be inaccuracies in the reported age. These inaccuracies occurred in response to U. S. immigration laws in the 1960s and 1970s, which attempted to limit the numbers of Southeast Asians entering the United States.

One of the first areas that you should assess is the client's cultural affiliation. With what cultural group(s) does the client report affiliation? Where was the client born? What is the **ethnohistory** of the client? Knowledge of the client's ethnohistory is important in determining his or her risk factors for genetic and acquired diseases and in understanding the client's cultural heritage. How many years have the client and his or her family lived in this country? If the client is a recent immigrant, ask him or her to describe what the migration experience was like.

Reason for Seeking Care

The *reason for seeking care* refers to a brief statement describing in clients' own words why they are visiting a health care provider. In the past, this statement has been called the *chief complaint*, a term that is now avoided because it focuses on illness rather than wellness and tends to label the person as a complainer. All symptoms are believed to have cultural meanings, and the nurse should realize that they are usually more than manifestations of a biologic reality.

Symptoms are defined as phenomena experienced by individuals that signify a departure from normal function, sensation, or appearance and that might include physical aberrations. By comparison, *signs* are objective abnormalities that the examiner can detect on physical examination or through laboratory testing. As individuals experience symptoms, they interpret them and react in ways that are congruent with their cultural norms. Symptoms cannot be attributed to another person; rather, individuals experience symptoms from their knowledge of bodily function and sociocultural interactions. Symptoms are perceived, recognized, labeled, reacted to, ritualized, and articulated in ways that make sense within the cultural worldview of the person experiencing them (Good & Good, 1980; Wenger, 1993).

Symptoms are defined according to the client's perception of the meaning attributed to the event. This perception must be considered in relation to other sociocultural factors and biologic knowledge. People develop culturally based explanatory models to explain how their illnesses work and what their symptoms mean. The search for cultural meaning in understanding symptoms involves a translation process that includes both the nurse's worldview and the client's. You need to assess the symptoms within the client's sociocultural and ethnohistorical context. It is important to use the same terms for symptoms that clients use. For example, if the client refers to "swelling" of the leg, refrain from medicalizing that to "edema." Knowledge of the cultural expression of symptoms will influence the deci-

sions you make and will facilitate your ability to provide culturally congruent or culturally competent nursing care (Wenger, 1993).

Present and Past Illnesses

Table 3-1 provides an alphabetic listing of selected diseases and their increased or decreased prevalence among members of certain cultural groups. Accurate assessment and evaluation of the present and past illnesses requires knowledge of the biocultural aspects of acute and chronic diseases. The distribution of selected genetic traits and disorders prevalent among children from selected cultural groups is presented in Chapter 6, *Transcultural Perspectives in the Nursing Care of Children*.

Culture-Bound Syndromes

Although all illness might be culturally defined, the term **culture-bound syndromes** refers to disorders restricted to a particular culture or group of cultures because of certain psychosocial characteristics of those cultures. Culture-bound syndromes are often referred to as folk illnesses in which alterations of behavior and experience are prominent features. More than 200 culture-bound syndromes have been identified. For example, anorexia nervosa is believed to be a Western culture-bound syndrome because the condition is largely confined to Western cultures or to non-Western cultures undergoing the process of westernization, such as Japan. Culture-bound syndromes are thought to be illnesses created by personal, social, and cultural reactions to malfunctioning biologic or psychologic processes and can be understood only within defined contexts of meaning and social relationships (Kleinman, 1980). When you encounter clients with culture-bound syndromes, it is important to find out what they and other concerned individuals believe is happening. What prior efforts for help or cure have been tried? What were the results? It is impossible to produce a definitive list of all culture-bound syndromes, but Table 3-2 summarizes selected examples that are found in specific cultural groups. For a more comprehensive list of culture-

bound syndromes and descriptions of them, visit http://experts.about.com/c/c/cu/Culture-bound_syndrome.htm.

Current Medications

In the health history you should note the name, dose, route of administration, schedule, frequency, purpose, and length of time of each medicine that has been taken. It is also important to note all prescription and over-the-counter medications, including herbs that clients might purchase or grow in home gardens. Because of cultural differences in people's perception of what substances are considered medicines, it is important to ask about specific items by name. For example, you should inquire about vitamins, birth control pills, aspirin, antacids, herbs, teas, inhalants, poultices, vaginal and rectal suppositories, ointments, and any other items taken by the client for therapeutic purposes.

PLANT-DERIVED DRUGS

In particular, it is important to be aware of the widespread use of **plant-derived medications** among various cultures (Table 3-3). Since prehistoric times, people have attempted to identify plants, marine organisms, arthropods, animals, and minerals with healing properties. According to the World Health Organization, 80% of people residing in less developed countries use traditional medicine, including medicinal plants, for their major primary health care needs. Although the exact number of plants being used medicinally worldwide is unknown, approximately 5% of the 250,000 known species of plants have ever been studied for bioactive compounds that might have healing effects. (It is estimated that approximately 75% of the plant-derived drugs currently used in the United States and Canada were discovered as a result of chemical studies designed to isolate the active ingredients responsible for the use of the plants in traditional medicine. These drugs are derived from approximately 90 of the 250,000 known species of plants on this planet.) The global market for plant-derived drugs is worth an estimated \$18 billion and is projected to grow to \$26 billion by 2011.



