Chapter 8

Gender, Socioeconomic, and Cultural Attributes of the Learner

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CHAPTER HIGHLIGHTS

KEY TERMS

- ❑ gender-related cognitive abilities
- ❑ gender-related personality behaviors
- ❑ gender gap
- ❑ gender bias
- ❑ socioeconomic status (SES)
- ❑ poverty circle (cycle of poverty)
- ❑ acculturation
- ❑ assimilation
- ❑ cultural awareness
- ❑ cultural competence
- ❑ ethnocentrism
- ❑ ideology
- ❑ subculture
- ❑ transcultural
- ❑ primary characteristics of culture
- ❑ secondary characteristics of culture
- ❑ cultural assessment
- ❑ worldview
- ❑ cultural knowledge
- ❑ cultural skill

- ❑ cultural diversity
- ❑ cultural relativism
- ❑ culture
- ❑ ethnic group
- ❑ cultural encounter
- ❑ spirituality
- ❑ religiosity
- ❑ stereotyping

OBJECTIVES

After completing this chapter, the reader will be able to

1. Identify gender-related characteristics in the learner based on social and hereditary influences on brain functioning, cognitive abilities, and personality traits.
2. Recognize the influence of socioeconomics in determining health status and health behaviors.
3. Define the various terms associated with diversity.
4. Examine cultural assessment from the perspective of different models of care.
5. Distinguish between the beliefs and customs of the four predominant ethnic groups in the United States.
6. Suggest teaching strategies specific to the needs of learners belonging to each of the four ethnic groups.
7. Examine ways in which transcultural nursing can serve as a framework for meeting the learning needs of various ethnic populations.
8. Identify the meaning of stereotyping, the risks involved, and ways to avoid stereotypical behavior.

Gender, socioeconomic level, and cultural background have a significant influence on a learner's willingness and ability to respond to and make use of the teaching–learning situation. Two of these factors—gender and socioeconomic status—have been given very little attention to date by nurse educators. The third factor, cultural and ethnic diversity, has been the focus of considerable study in recent years with respect to its effects on learning. Understanding diversity, particularly those variations among learners related to gender, socioeconomics, and culture, is of major importance when designing and implementing education programs to meet the needs of an increasingly unique population of learners.

This chapter explores how individuals respond differently to healthcare interventions through examination of gender-related variations resulting from heredity or social conditioning that affects how the brain functions for learning. Secondly, the influence of environment on the learner from a socioeconomic viewpoint is examined. Thirdly, consideration is given to the significant effects cultural norms have on the behaviors of learners from the perspective of the four major ethnic groups in the United States. In addition, models for cultural assessment and the planning of care are highlighted. This chapter also includes ways to prepare nurses for diversity care and to deal with the issue of stereotyping.

Gender Characteristics

Most of the information on gender variations with respect to learning can be found in the educational psychology and neuroscience literature. Nursing literature contains scant information about this subject from a teaching–learning perspective. There are, however, characteristics of male and female orientations that affect learning, which need to be addressed more closely. Two well-established facts exist. First, individual differences within a group of males or females are usually greater than differences between groups of males versus groups of females. Second, studies that compare the sexes seldom are able to separate genetic differences from environmental influences on behavior (Santrock, 2006; Vander Zanden, Crandell, & Crandell, 2007.)

There remains a gap in knowledge of what the sexes would be like if humans were not subject to behavioral conditioning. No person can survive outside a social matrix, and, therefore, individuals begin to be shaped by their environment right from birth. For example, our U.S. culture exposes girls and boys, respectively, to pink and blue blankets in the nursery, dolls and trucks in preschool, ballet and basketball in the elementary grades, and cheerleading and football in high school. These social influences continue to affect the sexes throughout the life span.

Of course, men and women are different. But the question is: are they different or the same when it comes to learning, and to what can the differences and similarities be attributed? Biological and behavioral scientists have, to date, been unable to quantify the exact impact that genetics and environment have on the brain. Opinions are rampant, and research findings are inconclusive.

To date, there has been a great divide between neuroscience and education. What is needed is multidisciplinary research to bridge the gap in the discoveries being made in cognitive science laboratories and the application of this information to teaching in the real world. To address this need, the National Science Foundation in 2005 pledged $90 million in grants over 5 years to support four teams of cognitive neuroscientists, psychologists, computer scientists, and educationalists to "give the craft of teaching a solid scientific underpinning" (Gura, 2005, p. 1156). By discovering how the brain works in learning, teaching methods and tools can be designed "to complement the brain's natural development" (Gura, 2005, p. 1156). This is "a massive effort to put the way children are taught on a sounder scientific footing" (Gura, 2005, p. 1156).

The fact remains that there are gender differences as to how males and females act, react, and perform in situations affecting every aspect of life (Cahill, 2006). As Cahill contends, the issue of gender influences is much too important to be ignored or marginalized. The national Academy of Sciences reports "sex does matter in ways that we did not expect. Undoubtedly, it matters in ways that we have not yet begun to imagine" (Cahill, 2006, p. 7).

For example, when it comes to human relationships, intuitively women tend to pick up subtle tones of voice and facial expressions, whereas men tend to be less sensitive to these communication cues. In navigation, women tend to have difficulty finding their way, while men seem to have a better sense of direction. In cognition, females tend to excel in languages and verbalization, and men are likely to demonstrate stronger spatial abilities and interest in mathematical problem solving. Scientists are beginning to believe that gender differences have as much to do with the biology of the brain as with the way people are raised (Baron-Cohen,

2005; Gorman, 1992). Kimura (1999) reported on the many different patterns of behavior and cognition between men and women that are thought to be due to varying hormonal influences on brain development.

Some would argue that these examples are representative of stereotyping. But as generalizations, these statements seem to hold some truth. Neuroscientists have begun to detect structural as well as functional differences in the brains of males and females. These early findings have led to an upsurge in neuroscience research into the mental lives of men and women (Baron-Cohen, 2005).

Neurobiologists are just at the dawn of understanding how the human brain works and exactly the types of sensory input that wire the brain and how that input affects it. Scientists suspect that cognitive abilities work much like sensory ones in that they are promoted by those activities and experiences to which a person is exposed right from birth. Circuits in different regions of the brain are thought to mature at different stages of development. These circuits are critical windows of opportunity at different ages for the learning of math, music, language, and emotion.

Brain development is much more sensitive to life experiences than once believed (Begley, 1996; Hancock, 1996). A baby's brain is like "a work in progress, trillions of neurons waiting to be wired . . . to be woven into the intricate tapestry of the mind" (Begley, 1996, pp. 55–56). Some of the neurons of the brain have been hard wired by genes, but trillions more have almost infinite potential and are waiting to be connected by the influence of environment. The first 3 years of life, it is being discovered, are crucial in the development of the mind. The wiring of the brain, a process both of nature and nurture, dubbed the "dual sculptors," forms the connections that determine the ability to learn and the interest for learning different types of skills (Harrigan, 2007; Nash, 1997).

