Cultural Diversity *in* Health and Illness

Rachel E. Spector

Pearson

Cultural Diversity in Health and Illness

CulturalCare

There is something that transcends all of this
I am I . . . You are you
Yet. I and you
Do connect
Somehow, sometime.

To understand the "cultural" needs
Samenesses and differences of people
Needs an open being
See—Hear—Feel
With no judgment or interpretation
Reach out
Maybe with that physical touch
Or eyes, or aura
You exhibit your openness and willingness to
Listen and learn
And, you tell and share
In so doing—you share humanness
It is acknowledged and shared
Something happens—
Mutual understanding

—Rachel E. Spector

Cultural Diversity in Health and Illness

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Rachel E. Spector, PhD, RN, CTN-A, FAAN
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Executive Editor: Katrin Beacom
Editorial Assistant: Erin Sullivan
Content Producer: Erin Rafferty
Director, Publishing Operations: Paul DeLuca
Managing Content Producer: Melissa Bashe
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I would like to dedicate this text to

My husband, Manny;
Sam, Hilary, Julia, and Emma;
Becky, Perry, Naomi, Rose, and Miriam;
the memory of my parents, Joseph J. and Freda F. Needleman,
and my in-laws, Sam and Margaret Spector;
and the memory of my beloved mentor, Irving Kenneth Zola.

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Preface

Every book, every volume you see here, has a soul. The soul of the person who wrote it and of those who read it and lived and dreamed with it.

—*Carlos Ruiz Zafon*,
The Shadow of the Wind, *2001*

In 1977—nearly 40 years ago—I prepared the first edition of *Cultural Diversity in Health and Illness*. Now, as I begin the ninth edition of this book—the eighth revision—I realize that this is an opportunity to reflect on an endeavor that has filled a good deal of my life for the past 39 years. I believe this book has a soul and it, in turn, has become an integral part of my soul. I have lived—through practice, teaching, consulting, and research—this material since 1974 and have developed many ways of presenting this content. In addition, I have tracked for countless years:

1. The U.S. Census
2. Immigration—numbers and policies
3. Poverty—figures and policies
4. Healthcare—costs and policies
5. Morbidity and mortality rates
6. Nursing and other healthcare manpower issues, and
7. The emergence and growth of the concepts of health disparities and cultural and linguistic competence.

My concepts are *HEALTH*, defined as "the balance of the person, both within one's being—physical, mental, and spiritual—and in the outside world—natural, communal, and metaphysical"; *ILLNESS*, "the imbalance of the person, both within one's being—physical, mental, and spiritual—and in the outside world—natural, communal, and metaphysical"; and *HEALING*, "the restoration of balance, both within one's being—physical, mental, and spiritual—and in the outside world—natural, communal, and metaphysical." I have learned over these years that within many traditional heritages (defined as "old," not contemporary or modern), people tend to define *HEALTH*, *ILLNESS*, and *HEALING* in this manner. Imagine a kaleidoscope—the tube can represent *HEALTH*, *ILLNESS*, and *HEALING*. The objects within the kaleidoscope reflect the traditional tools used to care for a given person. If you love kaleidoscopes, you know what I am describing and that the patterns that emerge are infinite.

In addition, I have had the unique opportunity to travel to countless places in the United States and abroad. I make it a practice to visit the traditional markets, pharmacies, and shrines and dialogue with the people who work in or patronize those settings, and I have gathered invaluable knowledge and unique items and images. My tourist dollars are invested in amulets and remedies, and my collection is large. Digital photography has changed my eyes; I may be a "digital immigrant," rather than a "digital native," but the camera has proven to be my most treasured companion. I have been able to use the images of sacred objects and sacred places to create HEALTH Traditions Imagery. The opening images for each chapter and countless images within the chapters are the results of these explorations. Given that there are times when we do not completely understand a concept or an image, several images are slightly blurred or dark to represent this wonderment.

The first edition of this book was the outcome of a *promesa*—a promise—I once made. The promise was made to a group of Asian, Black, and Hispanic students I taught in a medical sociology course in 1973. In this course, the students wound up being the teachers, and they taught me to see the world of healthcare delivery through the eyes of the healthcare consumer rather than through my own well-intentioned eyes. What I came to see, I did not always like. I did not realize how much I did not know; I believed I knew a lot. I promised the students that I would take what they taught me regarding HEALTH and teach it to students and colleagues. I have held on to the *promesa*, and my experiences over the years have been incredible. I have met people and traveled. At all times I have held on to the idea and goal of attempting to help nurses, other healthcare providers, and, as often as possible, laypeople be aware of and sensitive to the HEALTH, ILLNESS, and HEALING beliefs and needs of people from varied backgrounds.

I know that looking inside closed doors carries with it a risk. I know that people prefer to think that our society is a "melting pot" and that the traditional beliefs and practices have vanished with the expected acculturation and assimilation into mainstream North American modern life. Many people, however, have continued to carry on the traditional customs and culture from their native lands and heritage, and HEALTH, ILLNESS, and HEALING beliefs are deeply entwined within the cultural and social beliefs that people have. To understand HEALTH and ILLNESS beliefs and practices, it is necessary to see each person in his or her unique sociocultural world. The theoretical knowledge that has evolved for the development of this text is cumulative, and much of the "old" material is relevant *today* as many HEALTH, ILLNESS, and HEALING beliefs do not change. However, many beliefs and practices do go underground.

The purpose of each edition has been to increase awareness of the dimensions and complexities involved in caring for people from diverse cultural backgrounds. I wished to share my personal experiences and thoughts concerning the introduction of cultural concepts into the education of healthcare professionals. The books represented my answers to the questions:

- How does one effectively expose a student to cultural diversity?
- How does one examine healthcare issues and perceptions from a broad social viewpoint?

As I have done in the classroom over the years, I attempt to bring you, the reader, into direct contact with the interaction between providers of care within the North American healthcare system and the consumers of healthcare. The staggering issues of healthcare delivery are explored and contrasted with the choices that people may make in attempting to deal with healthcare issues.

When I began this journey in nursing, there were limited resources available to answer my questions and to support me in my passion for knowledge. The situation has dramatically changed, and today there is almost more information than one can absorb! Not only is this information being sought by nurses, but all stakeholders in the healthcare industry are struggling with this concept. The demographics of America, and the world, have changed, and perhaps this challenge of building bridges between cultural groups can be seen as a way to open opportunities to do this in many disciplines. Indeed, the content is readily available:

- Countless books and articles have been published in nursing, medicine, public health, and the popular media over the past 40 years that contain invaluable information relevant to CULTURALCOMPETENCY.
- Innumerable workshops and meetings have been and are available where the content is presented and discussed.
- "Self-study" programs on the internet have been developed that provide continuing education credits to nurses, physicians, and other providers.

However, *the process of becoming CULTURALLYCOMPETENT* is not generally provided for. Issues persist, such as:

- Demographic disparity exists in the profile of healthcare providers and in health status.
- Patient needs, such as modesty, space, and gender-specific care, are not universally met.
- Religious-specific needs are not met in terms of meal planning, procedural planning, conference planning, and so forth.
- Communication and language barriers exist.

As you build a base of knowledge and experiences, you begin making your way to CULTURALCOMPETENCY. As your base of knowledge and experience matures and grows, you become an advocate of CULTURALCARE, as it will be described in Chapter 1.

Overview

Unit I focuses on the background knowledge that healthcare providers must recognize as the foundation for developing CULTURALCOMPETENCY.

- Chapter 1 presents an overview of the significant content related to the ongoing development of the concepts of cultural and linguistic competency as it is described by several different organizations.

- Chapter 2 explores the concept of cultural heritage and history and the roles they play in one's perception of health and illness. This exploration is first outlined in general terms: What is culture? How is it transmitted? What is ethnicity? What is religion? How do they affect a person's health? What major sociocultural events occurred during the life trajectory of a person that may influence his or her personal health beliefs and practices?
- Chapter 3 presents a discussion of the diversity—demographic, immigration, and poverty—that impacts on the delivery of and access to healthcare. The backgrounds of each of the U.S. Census Bureau's categories of the population, an overview of immigration, and an overview of issues relevant to poverty are presented.
- Chapter 4 reviews the provider's knowledge of his or her own perceptions, needs, and understanding of health and illness.

Unit II explores the domains of HEALTH, blends them with one's personal heritage, and contrasts them with the allopathic philosophy.

- Chapter 5 introduces the concept of HEALTH and develops the concept in broad and general terms. The HEALTH Traditions Model is presented, as are natural methods of HEALTH maintenance and protection.
- Chapter 6 explores the concept of HEALTH restoration or HEALING and the role that faith plays in the context of HEALING, or magico-religious, traditions. This is an increasingly important issue, which is evolving to a point where the healthcare provider must have some understanding of this phenomenon.
- Chapter 7 discusses family heritage and explores personal and familial HEALTH traditions. It includes an array of familial health/HEALTH beliefs and practices shared by people from many different heritages.
- Chapter 8 focuses on the healthcare provider culture and the allopathic healthcare delivery system.

Once the study of each of these components has been completed, Unit III (Chapters 9 to 13) moves on to explore selected population groups in greater detail, to portray a panorama of traditional HEALTH and ILLNESS beliefs and practices, and to present relevant healthcare issues.

Chapter 14 is devoted to an overall analysis of the book's contents and how best to apply this knowledge in healthcare delivery, health planning, and health education, for both the patient and the healthcare professional.

Each chapter in the text opens with images relevant to the chapter's topic. They may be viewed in the CULTURALCARE Museum on the accompanying Web page. The CULTURALCARE Museum is cumulative, and the images from earlier versions of this text are included.