TABLE 3-1 Biocultural Aspects of Disease

Disease	Remarks
Alcoholism	Indians have double the rate of Whites; lower tolerance to alcohol among Chinese and Japanese North Americans
Anemia	High incidence among Vietnamese because of the presence of infestations among immigrants and low iron diets; low hemoglobin and malnutrition found among 18.2% of Native North Americans, 32.7% of Blacks, 14.6% of Hispanics, and 10.4% of White children under 5 years of age
Arthritis	Increased incidence among Native North Americans Blackfoot 1.4% Pima 1.8% Chippewa 6.8%
Asthma	Six times greater for Native North American infants <1 year; same as general population for Native North Americans aged 1-44 years
Bronchitis	Six times greater for Native North American infants <1 year; same as general population for Native North Americans aged 1-44 years. Main cause of death for Aboriginal Canadian infants in the postnatal period
Cancer	Nasopharyngeal: high among Chinese North Americans and Native Americans Breast: Black women 1 1/2 times more likely than White Colorectal: Blacks 40% higher than Whites Esophageal: No. 2 cause of death for Black men aged 35-54 years <i>Incidence:</i> White men 3.5/100,000 Black men 13.3/100,000 Liver: Highest among all ethnic groups are Filipino Hawaiians Latinos have twice the rate of Whites Stomach: Black men twice as likely as White men; low among Filipinos Cervical: 120% higher in Black women than in White women Mexican American and Puerto Rican women 2-3 times higher than Whites Uterine: 53% lower in Black women than White women Prostate: Black men have highest incidence of all groups Most prevalent cancer among Native North Americans: biliary, nasopharyngeal, testicular, cervical, renal, and thyroid (females) cancer Lung cancer among Navajo uranium miners 85 times higher than among White miners Most prevalent cancer among Japanese North Americans: esophageal, stomach, liver, and biliary cancer Among Chinese North Americans, there is a higher incidence of nasopharyngeal and liver cancer than among the general population
Cholecystitis	<i>Incidence:</i> Whites 0.3% Puerto Ricans 2.1% Native Americans 2.2% Chinese 2.6%
Colitis	High incidence among Japanese North Americans
Diabetes mellitus	Three times as prevalent among Filipino North Americans as Whites; higher among Hispanics than Blacks or Whites

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TABLE 3-2 Selected Culture-Bound Syndromes

Group	Disorder	Remarks
Blacks, Haitians	Blackout	Collapse, dizziness, inability to move
	Low blood	Not enough blood or weakness of the blood that is often treated with diet
	High blood	Blood that is too rich in certain things because of the ingestion of too much red meat or rich foods
	Thin blood	Occurs in women, children, and old people; renders the individual more susceptible to illness in general
Chinese/Southeast Asians	Diseases of hex, witchcraft, or conjuring	Sense of being doomed by spell; gastrointestinal symptoms, e.g., vomiting; hallucinations; part of voodoo beliefs
	<i>Koro</i>	Intense anxiety that penis is retracting into body
Greeks	Hysteria	Bizarre complaints and behavior because the uterus leaves the pelvis for another part of the body
Hispanics	<i>Empacho</i>	Food forms into a ball and clings to the stomach or intestines, causing pain and cramping
	Fatigue	Asthma-like symptoms
	<i>Mal ojo</i> , "evil eye"	Firful sleep, crying, diarrhea in children caused by a stranger's attention; sudden onset
	<i>Pasmo</i>	Paralysis-like symptoms of face or limbs; prevented or relieved by massage
Japanese	<i>Susto</i>	Anxiety, trembling, phobias from sudden fright
	<i>Wagamama</i>	Apathetic childish behavior with emotional outbursts
Korean	<i>Hwa-byung</i>	Multiple somatic and psychologic symptoms; "pushing up" sensation of chest; palpitations, flushing, headache, "epigastric mass," dysphoria, anxiety, irritability, and difficulty concentrating; mostly afflicts married women
Native Americans	Ghost	Terror, hallucinations, sense of danger
North India Indians	Ghost	Death from fever and illness in children; convulsions, delirious speech (or incessant crying in infants); choking, difficulty breathing; based on Hindu religious beliefs and curing practices
Whites	Anorexia nervosa	Excessive preoccupation with thinness; self-imposed starvation
	Bulimia	Gross overeating and then vomiting or fasting

Currently respiratory problems such as asthma represent the largest medical application of plant-derived drugs, accounting for 24% of total sales of plant-derived medicines. In the future, cancer treatment is expected to become the largest application of plant-derived drugs, cap-

turing 24% of the market by 2011 (BCC Research, 2006; Ma et al., 2005) (Figure 3-1).

Many of the active ingredients in plant-derived drugs or herbs are unknown and remain largely unregulated by government agencies, except for customs officials who make efforts to

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Echinacea*Echinacea angustifolia*, *E. pallida*, *E. purpurea*

Source	Member of the daisy family; also known as purple coneflower
Action	Reduces cold symptoms
Traditional Uses	Used by Native Americans in poultices, mouthwashes, and teas for colds, cancer, and other disorders Some herbalists consider it a blood purifier and an aid to fighting infections
Current Uses	Enhances the immune system by stimulating the production of white blood cells needed to fight infection or cancer
Dosage	Follow directions on label; needed at onset of symptoms; usually taken for no longer than 2 weeks
Warnings	Contraindicated for pregnant or breast-feeding women, children, and those who are allergic to ragweed. Not recommended for people with severely compromised immune systems such as those with HIV/AIDS, tuberculosis, or multiple sclerosis Look for reputable suppliers, because a high percentage of the root currently marketed is adulterated with less expensive inactive substitutes

Evening Primrose Oil*Oenothera biennis*

Source	Seeds of the wildflower evening primrose
Action	Antihypertensive, immunostimulant, weight reduction
Traditional Uses	Used by Native Americans for food; in eastern North America, used to treat obesity and hemorrhoids; new settlers to North America used the plant for gastrointestinal upsets and sore throats
Current Uses	Used as a dietary supplement for essential fatty acids; believed to help asthma, migraine headaches, inflammations, PMS, diabetes mellitus, and arthritis; also believed to lower blood pressure and lower cholesterol, slow the progression of multiple sclerosis, promote weight loss without dieting, alleviate hangovers, and moisturize dry eyes, brittle hair, and fingernails
Dosage	Follow directions on label; will take at least 1 month to experience benefits
Warnings	Side effects include occasional reports of headache, nausea, and abdominal discomfort; not recommended for children Some capsules may be altered with other types of oil such as soy or safflower

Ginger

Current Uses	Effective in reducing morning sickness and postoperative nausea for some people; used in China to treat first- and second-degree burns
Dosage	Boil 1 oz dried ginger root in 1 cup water for 15 to 20 minutes Follow label directions on ginger supplements