Thanks to modern technology, imaging machines are revolutionizing the field of neuroscience. Functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) are being used to observe human brains in the very act of thinking, feeling, or remembering (Kawamura, Midorikawa & Kezuka, 2000; Monastersky, 2001; Speck et al., 2000; Yee et al., 2000). Amazing discoveries through brain scanning have been made, such as where the emotion of love resides in the brain. Although machines can measure the brain's blood flow that supports nerve activity, no machines have been developed to date that can read or interpret a person's thoughts. The field of brain scanning still has far to go, but experts consider its potential to be incredible.

The trend in current studies is to focus on how separate parts of the brain interact while performing different tasks rather than focusing on only isolated regions of the brain associated with certain tasks (Monastersky, 2001). Researchers have already reported that men and women use different clusters of neurons when they read than when their brains are idling. For example, Karwamura and colleagues (2000) focused on the cerebral localization of the center for reading and writing music of a male patient. They concluded that the left side of the brain is involved in this type of task, just as it is in an individual's ability to read and write language.

Also, gender differences in brain activity during working memory—an important component for performing many higher functions—have been examined with fMRI. For example, in a study of verbal working memory by Speck et al.

(2000), the amount of brain activity increased with task difficulty. Interestingly, male subjects demonstrated more right-sided hemispheric dominance, whereas females showed more left-sided hemispheric dominance, with higher accuracy and slightly slower reaction times than their male counterparts. The results revealed significant gender differences in the functional brain organization for working memory.

In general, the brains of men and women seem to operate differently. Provocative new studies are revealing that women engage more of their brains when thinking sad thoughts. When men and women subjects were asked to conjure up sad memories, the front of the limbic system in the brain of women glowed with activity eight times more than in men. Although men and women were able to perform equally well in math problems, tests indicated that they seemed to use the temporal lobes of the brain differently to figure out problems. Also, it has been found that men and women employ different parts of their brains to figure out rhymes. These results are just a few examples of some of the tentative, yet tantalizing, findings from research that are beginning to show that male and female identity is a creation of both nature and nurture. Along with genetics, life experiences and the choices men and women make in the course of a lifetime help to mold personal characteristics and determine gender differences in the very way the sexes think, sense, and respond (Begley, Murr, & Rogers, 1995).

In comparing how men and women feel, act, process information, and perform on cognitive tests, scientists have been able to identify only a few gender differences in the actual brain structure of humans (**Table 8–1**). Most differences that have been uncovered are quite small, as measured statistically. Even the largest differences in *gender-related cognitive abilities* are not as significant as, for example, the disparity found between male and female height. There seems to be, in fact, a great deal of overlap in how the brains of the two sexes work. Otherwise, "women could never read maps and men would always be left-handed. That flexibility within the sexes reveals just how complex a puzzle gender actually is, requiring pieces from biology, sociology, and culture" (Gorman, 1992, p. 44).

With respect to brain functioning, there is likely a mix between the factors of heredity and environment that accounts for gender characteristics. The following is a comparison of cognitive abilities between the genders based on developmental and educational psychology findings in Vander Zanden et al. (2007), Santrock (2006), Snowman & Biehler (2006), and Baron-Cohen (2005).

Cognitive Abilities

General intelligence: Various studies have not yielded consistent findings on whether males and females differ in general intelligence. But if any gender differences exist, they seem to be attributed to patterns of ability rather than IQ (Kimura, 1999). When mean differences have occurred, they are small. However, what is well documented is the strong correlation between IQ and heredity (Santrock, 2006). On IQ tests during preschool years, girls score higher; in high school, boys score higher on these tests. Differences may be due to greater dropout rates in high school for low-ability boys and gender identity formation in adolescence. Thus, overall no dramatic differences between the sexes have been found on measures of general intelligence (Vander Zanden et al., 2007).

However, a very interesting trend in IQ scores has been noted. IQs (as measured by the Stanford-Binet intelligence test) are increasing

Table 8–1 GENDER DIFFERENCES IN BRAIN STRUCTURE

	Men	Women
Temporal Lobe		
Regions of the cerebral cortex help to control hearing, memory, and a person's sense of self and time.	In cognitively normal men, a small region of the temporal lobe has about 10% fewer neurons than it does in women.	More neurons are located in the temporal region where language, melodies, and speech tones are understood.
Corpus Callosum		
The main bridge between the left and right brain contains a bundle of neurons that carry messages between the two brain hemispheres.	This part of the brain in men takes up less volume than a woman's does, which suggests less communication between the two brain hemispheres.	The back portion of the callosum in women is bigger than in men, which may explain why women use both sides of their brains for language.
Anterior Commissure		
This collection of nerve cells, smaller than the corpus callosum, also connects the brain's two hemispheres.	The commissure in men is smaller than in women, even though men's brains are, on average, larger in size than women's brains.	The commissure in women is larger than in men, which may be a reason why their cerebral hemispheres seem to work together on tasks from language to emotional responses.
Brain Hemispheres		
The left side of the brain controls language, and the right side of the brain is the seat of emotion.	The right hemisphere of men's brains tends to be dominant.	Women tend to use their brains more holistically, calling on both hemispheres simultaneously.
Brain Size		
Total brain size is approximately 3 pounds.	Men's brains, on average, are larger than women's.	Women have smaller brains, on average, than men because the anatomical structure of their entire bodies is smaller. However, they have more neurons than men (an overall 11%) crammed into the cerebral cortex.

Source: Adapted from Begley, S., Murr, A., & Rogers, A. (1995, March 27). Gray Matters. *Newsweek,* 51.

rapidly worldwide. In America, children seem to be getting smarter. As compared with IQs tested in 1932, if people took the same test today, a large percentage would score much higher. Since the increase has occurred over such a relatively short time, heredity is not the cause. It is thought that increasing levels of education and the information-age explosion are the reasons. This increase in IQ scores is known as the *Flynn effect* after the researcher who discovered it (Santrock, 2006).

Verbal ability: Girls learn to talk, form sentences, and use a variety of words earlier than boys. In addition, girls speak more clearly, read earlier, and do consistently better on tests of spelling and grammar. Originally, researchers believed females performed better than males on measures of verbal fluency, but recent research has questioned this early superiority of females in the verbal domain. On tests of verbal reasoning, verbal comprehension, and vocabulary, the findings are not consistent. The conclusion is that no significant gender differences in verbal ability exist.

Mathematical ability: During the preschool years, there appear to be no gender-related differences in ability to do mathematics. By the end of elementary school, however, boys show signs of excelling in mathematical reasoning, and the differences in math abilities of boys over girls become even greater in high school. Recent studies reveal that any male superiority likely is related to the way math is traditionally taught—as a competitive individual activity rather than as a cooperative group learning endeavor.

When the approach to teaching math is taken into consideration, only about a 1% variation in quantitative skills is seen in the general population. In our culture, math achievement differences may result from different role expectations. The findings on math ability and achievement can also be extended to science ability and achievement, as these two subjects are related.