These pages cannot do full justice to the richness of any one culture or any one health/HEALTH belief system. By presenting some of the beliefs and practices and suggesting background reading, however, the book can begin to inform and sensitize the reader to the needs of a given group of people. It can

also serve as a model for developing cultural knowledge of populations that are not included in this text. The template used for Chapters 9–13 presents each community's background; traditional definitions of HEALTH and ILLNESS; traditional methods of HEALTH maintenance and protection, and restoration; traditional methods of HEALING and HEALERS; and current health problems. This template can be followed in doing research in the populations you may be working with. The template is also practical in other countries.

There is so much to be learned. Countless books and articles are now available that address these problems and issues. It is not easy to alter attitudes and beliefs or stereotypes and prejudices, to change a person's philosophy. Some social psychologists state that it is almost impossible to lose all of one's prejudices; yet changes can be made. I believe the healthcare provider *must* develop the ability to deliver CULTURALCARE and knowledge regarding personal fundamental values regarding health/HEALTH and illness/ILLNESS. With acceptance of one's own values come the framework and courage to accept the existence of differing beliefs and values. This process of realization and acceptance can enable the healthcare provider to be instrumental in meeting the needs of the consumer in a collaborative, safe, and professional manner.

This book is written primarily for the student in allied health professional programs, nursing, medical, social work, and other healthcare provider disciplines. I believe it will be helpful also for providers in all areas of practice, especially community health, long-term oncology, chronic care settings, and geriatric and hospice centers. I am attempting to write in a direct manner and to use language that is understandable by all. The material is sensitive, yet I believe that it is presented in a sensitive manner. At no point is my intent to create a vehicle for stereotyping. I know that one person will read this book and nod, "Yes, this is how I see it," and someone else of the same background will say, "No, this is not correct." This is the way it is meant to be. It is incomplete by intent. It is written in the spirit of open inquiry, so that an issue may be raised and so that clarification of any given point will be sought *from the patient* as healthcare is provided.

The deeper I travel into this world of cultural diversity, the more I wonder at the variety. It is wonderfully exciting. By gaining insight into the traditional attitudes that people have toward HEALTH and HEALTHCARE, I found my own nursing practice was enhanced, and I was better able to understand the needs of patients and their families. It is thrilling to be able to meet, to know, and to provide care to people from all over the world and every walk of life. It is the excitement of nursing. As we go forward in time, I hope that these words will help you, the reader, develop CULTURALCARE skills and help you provide the best care to all.

You don't need a masterpiece to get the idea.

—Pablo Picasso

Features

- The ***HERITAGECHAIN*** links the chapters and concepts to one another (see pages 1, 67, and 147).
- ***Research on Culture and Health.*** As evidence-based practice grows in importance, its application is expected in all aspects of healthcare. This special feature spotlights how current research informs and impacts cultural awareness and competence.
- ***Unit and Chapter Objectives.*** Each unit and chapter opens with objectives to direct the reader when studying.
- ***Unit Exercises and Activities.*** The beginning of each unit provides exercises and activities related to the topic. Questions stimulate reflective consideration of the reader's own family and cultural history as well as to develop an awareness of one's own biases. Reflective questions can be identified by specially designed bullets (🔗).
- ***Figures, Tables, and Boxes.*** Throughout the book are photographs, illustrations, tables, and boxes that exemplify and expand on information referenced in the chapter.
- ***HEALTH Traditions Imagery.*** These symbolic images are used to link the chapters. The images were selected to awaken you to the richness of a given heritage and the practices inherent within both modern and traditional cultures, as well as the beliefs surrounding health and HEALTH. (HEALTH, when written this way, is defined as the balance of the person, both within one's being—physical, mental, spiritual—and in the outside world—natural, familial and communal, metaphysical.)
- ***Keeping Up.*** Selected resources that present information that is frequently published in a timely manner to keep you abreast of data, on such topics as poverty, income, immigration, and so forth, as the facts and figures change. This is an ongoing feature in this text.

Supplemental Resources

- ***Online Student Resources.*** The student resources available for download at pearsonhighered.com/nursingresources include a wealth of supplemental material to accompany each chapter. The resources present chapter-related review questions, case studies, and exercises to provide additional information.
  - **The CULTURALCARE Museum.** This museum contains a collection of the author's photographs and culturally significant images.
  - **Bibliography.** An extensive bibliography is provided to suggest further reading and research.
- ***Instructor's Resource Center.*** Available to instructors adopting this book are Lecture Note PowerPoints, an Instructor's Manual, and a complete test bank available for download from the Instructor's Resource Center, which can be accessed through the online catalog.

About the Author

Dr. Rachel E. Spector has been a student of culturally diverse HEALTH and ILLNESS beliefs and practices for over 40 years and has researched and taught courses on culture and HEALTHCARE for the same time span. Dr. Spector has had the opportunity to work in many different communities, including the American Indian and Hispanic communities in Boston, Massachusetts. Her studies have taken her to many places: most of the United States, Canada, and Mexico; several European countries, including Denmark, England, Greece, Finland, Iceland, Italy, France, Russia, Spain, and Switzerland; Cuba; Israel; Pakistan; and Australia and New Zealand. She was fortunate enough to collect traditional amulets and remedies from many of these diverse communities, visit shrines, and meet practitioners of traditional HEALTHCARE in several places. She was instrumental in the creation and presentation of the exhibit "Immigrant HEALTH Traditions" at the Ellis Island Immigration Museum, May 1994 through January 1995. She has exhibited HEALTH-related objects in several other settings. Recently, she served as a *Colaboradora Honorifica* (Honorary Collaborator) in the University of Alicante in Alicante, Spain, and Tamaulipas, Mexico. In 2006, she was a Lady Davis Fellow in the Henrietta Zold-Hadassah Hebrew University School of Nursing in Jerusalem, Israel. This text was translated into Spanish by Maria Munoz and published in Madrid by Prentice Hall as *Las Culturas de la SALUD* in 2003 and into Chinese in 2010. There have been two International Editions of the book. She is a Fellow in the American Academy of Nursing and a Scholar in the Transcultural Nursing Society. The American Nurses' Association–Massachusetts, the state organization of the American Nurses' Association, honored her as a "Living Legend" in 2007. In 2008, she received the Honorary Human Rights Award from the American Nurses Association. This award recognized her contributions and accomplishments that have been of national significance to human rights and have influenced healthcare and nursing practice.

Acknowledgments

I have had a 45-year adventure of studying the forces of culture, ethnicity, and religion and their profound influence on HEALTH, ILLNESS, and HEALING beliefs and practices. Many, many people have contributed generously to the knowledge I have acquired over this time as I have tried to serve as a voice for traditional people and the HEALTH, ILLNESS, and HEALING beliefs and practices derived from their given heritage. It has been a continuous struggle to ensure that this information be included not only in nursing education, but in the educational content of all helping professions—including medicine, the allied health professions, and social work.

For the past 15 years I have been teaching a course, Holistic Living, to students who are not nursing majors. The course explores HEALTH under the embracing umbrella of spirituality. I have learned a lot from the students. Not only have they been interested in learning about health/HEALTH, but also they have become empowered by learning about their cultural heritage. The questions "Who are you?" and "Why are you here?" are fundamental themes of this course. These questions have given students an opportunity to explore both their generational heritage and their intangible cultural heritage. They have opened doors to knowledge and experiences they had never expected to encounter. Given that they will be living and working in a society that is far more complex and multicultural than the one I began my adult life in, they heartily embrace the cultural aspects of this book and course.

I particularly wish to thank the following people for their guidance, professional support, and encouragement over the 40 years that this book, now in its ninth edition, has been an integral part of my life. They are people from many walks of life and have touched me in many ways. The people from Appleton-Century-Crofts, which became Appleton & Lange, then became Prentice Hall, and is now Pearson. They include Katrin Beacom, Erin Rafferty, and countless people involved in the production of this edition. My first encounter with publishing was with Leslie Boyer, an acquisition editor from Appleton-Century-Crofts, who simply said "write a book" in 1976. I had no idea what she was talking about or what she really meant and what this would set in motion! In 1976, when the first edition of this book was conceived, I never dreamt that this is where it would be in 2016. The experience of preparing this ninth edition has been a formidable one. Most of the new content has been gathered via the World Wide Web. In addition, for this edition I have worked closely with the developmental editor Addy McCulloch. Without her outstanding help and guidance, this book would not be here today. It is impossible to thank her for all she has contributed.

The many people who helped with advice and guidance to resources over the years include Dr. Gaurdia E, Bannister, Dr. Billye Brown, Jenny Chan, Dr. P. K. Chan, Joe Colorado, Miriam Cook, Elizabeth Cucchiaro, Norine Dresser, Dr. Jose Siles Gonzalez, Orlando Isaza, Henry and Pandora Law, Dr. S. Dale McLemore, Dr. Anita Noble, Dr. Carl Rutberg, Sister Mary Nicholas Vincelli, Dr. David Warner, Dr. Deborah Washington, and the late Elsie Basque, Louise Buchanan, Julian Castillo, Leonel J. Castillo, Dr. Marjory Gordon, Hawk Littlejohn, Father Richard McCabe, Dr[a]. Carmen Chamizo Vega, and Irving K. Zola.

My students, over the many years that I have taught, have generously shared their experiences and insights. When the fall semester, 2015, ended, Elizabeth G. Arone, Alice I. Choi, Sydney L. Hoffman, and Jennifer M. Taylor helped by reviewing the new chapters for this edition. It was most useful to see their comments about the new work, and I deeply appreciate their efforts.

The reviewers for the manuscript added invaluable assistance. I hope they will be quite pleased when they read the completed book. I thank them for their diligence and attention to detail.

I wish to thank my friends and family, who have tolerated my distracted responses and absence at countless social functions, and the many people who have provided the numerous support services necessary for the completion of an undertaking such as this. My husband, Manny, has been the rock who has sustained and supported me through all these years—most of all, I can never thank him enough.

A lot has happened in my life since the first edition of this book was published in 1979. My family has shrunk with the deaths of my parents and in-laws, and it has greatly expanded with a new daughter, Hilary, and a new son, Perry, and five granddaughters—Julia, Emma, Naomi, Rose, and Miriam. The generations have gone, and come.