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Warning	Large doses may cause central nervous system depression and cardiac arrhythmias Side effects include heartburn Contraindicated in the presence of gallbladder disease
Ginkgo	
<i>Ginkgo biloba</i>	
Source	Extract from leaves of the ginkgo tree, a living fossil, believed to be more than 200 million years old
Action	Antioxidant; improves blood circulation
Traditional Uses	Used in China since the 15th century for cough, asthma, diarrhea, skin lesions, and removal of freckles
Current Uses	Promotes vasodilation and improves circulation of blood; may be an effective free radical scavenger or antioxidant; improves short-term memory, attention span, and mood in early stages of Alzheimer's disease by improving oxygen metabolism in the brain
Dosage	Range: 120–160 mg TID May take 6–8 weeks before results are evident
Warnings	Large doses may cause irritability, restlessness, diarrhea, nausea, and vomiting Some people (who are also sensitive to poison ivy) are unable to tolerate even low doses Contraindicated for women who are pregnant or breast-feeding Contraindicated for persons with clotting disorders Not recommended for children

Ginseng (American and Asian)

***Panax quinquefolius* (American)**

***Panax ginseng* (Asian)**

Source	Dried root of several species of the genus <i>Panax</i> of the family Aralaceae
Action	Tonic
Traditional Uses	Treatment of anemia, atherosclerosis, edema, ulcers, hypertension, influenza, colds, inflammation, and disorders of the immune system (American) In traditional China, used for treatment of shock, diaphoresis, dyspnea, fever, thirst, irritability, diarrhea, vomiting, abdominal distention, anorexia, and impotence; considered a “heat-raising” tonic for the blood and circulatory system (Asian)
Current Uses	Used to enhance sexual experience and treat impotence, though there is no current research to support this claim (American) In Germany may be labeled as a tonic to treat fatigue, reduced work capacity. In some parts of Asia, used for lack of concentration and for convalescence (Asian) Improved sense of well-being (Asian)

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TABLE 3-3 Herbal Remedies (continued)

Dosage	American: Follow directions on label Asian: 100 mg BID
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Warnings American: May cause headaches, insomnia, anxiety, breast tenderness, rashes, asthma attacks, hypertension, cardiac arrhythmias, and postmenopausal uterine hemorrhage
Should be used with caution for the following conditions: pregnancy, insomnia, hay fever, fibrocystic breasts, asthma, emphysema, hypertension, clotting disorders, and diabetes mellitus
Asian: Same as American

Gotu Kola

Centella asiatica

Source

Dried and powdered leaves of a member of the parsley family

Action

Improves memory

Traditional Uses

In ancient India, considered a rejuvenating herb that increases intelligence, longevity, and memory while slowing the aging process
In China, used as a tea for colds and for lung and urinary tract infections, and topically for snakebite, wounds, and shingles
Recommended for treatment of mental disorders, hypertension, abscesses, rheumatism, fever, ulcers, skin lesions, and jaundice

Current Uses

Acceleration of wound healing, diuretic, treatment of phlebitis

Dosage

Follow directions on label; lower dose needed for children and older adults

Warnings

Sides effects include headaches and skin rash
Contraindicated for pregnant or breast-feeding women and children younger than 2 years
Contraindicated when using tranquilizers or sedatives

Saint John's Wort

Hypericum perforatum

Source

Tea made from the leaves and flowering tops of the perennial *Hypericum perforatum*, which is particularly abundant on June 24th, the feast of St. John the Baptist

Action

Antidepressant

Traditional Uses

Used in 1st-century Greece for wound healing and menstrual disorders, and as a diuretic
In 19th-century North America, used for its astringent, wound healing, diuretic, and mild sedative effects

Current Uses

Treatment of mild to moderate depression; effects are linked to various substances that act as monoamine oxidase (MAO) inhibitors

Dosage

300 mg daily

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TABLE 3-3 Herbal Remedies (continued)

Warnings

Fair-skinned people may experience urticaria or vesicular skin lesions upon exposure to sunlight
Reduces effectiveness of some anticancer agents
Clinical manifestations of depression should be considered seriously

Valerian

Valeriana officianalis

Source	Dried rhizome and roots of the tall perennial <i>Valeriana officianalis</i>
Action	Mild tranquilizer and sedative
Traditional Uses	Used by the ancient Greeks for the treatment of epilepsy and menstrual disorders, and as a diuretic Used by 17th- and 18th-century Europeans as an antispasmodic and sedative Listed as an official remedy in the <i>United States Pharmacopoeia</i> from 1820 to 1936
Current Uses	Used as a mild tranquilizer and sedative; relieves muscle spasms Especially effective for insomniac persons and older adults
Dosage	300–400 mg daily; take 1 hour before bedtime as a sleeping aid
Warnings	Reported side effects include headache, gastrointestinal upset, and excitability Signs of overdose include severe headache, restlessness, nausea, morning grogginess, or blurred vision Must not be taken in combination with other tranquilizers or sedatives Client should be cautioned against operating a motor vehicle after ingesting

Table based on data accessed on January 1, 2007, at The Alternative Medicine Home Page (<http://www.pitt.edu/~cbw/herb.html>); MedlinePlus Herbal Medicine (www.nlm.nih.gov/medlineplus/herbalmedicine.html); National Center for Complementary and Alternative Medicine (<http://www.nccam.gov>); Sloan-Kettering: About Herbs, Botanicals and Other Products (<http://www.mskcc.org/mskcc/html/11570.cfm>).

control the flow of illegal drugs. Fresh or dried herbs are usually brewed into a tea, with the dosage adjusted according to the chronicity or acuteness of the illness, age, and size of the patient. Traditional Chinese medicine usually is used only as long as symptoms persist. Some patients extend the same logic to Western biomedicine. For example, they might stop taking an antibiotic as soon as the symptoms subside instead of completing the course of treatment for the prescribed length of time. Be sure to consider the potential interaction of herbs with Western biomedicines. The root of the shrub *ginseng*, for example, is widely used for the treatment of arthritis, back and leg pains, and sores. Because

ginseng is known to potentiate the action of some antihypertensive drugs, you must ask the patient whether he or she is experiencing side effects or toxicity, and monitor blood pressure frequently. It might be necessary to withhold doses of the prescribed antihypertensive medicine if the blood pressure is low or to ask the client to discontinue or reduce the strength of the *ginseng*. When assessing the patient's use of traditional Chinese medicine, you should be aware that some Chinese North Americans who use herbs topically do not consider them to be drugs. For further information about herbs, the nurse should ask the patient and family, consult with an herbalist, search for reputable sources on

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with clients' adherence to the yin/yang, hot/cold, or other belief system, it is unlikely that they will follow your advice concerning the medication. The nurse should be aware that some clients of Latino, Middle Eastern, and Asian heritage believe that it is important to take medicine with certain beverages or foods to provide the necessary balance for health. If clients give cues that they are uncomfortable with the manner or food



FIGURE 3-1. Shopkeeper of Indian ancestry sells herbal remedies used in Ayurvedic healing in a neighborhood store that attracts recent immigrants from India. People from diverse backgrounds who embrace Ayurvedic medicine also patronize the store, which sells prepackaged herbal remedies and dried herbs used to brew teas.

the Internet; or check reference books on herbal remedies.