Spatial ability: The ability to recognize a figure when it is rotated, to detect a shape embedded in another figure, or to accurately replicate a three-dimensional object is consistently better for males than for females. Of all possible gender-related differences in cognitive activity, the spatial ability of males is consistently higher than that of females and probably has a genetic origin. Rubin Gur, a noted researcher on gender differences in the brain, concurs with other research findings that men do perform better on spatial tasks than women (Gur et al., 2000). However, the magnitude of this sex difference accounts for only about 5% of the variation in spatial ability.

Interestingly, women surpass men in the ability to discern and later recall the location of objects in a complex, random pattern (Kimura, 1999). Scientists have reasoned that historically men may have developed strong spatial skills so as to be successful hunters, while women may have needed other types of visual skills so as to excel as gatherers and foragers of food (Gorman, 1992).

Problem solving: The complex concepts of problem solving, creativity, analytical skill, and cognitive styles, when examined, have led to mixed findings regarding gender differences. Men tend to try new approaches in problem solving and are more likely to be field independent. That is, they are less influenced by irrelevant cues and more focused on common features in certain learning tasks (see Chapter 4 on learning styles). Males also show more curiosity and significantly less conservatism than women in risk-taking situations. In the area of

human relations, however, women perform better at problem solving than do men.

School achievement: Without exception, girls get better grades on average than boys, particularly at the elementary school level. Scholastic performance of girls is more stable and less fluctuating than that of boys.

Although no compelling evidence proves significant gender-linked differences in the areas of cognitive functioning, except in spatial ability as mentioned above, some findings do reveal sex differences when it comes to personality characteristics. Evidence reported by Vander Zanden and others (2007), Santrock (2006), and Snowman and Biehler (2006) was used to substantiate the following summary findings unless otherwise noted.

Personality Traits

Most of the observed *gender-related personality behaviors* are thought to be largely determined by culture but are, to some extent, a result of mutual interaction between environment and heredity.

Aggression: Males of all ages and in most cultures are generally more aggressive than females (Baron-Cohen, 2005). The role of the gender-specific hormone testosterone is linked as a possible cause of the more aggressive behavior demonstrated by males (Kimura, 1999). However, anthropologists, psychologists, sociologists, and scientists in other fields continue to disagree about whether aggression is biologically based or environmentally influenced. Nevertheless, male and female roles differ widely in most cultures, with males usually being more dominant, assertive, energetic, active, hostile, and destructive.

Conformity and dependence: Females have been found generally to be more conforming and more influenced by suggestion. The gender biases of some studies have made these findings open to suspicion, however.

Emotional adjustment: The emotional stability of the sexes is approximately the same in childhood, but differences do arise in how emotional problems are manifested. Some evidence indicates that adolescent girls and adult females have more neurotic symptoms than males. However, this tendency may reflect how society defines mental health in ways that coincide with male roles. Also it has been pointed out that tests to measure mental health usually have been designed by men and, therefore, may be biased against females.

Values and life goals: In the past, men have tended to show greater interest in scientific, mathematical, mechanical, and physically active occupations as well as to express stronger economic and political values. Women have tended to choose literary, social service, and clerical occupations and to express stronger aesthetic, social sense, and religious values. These differences have become smaller over time as women have begun to think differently about themselves, have more freely pursued career and interest pathways, and society has begun to take a more equal opportunity viewpoint for both sexes.

Achievement orientation: Females are more likely to express achievement motivation in social skills and social relations, whereas men are more likely to try to succeed in intellectual or competitive activities. This difference is thought to be due to sex-role expectations that are strongly communicated at very early ages.

How do the preceding observations on gender characteristics in intellectual functioning and personality relate to the process of teaching clients whom the nurse as educator encounters? It is very difficult to differentiate between bio-

logical and environmental influences simply because these two factors are intertwined and influence each other. The cause, meaning, and outcome of these differences remain speculative at this time, and further research needs to be conducted.

The behavioral and biological differences between males and females, known as the *gender gap*, are well documented. Also well documented is *gender bias*, "a preconceived notion about the abilities of women and men that prevented individuals from pursuing their own interests and achieving their potentials" (Santrock, 2006, p. 66). Females have an accelerated biological timetable and, in general, are more prone to have early verbal ability. Conversely, males lag behind females in biological development and attention span but tend to excel in visual-spatial ability and mathematical pursuits (Vander Zanden et al., 2007). During adolescence, they also are likely to surpass females in physical strength.

With respect to gender differences and aging, as suggested by life-span mortality rates, currently, White females have a life expectancy of approximately 80 years compared to approximately 73 years for White males. Also, men have higher mortality rates for each of the 10 leading causes of death (U.S. Department of Health and Human Services, 2000). However, more needs to be understood about women's health because for years their health issues have been underrepresented in research studies. Fortunately, this trend has changed within the last 2 to 3 decades and significant evidence is beginning to surface about the physical and mental health status of females (Dignam, 2000; Kato & Mann, 1996; U.S. DHHS, 2000).

However, what has been known is that women are likely to seek health care more often than men do (U.S. Census Bureau, 2006). It is suspected that one of the reasons women have more contact with the healthcare system is that they traditionally have tended to be the primary caretakers of their children, who need pediatric services. In addition, during childbearing years, women seek health services for care surrounding pregnancy and childbirth (Kato & Mann, 1996).

Perhaps the reason that men tend not to rely as much as women on care from health providers is because of the sex-role expectation by our society that men should be stronger. They also have a tendency to be risk takers and to think of themselves as more independent. Although men are less likely to pursue routine health care for purposes of health and safety promotion and disease and accident prevention, they typically face a greater number of health hazards, such as a higher incidence of automobile accidents, use of drugs and alcohol, suicide, heart disease, and engaging in dangerous occupations. Furthermore, men are less likely to notice symptoms or report them to physicians (Kato & Mann, 1996).

Teaching Strategies

As health educators, nurses must become aware of the extent to which social and heredity-related characteristics of the genders affect health-seeking behaviors and influence individual health needs. As stated previously, in some areas males and females display different orientations and learning styles (Severiens & Ten Dam, 1994). The differences seem to depend on their interests and past experiences in the biological and social roles of men and women in our society.

Women and men are part of different social cultures, too. They use different symbols, belief systems, and ways to express themselves, much in the same manner that different ethnic groups have distinct cultures (Tear, 1995). In the future,

these gender differences may become less pronounced as the sex roles become more blended.

In addition, one of the two major goals of *Healthy People 2010* (goal no. 2) is to eliminate health disparities among segments of the population. This includes differences that occur by gender, such as men are two times more likely to die from injuries than women, and women are at greater risk for Alzheimer's disease and two times as likely to be affected by depression as men (U.S. DHHS, 2000).

Nurse educators are encouraged to include information on general health disparities when educating clients and staff. They also are encouraged to use versatile teaching style strategies so as not to perpetuate stereotypical approaches to teaching and learning with the two genders. In addition, the nursing profession has a responsibility to incorporate gender issues into nursing education curricula.