Reviewers

Teresa S. Burckhalter, MSN, RN, BC
University of South Carolina–Beaufort
Beaufort, SC

Margherite Matteis, PhD, RN, PMHCNS-BC
Regis College
Weston, MA

Kate Lewis Nolt, MPH, PhD
Motivation Intervention
Philadelphia, PA

Linda Sweigart, MSN, APRN
Ball State University
Muncie, IN

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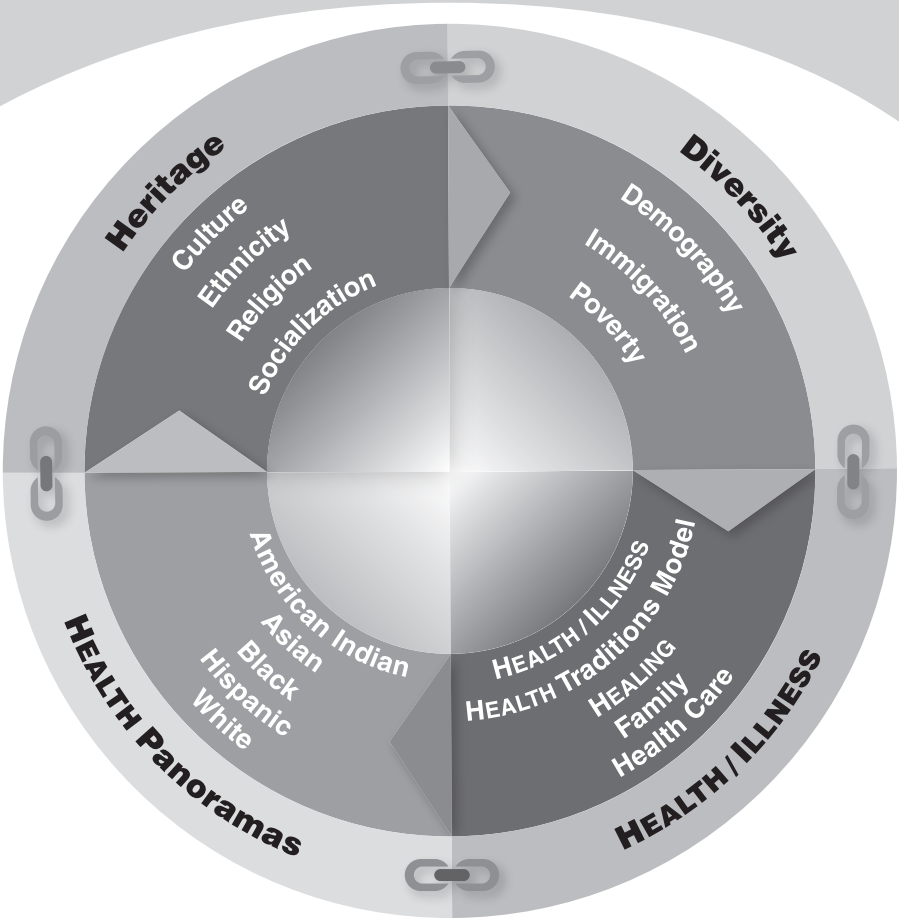
Unit I

Cultural Foundations



The *HERITAGECHAIN* (Figure U1-1) is the essential, distinct, and unifying theme of this book. It is a given that each of us is comprised of a genetic chain that is passed from generation to generation. We also possess an intangible cultural heritage (United Nations Educational, Scientific and Cultural Organization, n.d.) or sociocultural *HERITAGECHAIN* that includes traditional HEALTH beliefs and practices. These, too, are passed from generation to generation, but may have been lost or submerged in this modern era. The focus of this book will be the

impact that the *HERITAGECHAIN* has on our HEALTH, ILLNESS, and HEALING beliefs and practices. The chapters represent major concepts; the *HERITAGECHAIN* links concept to concept. The concepts include cultural foundations, health domains, and HEALTH and ILLNESS panoramas. The theoretical links will be discussed in each chapter of this book.

Unit I creates the foundation for this book and is designed to help you become aware of the importance of developing knowledge in the topics of (1) cultural and linguistic competency; (2) *cultural* heritage and history—both your own and those of other people; (3) *diversity*—demographic, immigration, and economic; and (4) the customary concepts of *health* and *illness*. The chapters in Unit I will present an overview of relevant historical and contemporary theoretical content. You will:

1. Understand the critical need for the development of cultural and linguistic competency.
2. Identify and discuss the factors that contribute to heritage consistency—culture, ethnicity, religion, acculturation, and socialization.
3. Identify and discuss sociocultural events that may influence the life trajectory of a given person.
4. Understand diversity in the population of the United States by observing:
   - The Census estimates for 2015,
   - Immigration patterns and issues, and
   - Economic issues.
5. Understand health and illness and the sociocultural and historical phenomena that affect them.
6. Reexamine and redefine the concepts of health and illness.
7. Understand the multiple relationships between health and illness.

Before you read Unit I, please answer the following questions:

1. Do you speak a language other than English?
2. What is your sociocultural heritage?
3. What major sociocultural events have occurred in your lifetime?
4. What is the demographic profile of the community you grew up in? Has it changed; if so, how has it changed?
5. How would you acquire economic help if necessary?
6. How do you define *health*?
7. How do you define *illness*?
8. What do you do to maintain and protect your health?
9. What do you do when you experience a noticeable change in your health?
10. Do you diagnose your own health problems? If yes, how do you do so? If no, why not?
11. From whom do you seek healthcare?
12. What do you do to restore your health? Give examples.

CHAPTER

1 Building Cultural and Linguistic Competence

Figure 1-1

Figure 1-2

Figure 1-3

When there is a very dense cultural barrier, you do the best you can, and if something happens despite that, you have to be satisfied with little success instead of total successes. You have to give up total control….

—*Anne Fadiman (2001)*

Objectives

1. Discuss the critical need for cultural and linguistic competence.
2. Describe the National Standards for Culturally and Linguistically Appropriate Services in Health Care.
3. Describe institutional mandates regarding cultural and linguistic competence.
4. Articulate the attributes of CULTURALCOMPETENCY[1] and CULTURALCARE.

The opening images for this chapter depict the rationale for the building of CULTURALCOMPETENCY. Figure 1-1 is a "bolted fake door" in Vejer de la Frontera, Spain. It is a reminder of personal beliefs that shut out all other arguments and ways of understanding people. Figure 1-2 is a translucent door in Avila, Spain, where it is possible to look into a different reality and because

[1] When terms such as *HERITAGECHAIN*, CULTURALCOMPETENCY, and CULTURALCARE and others, such as HEALTH, ILLNESS, and HEALING, are written in all capital letters, it is done so to imply that they are referring to a holistic philosophy, rather than to a dualistic philosophy.

it is not locked, you can open it and recognize the views of others. Figure 1-3 represents the practical side—the steps to CulturalCompetency. A more detailed discussion of each image follows in the forthcoming text.

In May 1988, Anne Fadiman, editor of *The American Scholar*, met the Lee family of Merced, California. Her subsequent book, *The Spirit Catches You and You Fall Down*, published in 1997, tells the compelling story of the Lees and their daughter, Lia, and their tragic encounter with the American healthcare delivery system. This book has now become a classic and is used by many healthcare educators and providers in situations where there is an effort to demonstrate the need for developing CulturalCompetency.

When Lia was 3 months old, she was taken to the emergency room of the county hospital with epileptic seizures. The family was unable to communicate in English; the hospital staff did not include competent Hmong interpreters. From the parents' point of view, Lia was experiencing "the fleeing of her soul from her body and the soul had become lost." They knew these symptoms to be *quag dab peg*—"the spirit catches you and you fall down." The Hmong regarded this experience with ambivalence, yet they knew that it was serious and potentially dangerous, as it was epilepsy. It was also an illness that evokes a sense of both concern and pride.

The parents and the healthcare providers both wanted the best for Lia, yet a complex and dense trajectory of misunderstanding and misinterpreting was set in motion. The tragic cultural conflict lasted for several years and caused considerable pain to each party (Fadiman, 2001). This moving incident exemplifies the extreme events that can occur when two antithetical cultural belief systems collide within the overall environment of the healthcare delivery system. Each party comes to a healthcare event with a set notion of what ought to happen—and, unless each is able to understand the view of the other, complex difficulties can arise.

The catastrophic events of September 11, 2001; the wars in Iraq, Afghanistan, and Libya; the Islamic State and the increase in incidents of global terrorism, such as the 2015 massacre in Paris, France; the countless natural disasters such as Hurricane Katrina and the earthquakes in Haiti and Japan; and our ongoing preoccupation with domestic terrorist threats—and reality in San Bernardino, California—have pierced the consciousness of all Americans in general and healthcare providers in particular. Now, more than ever, providers *must* become informed about and sensitive to the culturally diverse subjective meanings of **health/HEALTH**, **illness/ILLNESS**, and **curing/HEALING** practices. Cultural diversity and pluralism are a core part of the social and economic engines that drive the country. Their impact has significant implications for healthcare delivery and policymaking throughout the United States.

In all clinical practice areas—from institutional settings, such as acute and long-term care settings, to community-based settings, such as nurse practitioners', physician assistants', and doctors' offices and clinics, schools and universities, public health, and occupational settings—one observes diversity every day. The undeniable need for culturally and linguistically competent healthcare services for diverse populations has attracted increased attention from healthcare providers and those who judge their quality and efficiency for many years.

Personal cultural background, heritage, and language have a considerable impact on both how patients access and respond to healthcare services and how the providers practice within the system. Cultural and linguistic competence suggests an ability of healthcare providers and healthcare organizations to understand and respond effectively to the cultural and linguistic needs brought to the healthcare experience. This is a phenomenon that recognizes the diversity that exists among the patients, physicians, nurses, and caregivers. This phenomenon is not limited to the changes in the patient population in that it also embraces the members of the workforce—including providers from other countries. Many of the people in the workforce are new immigrants and/or are from ethnocultural backgrounds that differ from that of the dominant culture.