Dosage Modifications

As indicated in Table 3-4, there is growing evidence-based data indicating that modifications in dosages of some drugs should be made for members of selected racial and ethnic groups. It might be difficult to develop ethnic-specific norms for drug dosages because of intermarriage, individual differences (e.g., weight and body fat index), and related factors. It is possible, however, to alert nurses to the variations that occur in side effects, adverse reactions, and toxicity so that clients from diverse cultural backgrounds can be monitored for possible untoward clinical manifestations.

MEDICATION ADMINISTRATION

If the medication prescribed, its route of administration, or the substances given with it conflict

they are uncomfortable with the beverage or food being used in the health care setting, discuss alternatives. For example, in most health care facilities, medications are given with cold water, but they could be given with hot water, tea, coffee, or a similar beverage if the client believes that such a beverage would promote healing. Some Mexican Americans believe that grapefruit juice has healing properties, so you might contact the dietary department to ensure that this juice is available when medications are administered. If the cultural healing beliefs and practices of the client are incorporated into medication administration, there is a higher probability that the client will believe in the healing properties of the drugs and will continue to take them as prescribed after discharge.

Family and Social History

In addition to diagramming a family tree to identify familial relationships and the presence of disease conditions among those related to the client, you should assess the broader socioeconomic factors influencing the client. The health history should include in-depth data pertaining to the client's family and/or close social friends, including identification of *key decision makers*. Although personal financial information is often a sensitive topic, it is important to determine the overall economic factors that influence a client. For example, regardless of race or ethnicity, people from lower socioeconomic categories have poorer health and shorter lives. Unfortunately, there is a disproportionately high level of poverty among Blacks, Latinos/Latinas, First Nation People of Canada, and North American Indians/Alaska Natives. Economic factors have

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TABLE 3-4 *Cultural Differences in Response to Drugs*

Drug Category	Remarks
Arab Americans	
<i>Antiarrhythmics</i>	Some may need lower dosage
<i>Antihypertensives</i>	Some may need lower dosage
<i>Neuroleptics</i>	Some may need lower dosage

Opioids	Some may require higher dosage because of diminished ability to metabolize codeine to morphine
Psychotropics	Some may need lower dosage
Asian/Pacific Islanders	
Be aware that drugs are part of the yin/yang belief system embraced by some Asian Americans and that herbal remedies may be used in addition to prescription drugs	
Be sure to consider lower body weight and mass when calculating doses	
Narcotic analgesics	Chinese may be less sensitive to the respiratory depressant and hypotensive effects of morphine but more likely to experience nausea; Chinese have a significantly higher clearance of morphine
Antihypertensives	Respond best to calcium antagonists
Neuroleptics	Require lower dose
Psychotropics	Require lower dose, sometimes as little as half the normal dose for tricyclic antidepressants (TCAs) and lithium
Fat-soluble drugs	On average, Asian Americans have a lower percentage of body fat, so dosage adjustments must be made for fat-soluble vitamins and other drugs, e.g., vitamin K used to reverse the anticoagulant effect of Coumadin (warfarin); consider dietary intake of vitamins when calculating doses

Blacks

Analgesics	Despite decreased sensitivity to pain-relieving therapeutic action of drugs, there are increased gastrointestinal side effects, especially with acetaminophen
Antihypertensives	Respond best to treatment with a single drug (versus combined antihypertensive therapy) Research suggests favorable response to diuretics, calcium antagonists, and alpha-blockers Less responsive to beta-blockers (e.g., propranolol) and angiotensin-converting enzyme (ACE) inhibitors (e.g., enalapril, imidapril) Increased side effects such as mood response (e.g., depression) to thiazides (e.g., hydrochlorothiazide), which may explain reluctance to take drug as prescribed There is little justification to use racial profiling to avoid drug classes. Current research is focusing on differences in the causes of hypertension in Blacks to explain differences in drug responses
Mydriatics	Less dilation occurs with dark-colored eyes
Psychotropics	Increased extrapyramidal side effects with TCAs such as haloperidol

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fumes with scents that are deemed to be desirable. Ironically, some colognes and perfumes such as those with musk oil are marketed in the United States and Canada because of their more “natural” odor, which is alleged to give the wearer more sex appeal. Recent immigrants from some arid nations where water is scarce might bathe less frequently than those from countries where water is more abundant.

Mongolian Spots

Mongolian spots are irregular areas of deep blue pigmentation, are usually located in the sacral and gluteal areas but sometimes occur on the abdomen, thighs, shoulders, or arms. During embryonic development, the melanocytes originate near the embryonic nervous system in the neural crest. They then migrate into the fetal epidermis. Mongolian spots consist of embryonic pigment that has been left behind in the epidermal layer during fetal development. The result looks like a bluish discoloration of the skin.

looks like a bluish discoloration of the skin.

An accurate and comprehensive examination of the skin of clients from culturally diverse backgrounds requires that you possess knowledge of biocultural variations and skill in recognizing color changes, some of which might be subtle. Awareness of normal biocultural differences and the ability to recognize the unique clinical manifestations of disease are developed over time as you gain experience with clients having various skin colors.

The assessment of a client's skin is subjective and is highly dependent on your observational skill, ability to recognize subtle color changes, and repeated exposure to individuals having various gradations of skin color. *Melanin* is responsible for the various colors and tones of skin observed in different people. Melanin protects the skin against harmful ultraviolet rays—a genetic advantage accounting for the lower incidence of skin cancer among darkly pigmented Black and Native North American clients.