Socioeconomic Characteristics

Socioeconomic status (SES), in addition to gender characteristics, influences the teaching–learning process. SES is considered to be the single most important determinant of health in our society (Crimmins & Saito, 2001; Singh-Manoux, Ferrie, Lynch, & Marmot, 2005). Socioeconomic class is an aspect of diversity that must be addressed in the context of education and in the process of teaching and learning.

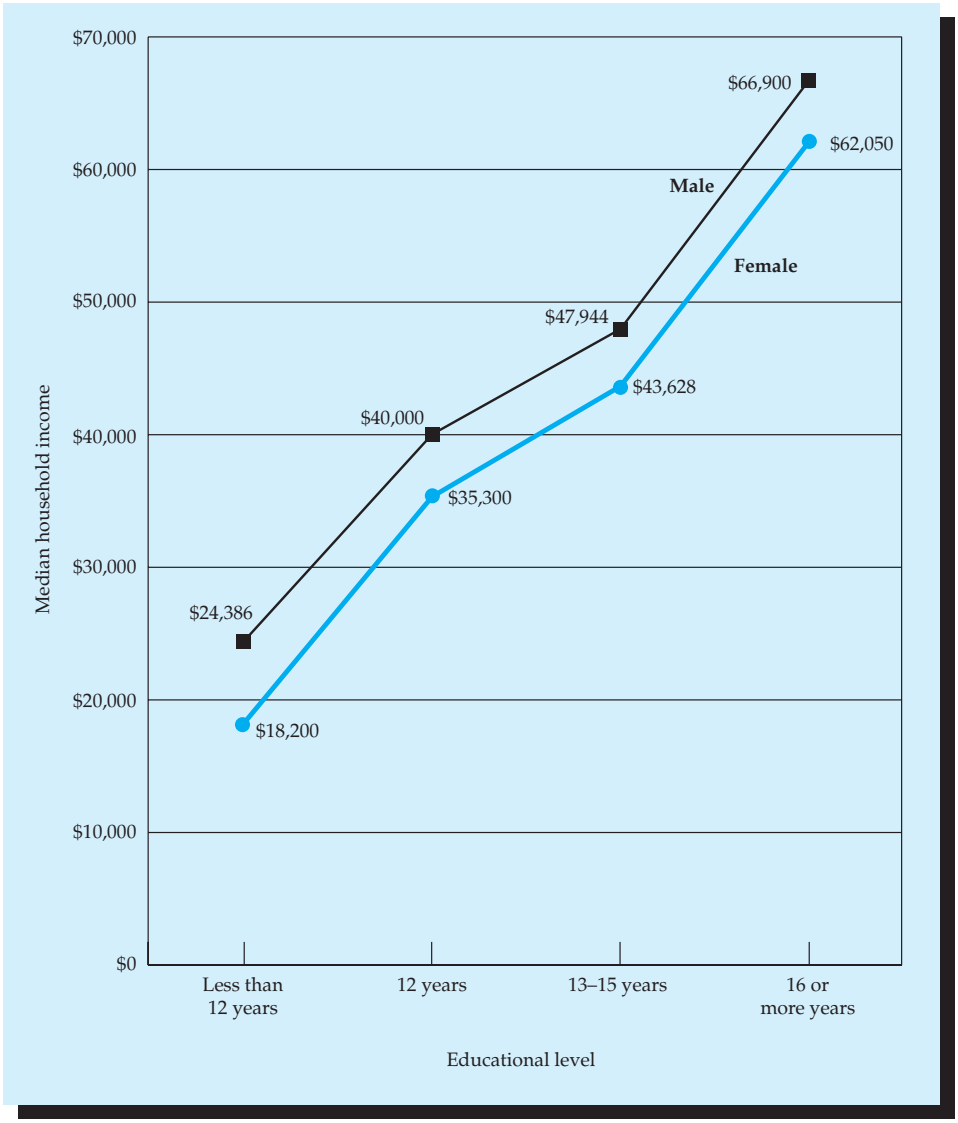
Class is the "unmentionable five-letter word" (Rhem, 1998, p. 1). Many people are hesitant to categorize themselves according to class. They also are reluctant to discuss the issue of class differences because of the widespread idea that the United States should be a classless society (Felski, 2002; Rhem, 1998). It is a myth, though, that America is a country without classes (McGoldrick, 1995). Class, as universal as race or gender, hides in the shadows. However, class consciousness seems to be a commonality shared by everyone. Those who are privileged often feel guilty about their advantages. Those who are poor feel ashamed or embarrassed about their disadvantages (Rhem, 1998).

Social and economic levels of individuals have been found to be significant variables affecting health status, literacy levels, and in determining health behaviors (Crimmins & Saito, 2001; Monden, van Lenthe & Mackenbach, 2006). Approximately 34 million Americans are living in poverty. The poverty threshold for a family of four is defined as an income of $18,400 and severe poverty is an annual income of at most half ($9,200) of this amount (Darling, 2004).

Disadvantaged people—those with low incomes, low educational levels, and/or social deprivation—come from many different ethnic groups, including millions of poor White people (U.S. DHHS, 2000). SES takes into account the variables of educational level, family income, and family structure (Vander Zanden et al., 2007). See **Figure 8–1** for the relationship between educational level and household income. All of these variables influence health beliefs, health practices, and readiness to learn (Darling, 2004; Mackenbach et al., 2003).

The relationships among socioeconomic position, cognitive ability, and health status have been explored, but the mechanics and processes involved are highly complex and remain poorly understood (Batty, Der, Macintyre, & Deary, 2006; Singh-Manoux et al., 2005). Heredity and environment usually vary together; that is, people who are genetically related (parents and

Figure 8–1 Relationship Between Education and Median Household Income Among Adults Aged 25 Years and Older, by Gender, United States, 1996



Source: U.S. Department of Commerce, Bureau of the Census. (1997, March). Current Population Survey. In *Healthy People 2010: Understanding and improving health* (p. 101). Rockville, MD: U.S. Department of Health and Human Services.

their children) tend to have similar environments. Evidence suggests that variations in heredity are equally as powerful as variations in environmental conditions in producing individual differences in cognitive ability (Santrock, 2006; Turkheimer, Haley, Waldron, D'Onofrio, & Gottesman, 2003; Vander Zanden et al., 2007). Also, socioeconomic class is correlated with low educational levels and health inequalities (Mackenbach, Cavelaars, Kunst, Groenhof, and the EU Working Group on Socioeconomic Inequalities in Health, 2000). The significant correlation between literacy levels and SES is well documented in Chapter 7.

Although many educators, psychologists, and sociologists have recognized that a cause and effect relationship exists among low SES, low cognitive ability, and poor quality of health and life, they are hard pressed to know what to do about breaking the cycle (Batty, Deary, & Macintyre, 2006). So, too, are healthcare providers, who recognize that clients belonging to lower social classes have higher rates of illness, more severe illnesses, and reduced rates of life expectancy (Mackenbach et al., 2003). People with low SES, as measured by indicators such as income, education, and occupation, have increased rates of morbidity and mortality compared to those with higher SES (U.S. DHHS, 2000).