In addition, health and illness can be interpreted and explained in terms of personal experience and expectations. We can define our own health or illness and determine what these states mean to us in our daily lives. We learn from our own cultural and ethnic backgrounds how to be healthy, how to recognize illness, and how to be ill. Furthermore, the meanings we attach to the notions of health and illness are related to the basic, culture-bound values by which we define a given experience and perception.

It is now *imperative,* according to the most recent policies of the Joint Commission of Hospital Accreditation and the Centers for Medicare & Medicaid Services, that *all* healthcare providers be "culturally competent." In this context, cultural competency implies that within the delivery of care, the healthcare provider understands and attends to the total context of the patient's situation; it is a complex combination of knowledge, attitudes, and skills, yet:

- How do you *really* inspire people to hear the content?
- How do you *motivate* providers to see the worldview and lived experience of the patient?
- How do you assist providers to *really* bear witness to the living conditions and lifeways of patients?
- How do you liberate providers from the burdens of prejudice, xenophobia, the "isms"—racism, ethnocentrism—and the "antis" such as anti-Semitism, anti-Catholicism, anti-Islamism, anti-immigrant, and so forth?
- How do you inspire philosophical changes from dualistic thinking to holistic thinking?

It can be argued that the development of CulturalCompetency does not occur in a short encounter with programs on cultural diversity but that it takes time to develop the skills, knowledge, and attitudes to safely and satisfactorily become "CulturallyCompetent" and to deliver CulturalCare. Indeed, the reality of becoming "CulturallyCompetent" is a complex process—it is time consuming, difficult, frustrating, and extremely interesting. It is a philosophical change wherein the CulturallyCompetent person is able to hear, understand, and respect the nonverbal and/or non-articulated needs and perspectives of a given patient.

CULTURALCOMPETENCY embraces the premise that all things are connected. Consider Figure U1-1, the *HERITAGECHAIN*. Each concept, or facet, discussed in this book—heritage, culture, ethnicity, religion, socialization, and identity—is a link connected to diversity, demographic change, population, immigration, and poverty. These links are connected to health/HEALTH, illness/ILLNESS, curing/HEALING, beliefs and practices, modern and traditional. All of these links are connected to the healthcare delivery system—the culture, costs, and politics of healthcare, the internal and external political issues, public health issues, and housing and other infrastructure issues. In order to fully understand a person's health/HEALTH beliefs and practices, each of these topics must be in the background of a provider's mind. Three assessment tools (see Appendix B) have been developed from the theoretical links that are delineated within the text:

1. Heritage Assessment
2. Ethnofamily Health Interview/Assessment
3. Ethnocultural Community Assessment

They will be further discussed in forthcoming chapters.

I have had the opportunity to live and teach in Spain and to explore many areas, including Cadiz and the surrounding small villages. There was a fake door within the walls of a small village, Vejer de la Frontera (Figure 1-1), that appeared to be bolted shut. The door was placed there during the early 14th century to fool the Barbary pirates. The people were able to vanquish them while they tried to pry the door open. It reminded me of the attempt to keep other ideas and people away and not open up to new and different ideas. Another door (Figure 1-2), found in Avila, Spain, was made of translucent glass. Here, the person has a choice—peer through the door and view the garden behind it, or open it and actually go into the garden for a finite walk. This reminded me of people who are able to understand the needs of others and return to their own life and heritage when work is completed. This polarity represents the challenges of "CULTURALCOMPETENCY."

The way to CULTURALCOMPETENCY is complex, but I have learned over the years that there are five steps, Figure 1-3, to master as you begin to achieve this goal:

1. ***Personal heritage:*** Who are *you*? What is *your* heritage? What are your health/HEALTH beliefs?
2. ***Heritage of others—demographics:*** Who is the other? Family? Community?
3. ***Health and HEALTH beliefs and practices:*** What the competing philosophies are.
4. ***Healthcare culture and system:*** What all the issues and problems are.
5. ***Traditional HEALTHCARE systems:*** The way HEALTH was for most, and the way HEALTH still is for many.

Once you have reached the sixth step, CULTURALCOMPETENCY, you are ready to open the door to CULTURALCARE.

Each link in the *HERITAGECHAIN* represents a discrete unit of study. The links represent the fundamental terms, or language, of the content. Table 1-1 lists many examples of the links, and these terms are used in the

Table 1-1 Selected CULTURALCARE Terms

Access	Acupuncture	Ageism	Alien
Allopathic philosophy	Amulet	Apparel	Assimilation
Bankes	Borders	Calendar	Care
Census	Citizen	CLAS	Community
Costs	Cultural conflict	CULTURALCARE	CULTURALCOMPETENCY
Culturally appropriate	Culturally competent	Culturally sensitive	**Culture**
Curandera/o	Customs	Cycle of poverty	Demographic disparity
Demographic parity	**Demography**	Diagnosis	**Diversity**
Documentation	Education	*Empacho*	*Envidia*
Ethics	**Ethnicity**	Ethnicity	Ethnocentrism
Evil eye	**Family**	Financing	Food
Garments	Gender specific care	Green Card	Gris-gris
Habits	Halal	**HEALING**	**Health**
HEALTH	**Healthcare system**	Health disparities	HEALTH Traditions
Healthy People 2020	Herbalist	Heritage	Heritage consistency
Heritage inconsistency	Heterosexism	Hex	Homeland security
Homeopathic philosophy	Homophobia	Iatrogenic	**Illness**
ILLNESS	**Immigration**	Kosher	Language
Law	Legal Permanent Resident (LPR)	Life trajectory	*Limpia*
Linguistic competence	Literacy	Mal ojo	Manpower
Meridians	Migrant labor	*Milagros*	Modern
Modesty	Morbidity	Mortality	Naturalization
Office of Minority Health	*Orisha*	Osteopathy	*Partera*
Pasmo	Politics	**Poverty**	Poverty guidelines
Powwow	Procedures	*Promesa*	*Quag dab peg*
Racism	Reflexology	Refugee	**Religion**
Remedies	Sacred objects	Sacred places	Sacred practices
Sacred spaces	Sacred times	*Santera/o*	*Senoria*
Sexism	Silence	Silence	Singer
Socialization	Spell	Spirits	Spiritual
Spirituality	Title VI	Traditional	Undocumented person
Visitors	Voodoo	Vulnerability	Welfare
Worldview	Xenophobia	*Yin &Yang*	*Yoruba*

following chapters as appropriate and are defined in the Key Terms list in Appendix A. These selected terms and many more are the evolving language or jargon of CULTURALCARE.

Contrary to popular belief and practice, CULTURALCOMPETENCY is not a "condition" that is rapidly achieved. Rather, it is an ongoing process of growth and the development of knowledge that takes a considerable amount of time to ingest, digest, assimilate, circulate, and master. It is, for many, a philosophical change in that they develop the skills to understand where a person from a different cultural background than theirs is coming from.

This discussion now presents an overview of the significant content related to the ongoing development of the concepts of cultural and linguistic competency as they are described by several different organizations. Presently, there has been a proliferation of resources related to this content and a discussion of selected items is included here. Box 1-2, at the conclusion of the chapter, lists numerous resources.

National Standards for Culturally and Linguistically Appropriate Services in Health Care

In 1997, the Office of Minority Health undertook the development of national standards to provide a much-needed alternative to the patchwork that had been undertaken in the field of cultural diversity. It developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. These 15 standards, improved over time (Box 1-1), must be met by most healthcare-related agencies. The standards are based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations. The standards were developed with input from a national advisory committee of policymakers, healthcare providers, and researchers and were primarily directed at healthcare organizations. The current 15 enhanced standards are a comprehensive series of guidelines. They guide practices related to culturally and linguistically appropriate health services. The goal is to advance health equity along the healthcare continuum. The CLAS principles and activities must be integrated throughout an organization and implemented in partnership with the communities being served (https://www.thinkculturalhealth.hhs.gov/).

Cultural Competence

Cultural competence implies that professional healthcare must be developed to be culturally sensitive, culturally appropriate, and culturally competent. Culturally competent care is critical to meet the complex culture-bound healthcare needs of a given person, family, and community. It is the provision of healthcare across cultural boundaries and takes into account the context in which the patient lives, as well as the situations in which the patient's health problems arise.

Box 1-1

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards)

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

(continued)

Box 1-1 *Continued*

14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

CLAS standards are non-regulatory and therefore do not have the force and effect of law. The standards are not mandatory, but they greatly assist healthcare providers and organizations in responding effectively to their patients' cultural and linguistic needs. Compliance with Title VI of the Civil Rights Act of 1964 is mandatory and requires healthcare providers and organizations that receive federal financial assistance to take reasonable steps to ensure Limited English Proficiency (LEP) persons have meaningful access to services.

CLAS standards use the term patients/consumers to refer to "individuals, including accompanying family members, guardians, or companions, seeking physical or mental healthcare services, or other health-related services" (p. 5 of the comprehensive final report; see http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15).

Source: National Standards for Culturally and Linguistically Appropriate Services in Health Care, by U.S. Department of Health and Human Services, Office of Minority Health, ThinkHealth. Retrieved from https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

- ***Culturally competent.*** Within the delivered care, the provider understands and attends to the total context of the patient's situation, and this is a complex combination of knowledge, attitudes, and skills.
- ***Culturally appropriate.*** The provider applies the underlying background knowledge that must be possessed to provide a patient with the best possible health/HEALTHcare.
- ***Culturally sensitive.*** The provider possesses some basic knowledge of and constructive attitudes toward the health/HEALTH traditions observed among the diverse cultural groups found in the setting in which he or she is practicing.