Normal skin color ranges widely. Some health care practitioners have made attempts to describe the variations by labeling their observations with some of the following adjectives: *copper, olive, tan*, and various shades of *brown (light, medium, and dark)*. In observing pallor in clients, the term *ashen* is sometimes used. Of most clinical significance, particularly for clients whose health condition might be linked to changes in skin color, is your ability to establish a reliable description of a baseline color and subsequently to recognize when variations occur in the same individual.

Mongolian spots are a normal variation in children of African, Asian, or Latin descent. By adulthood, these spots become lighter but usually remain visible. Mongolian spots are present in 90% of Blacks, 80% of Asians and Native North Americans, and 9% of Whites (Overfield, 1995). If you are unfamiliar with Mongolian spots, it is important to exercise caution so as not to confuse them with bruises. Recognition of this normal variation is particularly important when you are dealing with children who might be erroneously identified as victims of child abuse, causing much anguish to the parents or guardians.

Vitiligo

Vitiligo, a condition in which the melanocytes become nonfunctional in some areas of the skin, is characterized by unpigmented skin patches. Vitiligo affects an estimated 2–4 million Americans, primarily dark-skinned individuals. Clients with vitiligo also have a statistically higher-than-normal risk for pernicious anemia, diabetes mellitus, and hyperthyroidism. These factors are believed to reflect an underlying genetic abnormality. There are numerous online sites with information about vitiligo including Vitiligo Support International (www.vitiligosupport.org) and the National Vitiligo Foundation (www.nvfi.org).

Hyperpigmentation

Other areas of the skin affected by hormones and, in some cases, differing for people from certain ethnic backgrounds are the sexual skin

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areas, such as the nipples, areola, scrotum, and labia majora. In general, these areas are darker than other parts of the skin in both adults and children, especially among African-American and Asian clients. When assessing these skin surfaces on dark-skinned clients, you must observe carefully for erythema, rashes, and other abnormalities because the darker color might mask their presence.

Cyanosis

Cyanosis is the most difficult clinical sign to observe in darkly pigmented persons. Because

best place to accurately assess color. If the palate does not have heavy melanin pigmentation, jaundice can be detected there in the early stages (i.e., when the serum bilirubin level is 2 to 4 mg/100 mL). The absence of a yellowish tint of the palate when the sclerae are yellow indicates carotene pigmentation of the sclerae rather than jaundice. Light- or clay-colored stools and dark golden urine often accompany jaundice in both light- and dark-skinned clients. If you are to distinguish between carotenemia and jaundice, it will be necessary to inspect the posterior portion of the hard palate using bright daylight or good

peripheral vasoconstriction can prevent cyanosis, you need to be attentive to environmental conditions such as air conditioning, mist tents, and other factors that might lower the room temperature and thus cause vasoconstriction. For the client to manifest clinical evidence of cyanosis, the blood must contain 5 g of reduced hemoglobin in 1.5 g of methemoglobin per 100 mL of blood (Overfield, 1995).

Given that most conditions causing cyanosis also cause decreased oxygenation of the brain, other clinical symptoms, such as changes in the level of consciousness, will be evident. Cyanosis usually is accompanied by increased respiratory rate, use of accessory muscles of respiration, nasal flaring, and other manifestations of respiratory distress. You must exercise caution when assessing persons of Mediterranean descent for cyanosis because their circumoral region is normally dark blue.

Jaundice

In both light- and dark-skinned clients, **jaundice** is best observed in the sclera. When examining culturally diverse individuals, exercise caution to avoid confusing other forms of pigmentation with jaundice. Many darkly pigmented people, e.g., African Americans, Filipinos, and others, have heavy deposits of subconjunctival fat that contains high levels of carotene in sufficient quantities to mimic jaundice. The fatty deposits become denser as the distance from the cornea increases. The portion of the sclera that is revealed naturally by the palpebral fissure is the

artificial lighting (Overfield, 1995).

Pallor

When assessing for **pallor** in darkly pigmented clients, you might experience difficulty because the underlying red tones are absent. This is significant because these red tones are responsible for giving brown or black skin its luster. The brown-skinned individual will manifest pallor with a more yellowish brown color, and the black-skinned person will appear ashen or gray. Generalized pallor can be observed in the mucous membranes, lips, and nail beds. The palpebrae, conjunctivae, and nail beds are preferred sites for assessing the pallor of anemia. When inspecting the conjunctiva, you should lower the lid sufficiently so you can see the conjunctiva near the inner and outer canthi. The coloration is often lighter near the inner canthus.

In addition to changes seen on skin assessment, the pallor of impending shock is accompanied by other clinical manifestations, such as increasing pulse rate, oliguria, apprehension, and restlessness. Anemia, particularly chronic iron-deficiency anemia, might be manifested by the characteristic “spoon” nails, which have a concave shape. A lemon-yellow tint of the face and slightly yellow sclerae accompany pernicious anemia, which is also manifested by neurologic deficits and a red, painful tongue. Also, fatigue, exertional dyspnea, rapid pulse, dizziness, and impaired mental function accompany the most severe anemia (Overfield, 1995).

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Erythema

You might find that it is difficult to assess **erythema** (redness) in darkly pigmented clients. Erythema is frequently associated with localized inflammation and is characterized by increased skin temperature. The degree of redness is determined by the quantity of blood in the subpapillary plexus, whereas the warmth of the skin is related to the rate of blood flow through the blood vessels. In the assessment of inflammation in dark-skinned clients, it is often necessary to palpate the skin for increased warmth, tautness, or tightly pulled surfaces that might indicate edema, and hardening of deep tissues or blood vessels. You will find that the dorsal surfaces of

brown, petechiae cannot be seen in the skin. Most of the diseases that cause bleeding and the formation of microscopic emboli, such as thrombocytopenia, subacute bacterial endocarditis, and other septicemias, are characterized by petechiae in the mucous membranes and skin. Petechiae are most easily seen in the mouth, particularly the buccal mucosa, and in the conjunctiva of the eye (Overfield, 1995).