An inverse relationship exists between SES and health status. Individuals who have higher incomes and are better educated live longer and healthier lives than those who are of low income and poorly educated (Rognerud & Zahl, 2005; Crimmins & Saito, 2001). Thus, the level of socioeconomic well-being is a strong indicator of health outcomes. See **Figure 8–2** for the relationship between SES and health status.

These findings raise serious questions about health differences among our nation's people as a result of unequal access to health care due to SES. These unfortunate health trends are costly to society in general and to the healthcare system in particular. Although adverse health-related behavior and less access to medical care have been found to contribute to higher morbidity and mortality rates, there is newer but still limited research on the effect socioeconomic status has on disability-free or active life expectancy (Crimmins & Saito, 2001; Mackenbach et al., 2003).

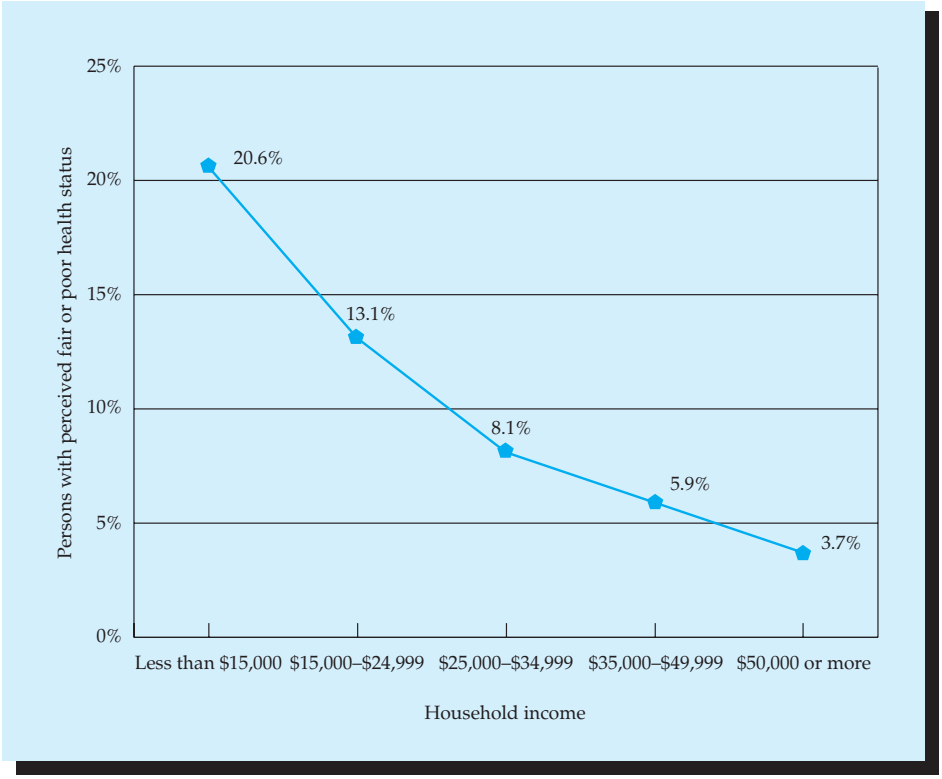
Social class is measured by one or more of the following types of indices:

- occupation of parents
- income of family
- location of residence
- educational level of parents

Vander Zanden et al. (2007) and Santrock (2006) explain that many factors, including poor health care, limited resources, family stress, discrimination, and low-paying jobs, maintain the cycle by which generation after generation are born into poverty. Elstad & Krokstand (2003) found that health inequalities as a result of socioeconomic factors are reproduced as people mature from young adulthood into middle age. That is, a social causation pattern exists whereby environments are the source of socioeconomic health inequalities. As such, people with good health tend to move up in the social hierarchy and those with poor health move downward.

In addition, rates of illiteracy and low literacy have been linked to poorer health status, high unemployment, low earnings, and high rates of welfare dependency, all of which are common measures of a society's economic well-being (Giorgianni 1998; Weiss, 2003). Whatever the factors that keep particular groups from achieving at higher levels, these groups are likely to remain on the lower end of the occupational

Figure 8–2 Percentage of Persons with Perceived Fair and Poor Health Status by Household Income, United States, 1995



Source: Centers for Disease Control andd Prevention, National Center for Health Statistics. (1995). National health interview survey. In *Healthy People 2010: Understanding and improving health* (p. 101). Rockville, MD: U.S. Department of Health and Human Services.

structure. This cycle has been coined the *poverty circle* (Gage & Berliner, 1998) or the *cycle of poverty*. The poverty circle is described as follows:

> *Parents low in scholastic ability and consequently in educational level create an environment in their homes and neighborhoods that produce children who are also low in scholastic ability and academic attainment. These children grow up and become parents, repeating the cycle. Like them, their children are fit only for occupations at lower levels of pay, prestige, and intellectual demand. (Gage & Berliner, 1998, p. 61)*

Family structure and the home environment are not the only factors affecting proficiency in learning. Hirsch (2001) contends that the alarming verbal and reading gap between rich and poor students "represents the single greatest

failure in American public schooling" (p. 5). Many low-income children entering kindergarten have heard only half the words and understand only half the meanings of language than the high-income child has heard and understands. This gap continues to widen along the same trajectory as students progress in each succeeding grade in school. Barriers to equal educational opportunity must be reduced by putting the responsibility on the educational system to become more intensive. That is, we need to develop standards for each grade and make sure each child meets these expectations before being allowed to progress to subsequent grades in school.

The lower socioeconomic class has been studied by social scientists more than other economic classes. This is probably because the health views of this group deviate the most from those viewpoints of health professionals who care for this group of individuals. People from the lower social stratum have been characterized as being indifferent to the symptoms of illness until poor health interferes with their lifestyle and independence. Their view of life is one of a sense of powerlessness, meaninglessness, and isolation from middle-class knowledge of health and the need for preventive measures, such as vaccination for their children (U.S. DHHS, 2000; Lipman, Offord, & Boyle, 1994; Winkleby, Jatulis, Frank, & Fortmann, 1992).

The high cost of health care may well be a major factor affecting health practices of people in the lower socioeconomic classes. Individuals with adequate financial and emotional resources are able to purchase services and usually have support systems on which to rely to sustain them during recovery or augment their remaining functions after the course of an acute illness. Conversely, individuals deprived of monetary and psychosocial resources are at a much greater risk for failing to reach an optimal level of health and well-being. Unfortunately, the number of Americans at or below the national poverty level is at 12.6% and almost 47 million Americans lack health insurance, an increase of 1.3 million between 2004 and 2005 (U.S. Census Bureau, 2006).