Linguistic Competence

Title VI of the Civil Rights Act of 1964 states, "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." To avoid discrimination based on national origin, Title VI and its implementing regulations require recipients of federal financial assistance to take reasonable steps to provide meaningful access to Limited English Proficiency (LEP) persons. Therefore,

under the provisions of Title VI of the Civil Rights Act of 1964, when people with LEP seek healthcare in healthcare settings such as hospitals, nursing homes, clinics, daycare centers, and mental health centers, services cannot be denied to them. It is said that "language barriers have a deleterious effect on healthcare and patients are less likely to have a usual source of healthcare, and have an increased risk if non-adherence to medication regimens" (Flores, 2006, p. 230).

The United States is home to millions of people from many national origins. Currently, because there are growing concerns about racial, ethnic, and language disparities in health and healthcare and the need for healthcare systems to accommodate increasingly diverse patient populations, language access services (LAS) have become more and more a matter of national importance. This need has become increasingly pertinent given the continued growth in language diversity within the United States. English is the official language of the United States and, according to the 2011 American Community Survey estimates, it is spoken at home by 79.2% of the residents over 5 years old. In the same year, however, 9% of the population over 5 years old spoke "no English at all." In the total of over 37.5 million Spanish-speaking people over 5 years old, 62.9% spoke "no English at all." Of the people over the age of 5 speaking other Indo-European languages, most spoke English very well. However, there are a number of people from many of the Indo-European countries, such as Russia and Armenia, that speak no English. Of those who speak the Asian and Pacific Island languages, most speak English very well or well, but there are many who either speak English not well or not at all (Ryan, 2013, p. 1).

People who are limited in their ability to speak, read, write, and understand the English language experience countless language barriers that can result in limiting their access to critical public health, hospital, and other medical and social services to which they are legally entitled. Many health and social service programs who once provided information about their services in English only are now using interpreter services and information in the languages of the populations in their service area. Each patient must be carefully assessed to determine his or her language needs, and information must be delivered in a manner that is understandable by the patient. When a patient does not understand English, competent interpreters or language resources must be available.

Institutional Mandates

Since 2003, the Joint Commission has been actively pursuing a course that ensures that cultural and linguistic competency standards become a part of their accreditation requirements. Since this time, they have published several documents relevant to this topic, and in 2010 they published a monograph, *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care: A Roadmap for Hospitals*. The monograph provides checklists to improve effective communication during the admission, assessment, treatment,

end-of-life, and discharge and transfer stages of a given patient's hospitalization trajectory. They strongly state that:

> Every patient that enters the hospital has a unique set of needs—clinical symptoms that require medical attention and issues specific to the individual that can affect his or her care. (The Joint Commission, 2010, p. 1)

They implicitly recognize that when a given person moves through the hospitalization continuum, he or she requires not only medical and nursing intervention, but also care that addresses the spectrum of each person's demographic and personal characteristics. The Joint Commission has made many efforts to understand personal needs and then provide guidance to organizations to address those needs. They initially focused on studying language, culture, and health literacy needs, and presently (as of 2011), they are focusing on effective communication, cultural competence, and patient- and family-centered care.

The Joint Commission defines cultural competency as:

> the ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter. (The Joint Commission, 2010, p. 91)

They further recognize that:

> cultural competence requires organizations and their personnel to: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served. (The Joint Commission, 2010, p. 91)

These principles apply to each segment of the institutional experience from admission to discharge or end of life, and for each facet, specific actions must be undertaken. These actions include informing patients of their rights, assessing communication needs, and involving the patient and family in care plans. Each segment is accompanied by a checklist for activities; for example, there is a checklist to Improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care during admission (The Joint Commission, 2010, p. 9).

CULTURALCARE

The term *CULTURALCARE* expresses all that is inherent in the development of healthcare delivery to meet the mandates of the CLAS standards and other cultural competency mandates. CULTURALCARE is holistic care. There are countless conflicts in the healthcare delivery arenas that are predicated on cultural misunderstandings. Although many of these misunderstandings are related to universal situations—such as verbal and nonverbal language misunderstandings, the conventions of courtesy and manners, the order in which conversations take place, how interactions are worded, and how the provider is perceived by the patient—many cultural misunderstandings are unique to the delivery of healthcare. The need to provide CULTURALCARE is essential, and providers must be

able to assess and interpret a patient's health beliefs and practices and cultural and linguistic needs. CULTURALCARE alters the perspective of healthcare delivery as it enables the provider to understand, from a cultural perspective, the manifestations of the patient's cultural heritage and life trajectory. The provider must serve as a bridge in the healthcare setting between the given institution, the patient, and people who are from different cultural backgrounds.

In conclusion, cultural and linguistic competency must be understood to be the foundations of a new healthcare *philosophy*. It is comprised of countless facets—each of which is a topic for study. CULTURALCOMPETENCY is a philosophy that appreciates and values holistic perspectives rather than, or in addition to, dualistic—modern and technological—viewpoints. CULTURALCOMPETENCY is more than a "willingness"—it is a philosophy that *must* be part of an institution's and a professional's mission and goal statement. Within the philosophy of cultural competency, **HEALTH**, **ILLNESS**, and **HEALING** are understood holistically.

The development of CULTURALCOMPETENCY is an ongoing, lifelong endeavor. This is a topic that requires deep study, reflection, and time. The days when a "bagged lunch" with an hour's lecture or discussion have passed, and hours—even a lifetime—must be dedicated to the topics, and countless others, this book presents. Critical questions must be asked: "Are healthcare providers institutional advocates? Modern healthcare advocates? Or, patient advocates?"

Explore MediaLink

Go to the Student Resource Site at pearsonhighered.com/nursingresources for chapter-related review questions, case studies, and activities. Contents of the CULTURALCARE Guide and CULTURALCARE Museum can also be found on the Student Resource Site. Click on Chapter 1 to select the activities for this chapter.

Box 1-2

Keeping Up

There are countless references, published weekly, monthly, annually, and periodically, that may be accessed to maintain currency in the domains of cultural and linguistic competency and with professional organizations concerned with this specialty area of practice. The following are selected suggestions:

American Association of Colleges of Nursing (AACN)

The AACN's Toolkit for Cultural Competent Education provides extensive resources including content and teaching-learning activities.

(continued)

Box 1-2 *Continued*

Health and Human Services (HHS) Data Council

The HHS Data Council coordinates all health and human services data collection and analysis activities of the Department of Health and Human Services, including integrated data collection strategy, coordination of health data standards and health and human services, and privacy policy activities.

Institute of Medicine

The Institute of Medicine (IOM) is a division of the National Academies of Sciences, Engineering, and Medicine. The Academies are private, nonprofit institutions that provide independent, objective analysis and advice to the nation and conduct other activities to solve complex problems and inform public policy decisions related to science, technology, and medicine. The IOM aids those in government and the private sector make informed health decisions predicated on reliable evidence.

Kaiser Family Foundation

Kaiser Fast Facts provides direct access to facts, data, and slides about the nation's healthcare system and programs, in an easy-to-use format.

The Kaiser Family Foundation has launched a new internet resource, State Health Facts Online, that offers comprehensive and current health information for all 50 states, the District of Columbia, and U.S. territories. State Health Facts Online offers health policy information on a broad range of issues such as managed care, health insurance coverage and the uninsured, Medicaid, Medicare, women's health, minority health, and data and slides about the nation's healthcare system and programs, in an easy-to-use format.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

NBCCEDP provides access to critical breast and cervical cancer screening services for underserved women in the United States, the District of Columbia, 4 U.S. territories, and 13 American Indian/Alaska Native organizations.

Office of Minority Health (OMH)

The OMH was created in 1986 and is one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health*. Reauthorized by the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), the OMH is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. In addition to the new standards, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* are available on the OMH website. The OMH also offers an excellent resource, Think Cultural Health: Advancing Health Equity at Every Point of Contact.

Robert Wood Johnson

The Robert Wood Johnson Foundation has an online tool that ranks state counties by health status, taking into account clinical care, socioeconomic, and environmental factors.

The National Center for Health Statistics (NCHS)

The NCHS provides quick and easy access to the wide range of information and data available, including HHS surveys and data collection systems.

The Joint Commission

Since 2007, the Joint Commission has been working toward improving access to care for all patients at its accredited organizations, emphasizing better communication, cultural competence, and patient- and family-centered care.

The *Online Journal of Cultural Competence in Nursing and Healthcare*

This journal's first issue appeared online in January 2011. It is a free quarterly peer-reviewed publication that provides a forum for discussion of the issues, trends, theory, research, evidence-based, and best practices in the provision of culturally congruent and competent nursing and healthcare.

Transcultural Nursing Society

The Transcultural Nursing Society has developed a core curriculum in Transcultural Nursing; Douglas, M. K., Editor-in-Chief, and Pacquiao, D. F., Senior Editor. (2010). *Core Curriculum for Transcultural Nursing and Health Care* is available here.

The Transcultural Nursing Society has also developed Standards for Culturally Competent Nursing Care and they can be found in Douglas, M. K., Pierce, J. U., Rosenkoetter, M., et al. (2011). Standards of Practice for Culturally Competent Care. *Journal of Transcultural Nursing, 22*(4), 318.

University of Michigan Health System: The Cultural Competency Division

The Cultural Competency Division plays a vital role in implementing cultural competency in the UMHS and in promoting good community healthcare practices. This is an excellent website with links to numerous sites.

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CHAPTER

2 Cultural Heritage and History

Figure 2-1

Figure 2-2

Figure 2-3

Samoans, remember your culture.

Objectives

1. Explain the links on the *HERITAGECHAIN* that contribute to heritage consistency—culture, ethnicity, and religion.
2. Explain the links related to acculturation themes.
3. Discuss and give examples of cultural conflicts.
4. Explain the factors involved in the cultural phenomena affecting health and healthcare.