Ecchymoses

In assessing **ecchymotic lesions** caused by systemic disorders, you will find them in the same locations as petechiae, although their larger size makes them more apparent on dark-skinned

your fingers will be the most sensitive to temperature sensations. The erythema associated with rashes is not always accompanied by noticeable increases in skin temperature. Macular, papular, and vesicular skin lesions are identified by a combination of palpation and inspection. In addition, it is important that you listen to the client's description of symptoms. For example, persons with macular rashes usually will complain of itching, and evidence of scratching will be apparent. When the skin is only moderately pigmented, a macular rash might become recognizable if the skin were gently stretched. Stretching the skin decreases the normal red tone, thus providing more contrast and making the macules appear brighter. In some skin disorders with a generalized rash, you will observe that the rash is most readily visible on the hard and soft palates (Overfield, 1995).

The increased redness that accompanies carbon monoxide poisoning and the blood disorders collectively known as *polycythemia* can be observed on the lips of dark-skinned clients. Because lipstick masks the actual color of the lips, you should ask the client to remove it prior to inspection.

Petechiae

In dark-skinned clients, **petechiae** are best visualized in the areas of lighter melanization, such as the abdomen, buttocks, and volar surface of the forearm. When the skin is black or very dark

individuals. When you are differentiating petechiae and ecchymoses from erythema in the mucous membrane, pressure on the tissue will momentarily blanch erythema but not petechiae or ecchymoses.

Normal Age-Related Skin Changes

Although aging is accompanied by the growing presence of wrinkles in all cultures, Blacks, Asian Americans, American Indians, and Eskimos wrinkle later in life than their Anglo American counterparts. Light skin shows the effects of sun damage more than dark skin, regardless of race or ethnicity. The area of the skin that is exposed to the sun shows the effects of aging more than protected skin, such as those parts covered by clothing. Regardless of climate, dry skin is inevitable in individuals older than 70 years of age. In part, dry skin is caused by transepidermal water loss, which decreases in older adults. African Americans have a significantly higher transepidermal water loss than Whites, which correlates with the water content of the stratum corneum layer of the skin. Because the number of *moles* increases with age, they are thought to be the result of long-term exposure to the sun. People with lighter skin have more moles than those with darkly pigmented skin. Whites have more moles than Asian North Americans or African Americans (Overfield, 1995).

Nurses and other health care providers often overestimate or underestimate age when dealing

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with clients whose cultural heritage is different from their own. Whites tend to underestimate the age of Africans, Asians, and North American Indians, whereas African Americans, Asians, and North American Indians tend to overestimate the age of White clients (Overfield, 1995).

Biocultural Variations in Body Secretions

The *apocrine* and *eccrine sweat glands* are important for fluid balance and for thermoregulation. Approximately 2 to 3 million glands open onto the skin surface through pores and are responsible for the presence of sweat. When they are contaminated by normal skin flora, odor results. Most Asians and Native North Americans have a

and straight to short, spiraled, thick, and kinky. The hair and scalp have a natural tendency to be dry and to require daily combing, gentle brushing, and the application of oil. By comparison, clients of Asian backgrounds generally have straight, silky hair.

Obtaining a baseline hair assessment is significant in the diagnosis and treatment of certain disease states. For example, hair texture is known to become dry, brittle, and lusterless with inadequate nutrition. The hair of Black children with severe malnutrition, as in the case of marasmus, frequently changes not only in texture but also in color. The child's hair often becomes straighter and turns a reddish copper color. Certain endocrine disorders are also known to affect the texture of hair.

mild to absent body odor, whereas Whites and African Americans tend to have strong body odor.

Eskimos have made an environmental adaptation whereby they sweat less than Whites on their trunks and extremities but more on their faces. This adaptation allows for temperature regulation without causing perspiration and dampness of their clothes, which would decrease their ability to insulate against severe weather and would pose a serious threat to their survival.

The amount of chloride excreted by sweat glands varies widely, and African Americans have lower salt concentrations in their sweat than do Whites. A study of Ashkenazi Jews (of European descent) and Sephardic Jews (of North African and Middle Eastern descent) revealed that those of European origin had a lower percentage of sweat chlorides (Levin, 1966). This variation might be significant in the care of clients with renal or cardiac conditions or of children with cystic fibrosis (Overfield, 1995).

Biocultural Variation in the Head, Eyes, Ears, and Mouth

Hair

Perhaps one of the most obvious and widely variable cultural differences occurs with assessment of the hair. African Americans' hair varies widely in texture. It is very fragile and ranges from long

texture of hair. Although gray hair correlates with age for both men and women, there are cultural differences in the rate of hair graying. Whites gray significantly faster than any other group. The hair of 66% of fair-haired individuals, but only 37% of dark-haired persons, is fully white by age 60 (Overfield, 1995). Among Asian Americans, graying might be delayed significantly, with some in their eighth or ninth decade of life showing little or no graying.

Eyes

Biocultural differences in both the structure and the color of the eyes are readily apparent among clients from various cultural backgrounds. Racial differences are evident in the palpebral fissures. Persons of Asian background are often identified by their characteristic epicanthal eye folds, whereas the presence of narrowed palpebral fissures in non-Asian individuals might be diagnostic of a serious congenital anomaly known as *Down syndrome or trisomy 21*.

There is culturally based variability in the color of the iris and in retinal pigmentation: Darker irises are correlated with darker retinas. Clients with light retinas generally have better night vision but can experience pain in an environment that is too light. The majority of African Americans and Asians have brown eyes, whereas many individuals of Scandinavian descent have blue eyes (Overfield, 1995).

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It is clinically relevant that differences in visual acuity occur among people from different cultures. Blacks have poorer corrected visual acuity than Whites. The visual acuity of Hispanic Americans is between that of Blacks and Whites. American Indians are comparable to Whites in visual acuity, whereas Japanese and Chinese Americans have the poorest corrected visual acuity because of a high incidence of myopia (Overfield, 1995).

Ears

It does not take long to notice that ears come in a variety of sizes and shapes. Earlobes can be free-standing or attached to the face. Ceruminous glands are located in the external ear canal and are functional at birth. Cerumen is genetically determined and comes in two major types: (1) dry

tion of postinflammatory oral changes (Overfield, 1995).