Just as SES can have a negative effect on illness, so, too, can illness have devastating implications for a person's socioeconomic well-being (Elstad & Krokstad, 2003). A catastrophic or chronic illness can lead to unemployment, loss of health insurance coverage or ineligibility for health insurance benefits, enforced social isolation, and a strain on social support systems (Lindholm, Burstrom, & Diderichsen, 2001; Mulligan, 2004). Without the socioeconomic means to counteract these threats to their well-being, impoverished individuals may be powerless to improve their situation.

These multiple losses tax the individual, their families, and the healthcare system. Low-income groups are especially affected by changes in federal and state assistance in the form of Medicare and Medicaid. The spiraling costs associated with illness and consequent overuse of the healthcare system have resulted in increased interest on the part of the public and healthcare providers to control costs (Baker, Parker, Williams, & Clark, 1998). Today, more emphasis is being given to health promotion, health maintenance, and disease prevention.

Teaching Strategies

The current trends in health care, as a result of these economic concerns, are directed toward teaching individuals how to attain and maintain health. The nurse plays a key role in educating the consumer about avoiding health risks, reduc-

ing illness episodes, establishing healthful environmental conditions, and accessing healthcare services. Educational interventions by nurses for those who are socially and economically deprived have the potential for yielding short-term benefits in meeting these individuals' immediate healthcare needs. However, more research must be done to determine whether teaching can ensure the long-term benefits of helping deprived people develop the skills needed to reach and sustain independence in self-care management.

Nurse educators must be aware of the probable effects of low SES on an individual's ability to learn as a result of suboptimal cognitive functioning, poor academic achievement, low literacy, high susceptibility to illness, and disintegration of social support systems. Low-income people are at greater risk for these factors that can interfere with learning, but one cannot assume that everyone at the poverty or near-poverty level is equally influenced by these threats to their well-being. To avoid stereotyping, it is essential that each individual or family be assessed to determine their particular strengths and weaknesses for learning. In this way, teaching strategies unique to particular circumstances can be designed to assist socioeconomically deprived individuals in meeting their needs for health care.

Nevertheless, it is well documented that individuals with literacy problems, poor educational backgrounds, and low academic achievement are likely to have low self-esteem, feelings of helplessness and hopelessness, and low expectations. They also tend to think in concrete terms, are more focused on satisfying immediate needs, have a more external locus of control, and have decreased attention spans. They have difficulty in problem solving and in analyzing and synthesizing large amounts of information. With these individuals, the nurse educator will most likely have to rely on specific teaching methods and tools similar to those identified as appropriate for intervening with clients who have low literacy abilities (see Chapter 7).

Cultural Characteristics

At the beginning of the 21st century, the composition of the U.S. population was approximately 71.3% White, 12.2% Black/African American, 11.2% Hispanic/Latino, 3.8% Asian/Pacific Islander, 0.7% American Indian/Alaskan Native, and 0.8% other. Thus, more than one quarter (28.7%) of the U.S. population consists of people from culturally diverse ethnic groups (U.S. Census Bureau, 2006). By 2010, one out of every three people in the United States is projected to belong to a racial or ethnic minority (Robinson, 2000). In addition, 7 million people indicated in their responses to the U.S. census survey taken in 2000 that they belonged to more than one race (Tashiro, 2002). By 2050, it is projected that people belonging to cultural subgroups will account for close to half of the U.S. total population (U.S. Census Bureau, 2006). If predictions prove true, by the middle of this century, it will be the first time in U.S. history that people from ethnic groups (subcultures) will constitute the majority of the total population.

To keep pace with a society that is increasingly more culturally diverse, nurses will need to have sound knowledge of the cultural values and beliefs of specific ethnic groups as well as be aware of individual practices and preferences (Price & Cortis, 2000; Purnell & Paulanka, 2003). In the past, healthcare providers have experienced difficulties in caring for clients whose cultural beliefs differ from their own because beliefs about health and illness vary

considerably among ethnic groups. Lack of cultural sensitivity by healthcare professionals has resulted in millions of dollars wasted annually through misuse of healthcare services, the alienation of large numbers of people, and the misdiagnosis of health problems with often tragic and dangerous consequences.

In addition, underrepresented ethnic groups are beginning to demand culturally relevant health care that respects their cultural rights and incorporates their specific beliefs and practices into the care they receive. This expectation is in direct conflict with the unicultural, Western, biomedical paradigm taught in many nursing and other healthcare provider programs across the country (Purnell & Paulanka, 2003). A serious conceptual problem exists within the nursing profession because nurses are presumed to understand and be able to meet the healthcare needs of a culturally diverse population, even though they do not have the formal educational preparation to do so (Boss, 2007; Carthron, 2007).

Definition of Terms

Before examining the major ethnic (subcultural) groups within the United States, it is imperative to define the following terms, as identified by Purnell and Paulanka (2003), that are commonly used in addressing the subject of culture:

Acculturation: A willingness to adapt or "to modify one's own culture as a result of contact with another culture" (p. 351).

Assimilation: The willingness of an individual or group "to gradually adopt and incorporate characteristics of the prevailing culture" (p. 351).

Cultural awareness: Recognizing and appreciating "the external signs of diversity" in other ethnic groups, such as their art, music, dress, and physical features (p. 352).

Cultural competence: A conscious process of recognizing one's own culture so as to avoid "undue influence on those from other cultural backgrounds" (p. 352).

Cultural diversity: A term meaning "representing a variety of different cultures (p. 352).

Cultural relativism: "The belief that the behaviors and practices of people should be judged only from the context of their cultural system" (p. 352).

Culture: "The totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristic of a population of people that guide their worldview and decision making. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, and are shared by the majority of the cultures" (p. 352–353).

Ethnic group: Also referred to as a subculture are populations of "people who have experiences different from those of the dominant culture" (p. 4).

Ethnocentrism: "The tendency of human beings to think that [their] own ways of thinking, acting, and believing are the only right, proper, and natural ones and to believe that those who differ greatly are strange, bizarre, or unenlightened" (p. 353).

Ideology: Consists of the thoughts, attitudes, and beliefs that reflect the social needs and desires of an individual or ethnocultural group" (p. 3).

Subculture: A group of people "who have had different experiences from the dominant culture by status, ethnic background, residence, religion, education, or other factors that functionally unify the group and act collectively on each other" (p. 357).

Transcultural: "Making comparisons for similarities and differences between cultures" (p. 358).

Worldview: Refers to "the way individuals or groups of people look at the universe to form values about their lives and the world around them" (p. 4).

Assessment Models for the Delivery of Culturally Sensitive Care

Given increases in immigration and birth rates in the United States as well as the significant increased geographical mobility of people around the globe, our system of health care and our educational institutions must respond by shifting from a dominant monocultural, ethnocentric focus to a more multicultural, transcultural focus (Narayan, 2003).

Tripp-Reimer and Afifi (1989) describe the interpretation of American cultural ideal from a historical perspective:

> *In the United States, the myth of the melting pot emerged largely from a combination of a cultural ideal of equality and a European ethnocentric perspective. This myth promoted the notion that all Americans are alike—that is, like white, middle-class persons. For many years, the notion that ethnicity should be discounted or ignored was prominent in the delivery of health care, including health teaching programs . . . (p. 613)*

The question posed by Leininger (1994) still remains relevant today: How can nurses competently respond to and effectively care for people from diverse cultures who act, speak, and behave in ways different than their own? Studies indicate that health professionals are often unaware of the complex factors influencing clients' responses to health care.