This link on the *HERITAGECHAIN* explores the concept of heritage—cultural, religious, and ethnic; acculturation themes, and cultural phenomena affecting health and healthcare. The banner (Figure 2-1) admonishes Samoans—"remember YOUR culture"—a searing message for each of us to hear. It is imperative for all of us to know our culture and heritage as we move forward to become CULTURALLYCOMPETENT. Figure 2-2 is a cement slide that was built into the side of a hill in a small playground. I played on it as a child, as did my mother, my children, and my grandchildren—a four-generation relic that evokes countless memories of childhood and child rearing. Figure 2-3 is my class ring, a cherished icon—I graduated from Salem (Massachusetts) High School.

As you begin to consider aspects of heritage consistency, first ask yourself:

- ***Who are you?*** What is *your* cultural, ethnic, and religious heritage? What are images of the places and icons of your generation and culture? How and where were you socialized to the roles and rules of your family, community, and occupation?
- ***Who is the person next to you?*** What is this person's cultural, ethnic, and religious heritage? How and where was this person socialized to the roles and rules of his or her family, community, and occupation? Are you this person's healthcare provider, instructor, colleague, or supervisor?

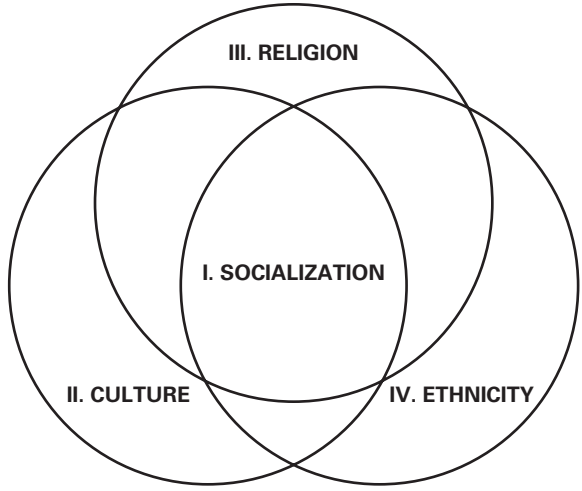
The foundation for CULTURALCOMPETENCY rests in the knowledge and understanding of heritage, not only your own, but also that of others with whom you are interacting.

This second chapter presents an overview of the salient and complex theoretical content related to one's heritage and its impact on health/HEALTH beliefs and practices. Two sets of theories are presented, the first of which analyzes the degree to which people have maintained their traditional heritage; the second, and opposite, set of theories relates to socialization and acculturation and the quasi-creation of a melting pot or some other common threads that are part of an American whole. It then becomes possible to analyze health beliefs by determining a person's ties to his or her traditional heritage, rather than to signs of acculturation. The assumption is that there is a relationship between people with strong identities—either with their heritage or the level at which they are acculturated into the American culture—and their health/HEALTH beliefs and practices. Hand in hand with the concept of ethnocultural heritage is that of a person's ethnocultural history; the journey a person has experienced predicated on the historical sociocultural events that have touched his or her life directly or indirectly.

Heritage Consistency

Heritage consistency is a concept developed by Estes and Zitzow (1980, p. 1) to describe "the degree to which one's lifestyle reflects his or her respective tribal culture." The theory has been expanded in an attempt to study the degree to which a person's lifestyle reflects his or her traditional culture, such as European, Asian, African, or Hispanic. The values indicating heritage consistency exist on a continuum, and a person can possess value characteristics of both a consistent heritage (traditional) and an inconsistent heritage (acculturated). The concept of heritage consistency includes a determination of one's cultural, ethnic, and religious background. Another way to consider the relationship between heritage and cultural, ethnic, and religious backgrounds is as a chain, with heritage forming the first link and the other factors—culture, religion, and ethnicity—being subsequent links (Figure 2-4).

It has been found over time that the greater a given person identifies with his or her traditional heritage—that is, his or her culture, ethnicity, and



I. SOCIALIZATION	Extended family Place reared Visits home Raised with extended family Name
II. CULTURE	Extended family Participation in folkways Language
III. RELIGION	Extended family Church membership and participation Historic beliefs
IV. ETHNICITY	Extended family Resides in ethnic community Participates in folkways Socializes with members of same ethnic group Identifies as ethnic—American

Figure 2-4 Components of heritage consistency.

religion—the greater the chance that the person's health and illness beliefs and practices may vary from those of the mainstream society and modern health-care providers. For example, Estes and Zitzow observed that when people who identified highly with their tribal culture were treated for alcoholism by a medicine man, the outcome was more favorable than with treatment in the modern culture. Other research found that people with a high level of heritage consistency frequented healthcare sources not used by modern providers. The Heritage Assessment Tool, another link on the chain of interrelated concepts and assessment tools that can be found in Appendix B, is a screening tool to assess for a person's immersion in their particular heritage. It is a useful tool in research development. A given respondent who answers affirmatively to a large

number of factors on this tool may well be "heritage consistent"—that is, identify deeply with their traditional heritage.

Culture

The word *culture* showed 1,460,000,000 results on August 22, 2015, on the internet. There is no single definition of *culture*, and all too often definitions omit salient aspects of culture or are too general to have any real meaning. Of the countless ideas of the meaning of this term, some are of particular note. The classical definition by Fejos (1959, p. 43) describes culture as "the sum total of socially inherited characteristics of a human group that comprises everything which one generation can tell, convey, or hand down to the next; in other words, the nonphysically inherited traits we possess." Another way of understanding the concept of culture is to picture it as the luggage that each of us carries around for our lifetime. It is the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals, and so forth that we learned from our families during the years of socialization. In turn, we transmit this cultural luggage to our children. The definition that is most relevant in the study of traditional HEALTH beliefs and practices is that culture is a "metacommunication system," wherein not only the spoken words have meaning but everything else does as well (Matsumoto, 1989, p. 14).

All facets of human behavior can be interpreted through the lens of culture, and everything can be related to and from this context. Culture has several characteristics, including that it is:

1. The medium of personhood and social relationships
2. A complex whole in which each part is related to every other part
3. Learned, and must be learned by each person in a family and social community, and
4. Dependent on an underlying social matrix, that includes knowledge, beliefs, art, law, morals, and customs (Bohannan, 1992, p. 13).

The symbols of culture—sound and acts—form the basis of all languages. Symbols are everywhere—in religion, politics, and gender; the meanings of which vary between and within cultural groups. There are countless cultural symbols relevant to traditional HEALTH and ILLNESS beliefs and practices and will be discussed in later chapters of this text.

Ethnicity

The word *ethnicity* showed 179,000,000 results on August 22, 2015, on the internet. A random exploration of selected sites did not provide information different from the classical information in the following discussion.

Cultural background is a fundamental component of one's ethnic background. Before we proceed with this discussion, though, we need to define some terms, so that we can move forward from the same point of reference. The classic reference defines *ethnic* as an adjective "relating to large groups of

people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background" ("Ethnic," *Merriam-Webster Dictionary*, n.d.). O'Neil (2008) described ***ethnicity*** as selected cultural and sometimes physical characteristics used to classify people into groups or categories considered to be significantly different from others.

The term *ethnic* has for some time aroused strongly negative feelings and is often rejected by the general population. One can speculate that the upsurge in the use of the term stems from the recent interest of people in discovering their personal backgrounds, a fact used by some politicians who overtly court "the ethnics." Paradoxically, in a nation as large as the United States and comprising as many different peoples as it does—with the American Indians being the only true native population—we find ourselves still reluctant to speak of ethnicity and ethnic differences. This stance stems from the fact that most foreign groups that come to this land often shed the ways of the "old country" and quickly attempt to assimilate into the mainstream, or the so-called melting pot (Novak, 1973). Other terms related to *ethnic* include:

- ***Ethnocentrism:*** (1) belief in the superiority of one's own ethnic group; (2) overriding concern with race
- ***Xenophobia:*** a morbid fear of strangers
- ***Xenophobe:*** a person unduly fearful or contemptuous of strangers or foreigners, especially as reflected in his or her political or cultural views.

The behavioral manifestations of these phenomena occur in response to people's needs, especially when they are foreign born and must find a way to function (1) before they are assimilated into the mainstream and (2) in order to accept themselves. The people cluster together against the majority, who in turn may be discriminating against them.

Ethnicity is indicative of the following selected characteristics a group may share in some combination:

1. Geographic origin and migratory status
2. Race
3. Language and dialect
4. Religious faith or faiths
5. Ties that transcend kinship, neighborhood, and community boundaries
6. Traditions, values, and symbols
7. Literature, folklore, and music.

There are at least 106 ethnic groups and 567 federally recognized American Indian tribes and Alaska Natives (Bureau of Indian Affairs, 2016) in the United States that meet many of these criteria. People from every country in the world have immigrated to this country. Some nations, such as Germany, England, Italy, and Ireland, were heavily represented in early immigration times. People continue to immigrate to the United States, with the present influx coming from Mexico, Haiti, South and Central America, India, and China (U.S. Department of Homeland Security, 2014, pp. 12–13).

Religion

The third major component of heritage consistency is religion. The word *religion* showed 660,000,000 results on August 24, 2015, on the internet. One customary way to understand religion is that it is "the belief in a divine or superhuman power or powers to be obeyed and worshipped as the creator(s) and ruler(s) of the universe; it is a system of beliefs, practices, and ethical values" (Abramson, 1980, pp. 869–875). Another way is to see religion as "an organized system of beliefs, ceremonies, and rules used to worship a god or a group of gods" ("Religion," *Merriam-Webster Dictionary*, n.d.). The practice of religion is revealed in numerous cults, sects, denominations, and churches. Ethnicity and religion are clearly related, and one's religion quite often determines one's ethnic group. Religion gives a person a frame of reference and a perspective with which to organize information. Religious teachings help present a meaningful philosophy and system of practices within a system of social controls having specific values, norms, and ethics. These are related to health in that adherence to a religious code is conducive to spiritual harmony and health. Illness is sometimes seen as a punishment for the violation of religious codes and morals.