Cleft uvula, a condition in which the uvula is split either completely or partially, occurs in 18% of some Native North American groups and 10% of Asians. The occurrence in Whites and Blacks is rare. *Cleft lip* and *cleft palate* are most common in Asians and Native North Americans and least common in African Americans (Overfield, 1995).

Leukoedema, a grayish white benign lesion occurring on the buccal mucosa, is present in 68% to 90% of Blacks but only 43% of Whites. Care should be taken to avoid mistaking leukoedema for oral thrush or related infections that require treatment with medication (Overfield, 1995).

Teeth

Because teeth are often used as indicators of

cerumen, which is gray and flaky and frequently forms a thin mass in the ear canal, and (2) wet cerumen, which is dark brown and moist. Asians and Native North Americans (including Eskimos) have an 84% frequency of dry cerumen, whereas African Americans have a 99% frequency and Whites have a 97% frequency of wet cerumen (Overfield, 1995). The clinical significance of this occurs when you are examining or irrigating the ears. You should be aware that the presence and composition of cerumen are not related to poor hygiene, and caution should be exercised to avoid mistaking flaky, dry cerumen for the dry lesions of eczema.

Hearing gradually declines with age, especially in the high frequencies. After age 40, men have poorer hearing than women. Blacks have better hearing at high and low frequencies, whereas Whites have better hearing at middle frequencies. Blacks are less susceptible to noise-induced hearing loss (Overfield, 1995).

Mouth

Oral hyperpigmentation also shows variation by race. Usually absent at birth, hyperpigmentation increases with age. By age 50 years, 10% of Whites and 50 to 90% of African Americans will show oral hyperpigmentation, a condition believed to be caused by a lifetime of accumula-

developmental, hygienic, and nutritional adequacy, you should be aware of biocultural differences. Although it is rare for a White baby to be born with teeth (1 in 3,000), the incidence rises to 1 in 11 among Tlingit Indian infants and to 1 or 2 in 100 among Canadian Eskimo infants. Although congenital teeth are usually not problematic, extraction is necessary for some breast-fed infants (Overfield, 1995).

The size of teeth varies widely, with the teeth of Whites being the smallest, followed by Blacks and then Asians and Native North Americans. The largest teeth are found among Eskimos and Australian Aborigines. Larger teeth cause some groups to have prognathic (protruding) jaws, a condition that is seen more frequently in African and Asian North Americans. The condition is normal and does not reflect a serious orthodontic problem.

Agenesis (absence of teeth) varies by race, with missing third molars occurring in 18% to 35% of Asians, 9% to 25% of Whites, and 1% to 11% of Blacks. Throughout life, Whites have more tooth decay than Blacks, which might be related to a combination of socioeconomic factors and biocultural variation. Complete tooth loss occurs more often in Whites than in African Americans despite the higher incidence of periodontal disease in Blacks. Approximately one third of

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TABLE 3-6 *Guide for Using the Culturally Competent Model (continued)*

Component	Remarks
Second tarsal	Second toe longer than the great toe <i>Incidence:</i> Whites 8–34% Blacks 8–12% Vietnamese 31% Melanesians 21–57%
Height	Clinical significance for joggers and athletes White males are 1.27 cm (0.5 in.) taller than Black males and 7.6 cm (2.9 in.) taller than Asian males White females = Black females Asian females are 4.14 cm (1.6 in.) shorter than White or Black females
Composition of long bones	Longer, narrower, and denser in Blacks than in Whites; bone density in Whites > Chinese, Japanese, and Eskimos Osteoporosis lowest in Black males; highest in White females

Muscle

Peroneus tertius Responsible for dorsiflexion of foot

Palmaris longus	<i>Muscle absent:</i>	
	Asians, Native Americans, and Whites	3–10%
	Blacks	10–15%
	Berbers (Sahara desert)	24%
	No clinical significance because the tibialis anterior also dorsiflexes the foot	
	Responsible for wrist flexion	
	<i>Muscle absent:</i>	
	Whites	12–20%
	Native Americans	2–12%
	Blacks	5%
	Asians	3%
	No clinical significance because three other muscles are also responsible for flexion	

Based on data reported by T. Overfield. (1995). *Biologic variation in health and illness: Race, age, and sex differences*. New York: CRC Press.

results of tests conducted during pregnancy. The *multiple-marker screening* test and two tests of *amniotic fluid constituents* are used to screen pregnant women for potential fetal problems. Although the reasons for these differences are unknown, genetic, environmental, dietary, socioeconomic, cultural, and lifestyle factors are being studied to determine the extent to which they contribute to the differences in test results. Table 3–8 identifies biocultural variations and

their clinical significance for selected laboratory tests.

Clinical Decision Making and Nursing Actions

After you have completed a comprehensive cultural assessment, you are ready to analyze your subjective and objective data, set mutual goals

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TABLE 3-7 *Distribution of Selected Genetic Traits and Disorders by Population or Ethnic Group*

Ethnic or Population Group	Genetic or Multifactorial Disorder Present in Relatively High Frequency
Aland Islanders	Ocular albinism (Forsius-Eriksson type)
Amish	Limb girdle muscular dystrophy (IN—Adams, Allen counties) Ellis-van Creveld syndrome (PA—Lancaster county) Pyruvate kinase deficiency (OH—Mifflin county) Hemophilia B (PA—Holmes county)
Armenians	Familial Mediterranean fever Familial paroxysmal polyserositis
Blacks (African)	Sickle cell disease Hemoglobin C disease Hereditary persistence of hemoglobin F G-6-PD deficiency, African type Lactase deficiency, adult β -thalassemia
Burmese	Hemoglobin E disease
Chinese	α -thalassemia G-6-PD deficiency, Chinese type Lactase deficiency, adult
Costa Ricans	Malignant osteopetrosis