From a sociological perspective, the symbolic interaction theory provides a theoretical framework for interacting with ethnic groups. It emphasizes social and group identities rather than just individual identity. Tashira (2002) points out that this framework is useful to understand the situational nature of identity and the negotiation and renegotiation necessary when working with groups.

Purnell & Paulanka (2003) propose that there are a number of factors that influence an individual's identification with an ethnic group and that cause the individual to share his or her worldview. They have labeled these factors as primary and secondary characteristics of culture. *Primary characteristics of culture* include nationality, race, color, gender, age, and religious affiliation. *Secondary characteristics of culture* include many of a person's attributes that are addressed in this chapter and this text, such as SES, physical characteristics, educational status, occupational status, and place of residence (urban versus rural). These two major characteristics affect one's worldview and belief system.

The *Purnell model for cultural competence* is presented as a popular organizing framework for understanding the complex phenomenon of culture and ethnicity. This framework "provides a comprehensive, systematic, and concise" approach that can assist healthcare providers in teaching students in educational settings and clients and staff in practice settings for the delivery of

"holistic, culturally competent, therapeutic interventions" (Purnell & Paulanka, 2003, p. 8).

The Purnell model, depicted in a circle format, includes the macro layers of the metaparadigm concepts of:

1. global society (outermost sphere)
2. community (second sphere)
3. family (third sphere)
4. individual (innermost sphere)

The interior of the circle is cut into 12 equally sized, pie-shaped wedges that represent the following 12 cultural domains that should be assessed when planning for educational interventions for clients in any setting:

1. communication (e.g., dominant language and nonverbal expressions and cues)
2. family roles and organization (e.g., head of household, gender roles, developmental tasks, social status, alternative lifestyles, roles of older adults)
3. workforce issues (e.g., language barriers, autonomy, acculturation)
4. biocultural ecology (e.g., heredity, biological variations, genetics)
5. high-risk behaviors (e.g., smoking, alcoholism, physical activity, safety practices).
6. nutrition (e.g., common foods, rituals, deficiencies, limitations)
7. pregnancy (e.g., fertility, practices, views toward childbearing, beliefs about pregnancy, birthing practices)
8. death rituals (e.g., views of death, bereavement, burial practices)
9. spirituality (e.g., religious beliefs and practices, meaning of life, use of prayer)
10. healthcare practices (e.g., traditions, responsibility for health, pain control, sick role, medication use)
11. healthcare practitioners (e.g., folk practitioners, gender issues, perceptions of providers)
12. overview/heritage (e.g., origins, economics, education, occupation, economics)

These two authors also put forth 19 explicit assumptions upon which the model is based, some of which are most pertinent to this chapter, such as:

- One culture is not better than another—they are just different.
- The primary and secondary characteristics of culture determine the degree to which one varies from the dominant culture.
- Culture has a powerful influence on one's interpretation of and responses to health care.
- Each individual has the right to be respected for his or her uniqueness and cultural heritage.
- Prejudices and biases can be minimized with cultural understanding.
- Caregivers who intervene in a culturally competent manner improve the care of clients and their health outcomes.
- Cultural differences often require adaptations to standard professional practices.

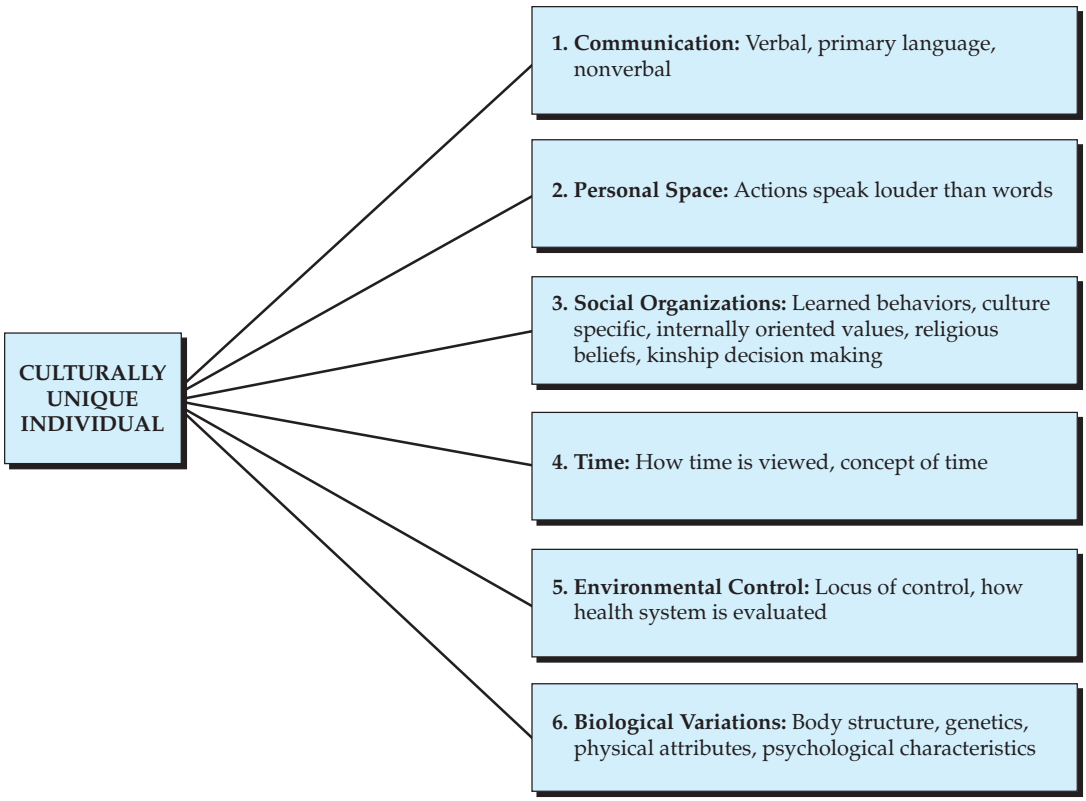
Four other models for conducting a nursing assessment include Giger & Davidhizar's (2004) model of six cultural phenomena that need to be taken into account: (1) communication, (2) personal space, (3) social organization, (4) time, (5) environmental control, and (6) biological vari-

ations (**Figure 8–3**) and Price and Cordell's (1994) model outlining a four-step approach to help nurses provide culturally sensitive patient teaching (**Figure 8–4**).

The third model, *the nurse–client negotiations model,* was developed in the mid-1980s for the purpose of *cultural assessment* and planning for care of culturally diverse people. The negotiations model, although 20 years old, is still relevant. It recognizes discrepancies that exist between notions of the nurse and client about health, illness, and treatments. This model attempts to bridge the gap between the scientific perspectives of the nurse and the popular perspectives of the client. (Anderson 1990).