Religion plays a fundamental and vital role in the health beliefs and practices of many people. For example, the use of meditation; rules regarding immunization; rules regarding modesty and who can examine a given person; family relationships; the concept of hope with terminal illness; and childrearing. Specific examples of a religious tradition and its influence on health include:

1. The Jewish and Muslim faiths prohibit eating pig products.
2. The Catholic faith forbids abortion.
3. The Jehovah's Witness faith forbids blood transfusions.
4. The Mormon faith prohibits the use of caffeine and tobacco.

An additional way of understanding the relationship of religion to health is to conceptualize religion as the domain of life that deals with things of the spirit and matters of ultimate concern, a way to answer the questions "*Who am I*?" and "*Why am I here*?" In addition, religious affiliation and membership benefit health by promoting healthy behavior and lifestyles in the following ways:

1. Regular religious fellowship benefits health by offering support that buffers and affects stress and isolation.
2. Participation in worship and prayer benefits health through the physiological effects of positive emotions.
3. Religious beliefs benefit health by their similarity to health promoting beliefs and personality styles.
4. Simple faith benefits health by leading to thoughts of hope, optimism, and positive expectation.

5. Mystical experiences benefit health by activating a healing bioenergy or life force or altered state of consciousness.
6. Absent prayer for others is capable of healing by paranormal means or by divine intervention (Levin, 2001, p. 9).

Unlike some countries, the United States does not include a question about religion in its census and has not done so for over 55 years. Religious adherent statistics in the United States are obtained from surveys and organizational reporting. A 2006 survey by Putnam and Campbell found that Americans are a highly religious people. We have high rates of belonging, behaving, and believing, and when compared to other industrialized nations, the United States ranks 7th in the rate of weekly attendance at religious services. Jordan, Indonesia, and Brazil are ahead of us. They also found that Mormons, Black Protestants, and Evangelicals are the most religiously observant groups in America; and that the Deep South, Utah, and the Mississippi Valley are the most religious regions of the country (Putnam & Campbell, 2010, pp. 7–23).

One source of information on religious preference is the Pew Forum on Religion and Public Life (2015). The forum delivers timely, impartial information on issues at the intersection of religion and public affairs. In a 2014 study by the Pew Research Center, it was found that the Christian share of the American population was declining and that the number of American adults who do not identify with any organized religion was growing. Christians now comprise 70.6%; Jews, 1.9%; Buddhists, 0.7%; Muslims. 0.9%; Hindus, 0.7%; and Other World Religions, 0.3%. Individuals identifying as unaffiliated were 22.8% of the population studied (Pew Forum on Religion and Public Life, 2015, p. 2).

Examples of Heritage Consistency

The following are examples of each factor that is examined in determining a person's degree of Heritage:

1. The person's childhood development occurred in the person's country of origin or in an immigrant neighborhood in the United States of like ethnic group.

   The person was raised in a specific ethnic neighborhood, such as Italian, Black, Hispanic, or Jewish, in a given part of a city and was exposed to only the culture, language, foods, and customs of that group.
2. Extended family members encouraged participation in traditional religious and cultural activities.

   The parents sent the person to religious school, and most social activities were church-related.
3. The individual engages in frequent visits to the country of origin or returns to the "old neighborhood" in the United States.

   The desire to return to the old country or to the old neighborhood is prevalent in many people; however, many people, for various reasons, cannot return. The people who came here to escape religious persecution or whose families were killed during world wars or the Holocaust may not want to return to European homelands.

Other reasons people may not return to their native country include political conditions in the homeland and lack of relatives or friends in that land.

4. The individual's family home is within the ethnic community of which he or she is a member.

   As an adult, the person has elected to live with family in an ethnic neighborhood.

5. The individual participates in ethnic cultural events, such as religious festivals or national holidays, sometimes with singing, dancing, and costumes.

   The person holds membership in ethno- or religious-specific organizations and primarily participates in activities with the groups.

6. The individual was raised in an extended family setting.

   When the person was growing up, there may have been grandparents living in the same household, or aunts and uncles living in the same house or close by. The person's social frame of reference was the family.

7. The individual maintains regular contact with the extended family.

   The person maintains close ties with members of the same generation, the surviving members of the older generation, and members of the younger generation who are family members.

8. The individual's name has not been Americanized.

   The person has restored the family name to its European original if it had been changed by immigration authorities at the time the family immigrated or if the family changed the name at a later time in an attempt to assimilate more fully.

9. The individual was educated in a parochial (nonpublic) school with a religious or ethnic philosophy similar to the family's background.

   The person's education plays an enormous role in socialization, and the major purpose of education is to socialize a person into the dominant culture. Children learn English and the customs and norms of American life in the schools. In the parochial schools, they not only learn English but also are socialized in the culture and norms of the religious or ethnic group that is sponsoring the school.

10. The individual engages in social activities primarily with others of the same religious or ethnic background.

    The major portion of the person's personal time is spent with primary structural groups.

11. The individual has knowledge of the culture and language of origin.

    The person has been socialized in the traditional ways of the family and expresses this as a central theme of life.

12. The individual expresses pride in his or her heritage.

    The person may identify him- or herself as ethnic American and be supportive of ethnic activities to a great extent.

It is not possible to isolate the aspects of culture, religion, and ethnicity that shape a person's worldview. Each is part of the other, and all three are united within the person. When one writes of religion, one cannot eliminate culture or ethnicity, but descriptions and comparisons can be made. Understanding such

differences can help enhance your understanding of the needs of patients and their families and the support systems that people may have or need.

Acculturation Themes

Several factors, also links on the chain, are relevant to the overall experience of acculturation. *Acculturation* is the broad term used to describe the process of adapting to and becoming absorbed into the dominant social culture. The overall process of acculturation into a new society is extremely difficult. Have you ever moved to a new community? Imagine moving to a new country and society where you are unable to communicate, do not know your way around, and do not know the "rules." The three facets to the process of overall acculturation are socialization, acculturation, and assimilation.

Socialization

Socialization is the process of being raised within a culture and acquiring the characteristics of that group. Education—be it preschool, elementary school, high school, college, or a healthcare provider program—is a form of socialization. For many people who have been socialized within the boundaries of a "traditional culture" or a non-Western culture, modern American culture becomes a second cultural identity. Those who immigrate here, legally or illegally, from non-Western or nonmodern countries may find socialization into the American culture, whether in schools or in society at large, to be an extremely difficult and painful process. They may experience biculturalism, which is a dual pattern of identification and one often of divided loyalty (LaFrombose, Coleman, & Gerton, 1993).

Understanding culturally determined health and illness beliefs and practices from different heritages requires moving away from linear models of process to more complex patterns of cultural beliefs and interrelationships.

Acculturation

While becoming a competent participant in the dominant culture, a member of the nondominant culture is always identified as a member of his or her original culture. The process of acculturation is involuntary, and a member of the nondominant cultural group is forced to learn the new culture to survive. *Acculturation* also refers to cultural or behavioral assimilation and may be defined as the changes of one's cultural patterns to those of the host society. In the United States, people assume that the usual course of acculturation takes three generations; hence, the adult grandchild of an immigrant is considered fully Americanized. It is with this population that the answers on the Heritage Assessment Tool may become more negative as family ties, spoken language at home, and other variables may be lost.

Assimilation

Acculturation also may be referred to as assimilation, the process by which an individual develops a new cultural identity. Assimilation means becoming in all ways like the members of the dominant culture. The process of assimilation encompasses various aspects, such as cultural or behavioral, marital, identification, and civic. The underlying assumption is that the person from a given cultural group loses this cultural identity to acquire the new one. In fact, this is not always possible, and the process may cause stress and anxiety (LaFrombose et al., 1993). Assimilation can be described as a collection of subprocesses: a process of inclusion through which a person gradually ceases to conform to any standard of life that differs from the dominant group standards and, at the same time, a process through which the person learns to conform to all the dominant group standards. The process of assimilation is considered complete when the foreigner is fully merged into the dominant cultural group (McLemore, 1980, p. 4).

The concepts of socialization, assimilation, and acculturation are complex and sensitive. The dominant society expects that all immigrants are in the process of acculturation and assimilation and that the worldview we share as healthcare practitioners is shared by our patients. Because we live in a pluralistic society, however, many variations of health beliefs and practices exist.

The debate still rages between those who believe that America is a melting pot and that all groups of immigrants must be acculturated and assimilated to an American norm, and those who dispute theories of acculturation and believe that the various groups maintain their own identities within the American whole. The concept of heritage consistency is one way of exploring whether people are maintaining their traditional heritage and of determining the depth of a person's traditional cultural heritage.

Cultural Conflicts

There are countless ways by which cultural conflicts occur. One is in the general way, a second is generational differences, and a third is within healthcare.

Cultural Conflicts

Hunter (1994) limited the classical discussion of "cultural conflicts" as events that occur when there is polarization between two groups and their differences are intensified by the way they are perceived. There may also be polarization between two people and between people and institutions. Hunter described the fields of conflict as found in family, education, media and the arts, law, and electoral politics. The struggles are centered on the control of the symbols of culture. This argument must be extended to include healthcare as a sixth field, and the conflict is between those who actively participate in traditional healthcare practices—that is, the practices of their given ethnocultural heritage—and those who are progressive and see the answers to contemporary health problems in the science and technology of the present.

When cultures clash, many misanthropic feelings, or "isms," can enter into a person's consciousness. Just as Hunter proclaimed that the "differences" must be confronted, so, too, must stereotypes, prejudices, and discrimination. It is impossible to describe traditional health and illness beliefs without a temptation to stereotype, but each person is an individual; therefore, just as levels of heritage consistency differ within and between ethnic groups, so do health beliefs and practices.