Druze	Alkaptonuria
English	Cystic fibrosis
Eskimos	Hereditary amyloidosis, type III
	Congenital adrenal hyperplasia
	Pseudocholinesterase deficiency
	Methemoglobinemia
French Canadians (Quebec)	Tyrosinemia
	Morquio syndrome
Finns	Congenital nephrosis
	Generalized amyloidosis syndrome, V
	Polycystic liver disease
	Retinoschisis
	Aspartylglycosaminuria
	Diastrophic dwarfism
Gypsies (Czech)	Congenital glaucoma
Hopi Indians	Tyrosinase-positive albinism
Icelanders	Phenylketonuria
Irish	Phenylketonuria
	Neural tube defects
Japanese	Acatalasemia
	Cleft lip/palate
	Oguchi disease

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TABLE 3-7 *Distribution of Selected Genetic Traits and Disorders by Population or Ethnic Group (continued)*

Ethnic or Population Group	Genetic or Multifactorial Disorder Present in Relatively High Frequency
Jews	
<i>Ashkenazi</i>	Tay-Sachs disease (infantile) Niemann-Pick disease (infantile) Gaucher disease (adult type) Familial dysautonomia (Riley-Day syndrome) Bloom syndrome Torsion dystonia
<i>Sephardi</i>	Factor XI (PTA) deficiency Familial Mediterranean fever Ataxia-telangiectasia (Morocco) Cystinuria (Libya) Glycogen storage disease III (Morocco)
Orientals	Dubin-Johnson syndrome (Iran) Ichthyosis vulgaris (Iraq, India) Werdnig-Hoffman disease (Karaite Jews) G-6-PD deficiency, Mediterranean type Phenylketonuria (Yemen) Metachromatic leukodystrophy (Habbanite Jews, Saudi Arabia)
Lapps	Congenital dislocation of hip

Lebanese	Dyggve-Melchoir-Clausen syndrome
Mediterranean people (Italians, Greeks)	G-6-PD deficiency, Mediterranean type
	β -thalassemia
	Familial Mediterranean fever
Navajo Indians	Ear anomalies
	Joseph disease
Polynesians	Clubfoot
Poles	Phenylketonuria
Portuguese	Joseph disease
Nova Scotia Acadians	Niemann-Pick disease, type D
Scandinavians (Norwegians, Swedes, Danes)	Cholestasis-lymphedema syndrome (Norwegians)
	Sjögren-Larsson syndrome (Swedes)
	Krabbe disease
Scots	Phenylketonuria
	Phenylketonuria
	Cystic fibrosis
	Hereditary amyloidosis, type III
Thoi	Lactase deficiency, adult
	Hemoglobin E disease
Zuni Indians	Tyrosinase-positive albinism

From Cohen, F. L. (1984). *Clinical Genetics in Nursing Practice* (pp. 23-24). Philadelphia: J.B. Lippincott.
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TABLE 3-8 *Biocultural Variations and Clinical Significance for Selected Laboratory Tests*

Test	Remarks
Hemoglobin/hematocrit	1 g lower for Blacks than other groups; Blacks < counterparts in other groups
Serum transferrin	Biocultural variation in children aged 1-3 1/2 years Mean for Blacks 22 mg/100 mL > Whites <i>Note:</i> May be due to lowered hemoglobin and hematocrit levels found in Blacks <i>Clinical significance:</i> Transferrin levels increase in the presence of anemia, thus influencing the diagnosis, treatment, and nursing care of children with anemia
Serum cholesterol	Biocultural variation across the life span Birth Blacks = Whites Childhood Blacks 5 mg/100 mL > Whites Pima Indians 20-30 mg/100 mL > Whites Adulthood Blacks < Whites Pima Indians 50-60 mg/100 mL < Whites <i>Clinical significance:</i> Prevention, treatment, and nursing care of clients with cardiovascular disease
High-density lipoproteins (HDLs)	Biocultural variation in adults Blacks > Whites Asians \geq Whites Mexican North Americans < Whites

Ratio of HDL to total cholesterol	Blacks < Whites
Low-density lipoproteins (LDLs)	Biocultural variation in adults Blacks < Whites <i>Clinical significance:</i> Prevention, treatment, and nursing care of clients with cardiovascular disease
Blood glucose	Biocultural variation in adults North American Indians, Hispanics, Japanese > Whites Blacks = Whites (for equivalent socioeconomic groups) <i>Clinical significance:</i> Diagnosis, treatment, and nursing care of adults with hypoglycemia and diabetes mellitus
Multiple-marker screening	Biocultural variations in blood levels for protein and hormones in pregnant women Alpha-fetoprotein (AFP), hCG, and estriol levels in Black and Asian women > Whites <i>Clinical significance:</i> High AFP levels signal that the woman is at increased risk for being delivered of an infant with spina bifida and neural tube defects, whereas low levels may signal Down syndrome; Down syndrome also is associated with low levels of estriol and high levels of hCG

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TABLE 3-8 *Biocultural Variations and Clinical Significance for Selected Laboratory Tests (continued)*

Test	Remarks
	Black and Asian American women have higher average levels of AFP, hCG, and estriol than White counterparts Using a single median for women of all cultures:
	<ul style="list-style-type: none"> ■ Causes Black and Asian women to be <i>falsely</i> identified as being <i>at risk</i> for having infants with spina bifida and neural tube defects; by being classified as <i>high risk</i>, women are more likely to be subjected to invasive and expensive procedures such as amniocentesis; some may elect to abort the pregnancy based on screening test results ■ <i>Inappropriately lowers</i> the identified Down syndrome risk for Black and Asian women
Lecithin/sphingomyelin ratio	Biocultural variations in amniotic fluid measures of fetal pulmonary maturity Blacks have higher ratios than Whites from 23 to 42 weeks gestation <i>Clinical significance:</i> The ratio is used to calculate the risk of respiratory distress in premature infants: lung maturity in Blacks is reached 1 week earlier than in Whites (34 versus 35 weeks); racial differences should be considered in making decisions about inducing labor or delivering by cesarean section

Table based on data from

Allanson, A., Michie, S., & Matreau, T. M. (1997). Presentation of screen negative results on serum screening for Down's Syndrome. *Journal of Medical Screening*, 4(1), 21-22.

Chapman, S. J., Brumfield, C. G., Wenstrom, K. D., & DuBard, M. B. (1997). Pregnancy outcomes following false-positive multiple marker screening test. *American Journal of Perinatology*, 14(8), 475-478.