Prejudice—such as racism, sexism, homophobia, ageism, and xenophobia—occurs either because the person making the judgment does not understand the given person or his or her heritage, or because the person making the judgment generalizes an experience of one individual from a culture to all members of that group. Discrimination occurs when a person acts on prejudice and denies another person one or more of his or her fundamental rights.

Generational Differences

Generational differences have been described as deep and gut-level ways of experiencing and looking at the cultural events that surround us. The ethnocultural life trajectories of population cohorts have established a situation where generations in America today are poles apart. Given the technology explosion and other social changes, the differences between elders and the millennials can be staggering. For example, I was discussing Humphrey Bogart with a group of senior college students, and they had no frame of reference as to who he was and what he had accomplished. And yet, when they discuss many of the popular culture figures of today, I, too, often react in wonderment! The changes in the past several decades have created cultural barriers that openly or more subtly create misunderstandings, tensions, and often conflicts between family members, coworkers, and other individuals. Remember, the cycle of our lives is an ethnocultural journey, and many of the aspects of this journey are derived from the social, political, religious, and cultural contexts in which we grew up. Factors that imprint our lives are the characters and events that we interacted with between 10 and 19 years of age, more or less.

The following are examples of what life may have been and what it is for people from various generations:

- ***The Silent Generation,*** people born between 1938 and 1945, may well remember World War II and Hiroshima. Members of this generation believe in community service and tend to conform to societies' norms.
- ***The Boomer Generation,*** people born between 1946 and 1964, is now entering retirement times and remembers Elvis Presley, Marilyn Monroe, and Rosa Parks. "Boomers" work and play hard, vote if convenient, may live a distance from family, and are close with friends.
- ***Generation X,*** people born between 1965 and 1980, grew up during the Vietnam War, Kent State, and Watergate. Members of this generation tend to not actively participate in voting and to work hard if work does not interfere with good times.

- ***The Millennial Generation,*** people born between 1977 and 1994, is the first generation to come of age in this new millennium. The older members well remember September 11, 2001, and the wars in Iraq and Afghanistan. Many millennials depend on smartphones, tablets, computers, and social media (Taylor & the Pew Research Center, 2014).
- ***Generation Z,*** people born between 1995 and 2012, is characterized by independence and an eagerness to move into life. They prefer personal contact but are technologically proficient. They are connected to people all over the world because of social media and want to take an active role in their communities (Levit, 2005).

Another example of generational conflict between elders and the millennials is both within families, the workplace, and institutional settings where the people are cared for not only by providers who are immigrants, but also by those who are much younger and have limited knowledge as to what has been their life trajectory. The patient may also be an immigrant who experienced a much different life trajectory than others of the same age and the caregivers. Imagine your life today and what it may have been like to live without a computer, a cell phone, an iPod, or an iPad. Many people may see today's commonplace objects as "strangers" rather than "friends," and could be "digital immigrants," not "digital natives."

Commingling Variables

Six commingling variables relate to this overall situation of social and generational divisions as they, too, are potential sources of conflict:

1. ***Decade of birth.*** As mentioned above, people's life experiences vary greatly, depending on the events of the decades in which they were born and the cultural values and norms of the times. People who tend to be heritage consistent—that is, have a high level of identification and association with a traditional heritage—tend to be less caught up in the secular fads of the time and popular sociocultural events.
2. ***Generation in the United States.*** Worldviews differ greatly between the immigrant generation and subsequent generations, and between people who score high as heritage consistent and mainstream people who may score low on the heritage consistency assessment and have been born into families who have resided in the United States for multiple generations.
3. ***Class and income.*** Social class is how people are rated or may rate themselves as "upper, middle, lower, blue collar, or working poor" and is an important factor to consider. There are countless differences among people predicated on class, including such variables as education, living conditions, social status, occupation, income, access to and utilization of healthcare, and so forth. Between 1979 and 2013, women's earnings rose for most age groups. However,

women's earnings were 74% to 80% of the earnings of men (U.S. Bureau of Labor Statistics, 2013, p. 2).

4. ***Language.*** There are frequent misunderstandings, as discussed in Chapter 1, when people who do not understand English must help and care for or take direction from English speakers. There are also countless conflicts when people who are hard of hearing attempt to understand people with limited English-speaking skills, and many cultural and social misunderstandings can develop.
5. ***Education.*** Increasing percentages of students have completed high school, from 69% in 1980 to 85.3% in 2009. "Every child in America deserves a world-class education." With these words, President Obama signed *A Blueprint for Reform: The Reauthorization of the Elementary and Secondary Education Act* in March 2010. This blueprint challenged the nation to embrace education standards that would put America back on a path to global leadership in education. It provides incentives for states to adopt academic standards that prepare students to succeed in college and the workplace, and to create accountability systems that measure student growth toward meeting the goal that all children graduate and succeed in college. (U.S. Department of Education, 2010).
6. ***Literacy.*** The 2003 National Assessment of Adult Literacy is a nationally representative assessment of English literacy among American adults age 16 and older. Eleven million adults fell in the *Below Basic* rank; 7 million could not answer simple test questions, and 4 million could not take the test because of language barriers. Fifty-five percent of adults with *Below Basic* prose literacy did not graduate from high school, compared to 15% of adults in the general population (Baer, Kutner, Sabatini, & White, 2009).

Cultural Phenomena Affecting Health

The cultural phenomena identified by Giger and Davidhizar (1995) that vary among cultural groups and affect social interaction and/or healthcare are biological variations, communication, environmental control, social organization, space, and time orientation. The following discussion broadly defines these phenomena and provides examples of practical manners when they are faced.

Biological Variations

The several ways in which people from one cultural group differ biologically (i.e., physically and genetically) from members of other cultural groups constitute their biological variations; for example, body build and structure, including specific bone and structural differences between groups, such as the smaller stature of Asians, and skin color, including variations in tone, texture, healing abilities, and hair follicles.

It is important to know the variations in food intolerance as found in many people and in the amount of time that it may take a person to physically heal after surgery.

Communication

Communication differences present themselves in many ways, including language differences, verbal and nonverbal behaviors, and silence. Language differences are possibly the most important obstacle to providing multicultural healthcare because they affect all stages of the patient–caregiver relationship.

Proper manners dictate that you understand the correct greetings (e.g., if a form of touch such as a handshake is permissible), what gestures mean, and the interpretation of eye contact. People from most European cultures believe that if a person does not look them in the eye, the person is lying; however, many people from African and Asian heritages do not allow eye contact.

Environmental Control

Environmental control is the ability of members of a particular cultural group to plan activities that control nature or direct environmental factors. Included in this concept are the complex systems of traditional health and illness beliefs, the practice of folk medicine, and the use of traditional healers.

Be knowledgeable of the dietary practices of people and the health beliefs and practices they may adhere to.

Social Organization

The social environment in which people grow up and live plays an essential role in their cultural development and identification. Children learn their culture's responses to life events from the family and its ethnoreligious group. This socialization process is an inherent part of heritage—one's cultural, religious, and ethnic background.

Be sensitive to the celebration of religious holidays by those from backgrounds other than your own.

Space

Personal space refers to people's behaviors and attitudes toward the space around themselves. Territoriality is the behavior and attitude people exhibit about an area they have claimed and defend or react emotionally to when others encroach on it. Both personal space and territoriality are influenced by culture, and thus different ethnocultural groups have varying norms related to the use of space.

Be respectful of the distance people may choose when interacting and body language.

Time Orientation

The viewing of time in the present, past, or future varies among cultural groups. Certain cultures in the United States and Canada tend to be future-oriented. People who are future-oriented are concerned with long-range goals and with healthcare measures in the present to prevent the occurrence of illness in the future. Others are oriented more to the present than the future and may be late for appointments because they are less concerned about planning to be on time. This difference in time orientation may become important in healthcare measures such as long-term planning and explanations of medication schedules.

Be aware of the meaning of ***time*** *to a person and when their expectations are that you will be prompt. Avoid scheduling elective procedures and meetings during holidays (see Appendix C).*

The examples used in the text to illustrate cultural phenomena affecting health and health traditions in different cultures are not intended to be stereotypical. With careful listening, observing, and questioning, the provider should be able to sort out the traditional health and illness beliefs of a given person.

This chapter has presented an overview of the link on the *HERITAGECHAIN* that explores the concept of heritage—cultural, religious, and ethnic; acculturation themes; and cultural phenomena affecting health and healthcare. It has served as the foundation that delineates the multiple, interrelating phenomena that underlie the cultural conflict that occurs between healthcare providers and patients, many of whom have difficulty interacting with the healthcare providers and healthcare system. It has presented both classical and contemporary definitions and explanations relevant to the foundation of this conflict and sets the stage for further discussion.

Explore MediaLink

Go to the Student Resource Site at pearsonhighered.com/nursingresources for chapter-related review questions, case studies, and activities. Contents of the CULTURALCARE Guide and CULTURALCARE Museum can also be found on the Student Resource Site. Click on Chapter 2 to select the activities for this chapter.

Box 2-1

Keeping Up

The following resources will be helpful in maintaining current information related to religious participation.

Department of Education
Pew Research Center

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CHAPTER

3 Diversity

Figure 3-1

Figure 3-2

Figure 3-3

… Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost to me,
I lift my lamp beside the golden door!

—*Emma Lazarus,* The New *Colossus (1886)*

Objectives

1. Describe the total population characteristics of the United States as presented in Census 2010.
2. Compare the population characteristics of the United States in 2000, 2010, and 2014.
3. Discuss the changes in points of origin of recent and past immigrants.
4. Explain the meanings of terms related to immigration, such as *citizen*, *refugee*, *legal permanent resident*, *and naturalization*.
5. Discuss the concepts of poverty.
6. Analyze the cycle of poverty.

The next links on the *HERITAGECHAIN* explore the diversity in our nation, and the opening images for this chapter represent the demographic and socioeconomic diversity that exists in countless communities in this nation. The