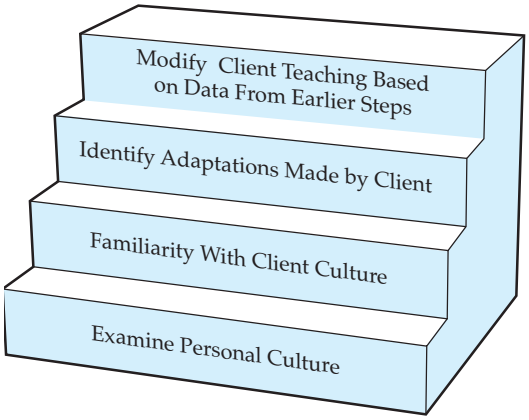
The nurse–client negotiations model serves as a framework to attend to the culture of the nurse as well as the culture of the client. In addition to the professional culture, each nurse has his or her own personal beliefs and values, which

Figure 8–3 Six Cultural Phenomena



Source: Adapted from Giger, J. N., & Davidhizar, R. E. (1995). *Transcultural nursing: Assessment and intervention* (2nd ed., p. 9). St. Louis: Mosby–Year Book.

Figure 8–4 Four-Step Approach to Providing Culturally Sensitive Care



Source: Reprinted with permission from Price, J. L., & Cordell, B. (1994). Cultural diversity and patient teaching. *Journal of Continuing Education in Nursing, 25*(4), 164.

may operate without the nurse being fully aware of them. These beliefs and values may influence nurses' interactions with patients and families.

Explanations of the same phenomena may yield different interpretations based on the cultural perspective of the layperson or the professional. For example, putting lightweight covers on a patient may be interpreted by family members as placing their loved one at risk for getting a chill, whereas the nurse will use this technique to reduce a fever. As another example, a Jehovah's Witness family considers a blood transfusion for their child as contamination of the child's body, whereas the nurse and other healthcare team members believe a transfusion is a lifesaving treatment (Anderson, 1987). The important aspect of this model is that it can open lines of communication between the nurse and the patient/family. It helps each understand how the other interprets or values a problem or practice such that they respect one another's goals.

Negotiation implies a mutual exchange of information between the nurse and client. The nurse should begin negotiation by learning from the clients about their understanding of their situation, their interpretations of illness and symptoms, the symbolic meanings they attach to an event, and their notions about treatment. The goal is to actively involve clients in the learning process so as to acquire healthy coping mechanisms and styles of living. Together, the nurse and client then need to engage in a transaction to work out how the popular and scientific perspectives can be meshed to achieve goals related to the individual client's interests (Anderson, 1990).

General areas to assess when first meeting the client include the following:

1. the client's perceptions of health and illness
2. his or her use of traditional remedies and folk practitioners
3. the client's perceptions of nurses, hospitals, and the care delivery system
4. his or her beliefs about the role of family and family member relationships
5. his or her perceptions of and need for emotional support (Anderson, 1987; Jezewski, 1993)

According to Anderson (1990) and Narayan (2003), the following are some questions that can be used as a means for understanding the client's perspectives or viewpoints. The answers then serve as the basis for negotiation:

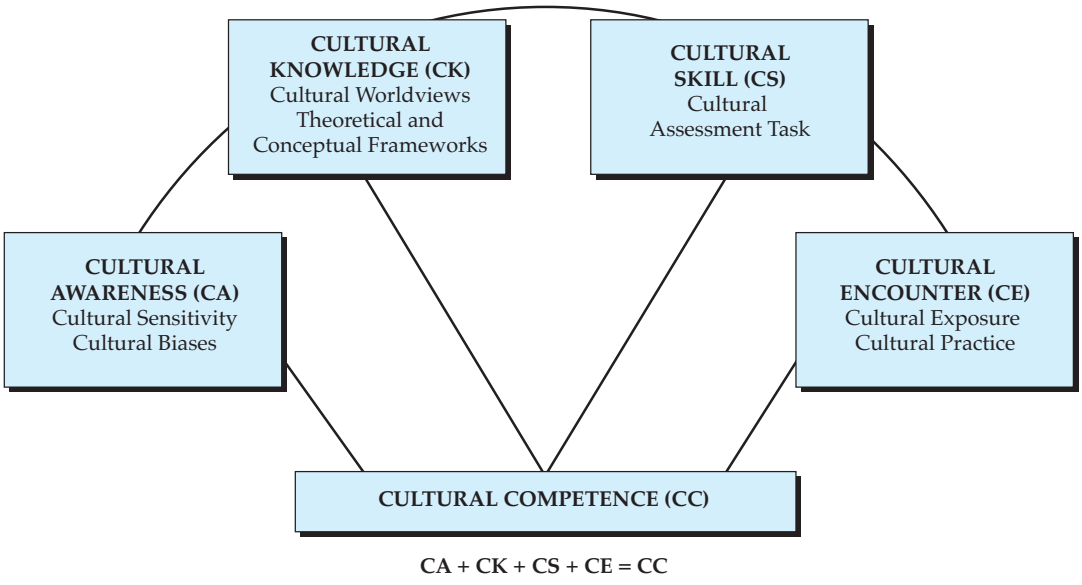
- What do you think caused your problem?
- Why do you think the problem started when it did?
- What major problems does your illness cause you?

- How has being sick affected you?
- How severe do you think your illness is? Do you see it as having a short- or long-term course?
- What kinds of treatments do you think you should receive?
- What are the most important results you hope to obtain from your treatments?
- What do you fear most about your illness?

The fourth model, *the culturally competent model of care* proposed by Campinha-Bacote (1995), serves as a resource for conducting a thorough and sensitive cultural assessment. Cultural competence, as defined by this author, is as a set of congruent behaviors, attitudes, and policies that enable a system, agency, or professional to work effectively in a cross-cultural situation. Through this model, cultural competence is seen as a continuous process involving four components: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, and (4) cultural encounter.

Cultural awareness is the process of becoming sensitive to interactions with other cultural groups. It requires nurses to examine their biases and prejudices toward others of another culture or ethnic background. *Cultural knowledge* is the process in which nurses acquire an educational foundation with respect to various cultural worldviews. *Cultural skill* involves the process of learning how to conduct an accurate cultural assessment. *Cultural encounter* encourages nurses to expose themselves in practice to cross-cultural interactions with clients of diverse cultural backgrounds. All four components are essential if one is to deliver culturally competent nursing care (**Figure 8–5**).

Figure 8–5 Culturally Competent Model of Care



Source: Reprinted with permission form Campinha-Bacote, J., (1995). The quest for cultural competence in nursing care. *Nursing Forum, 30*(4). 20.

Nurse educators who are competent in cultural assessment and negotiation likely will be the most successful at designing and implementing culturally effective teaching programs. They also will be able to assist their colleagues in working with clients who may be considered uncooperative, noncompliant, or difficult. In addition, they can help with identifying potential areas of cultural conflict and select teaching interventions that minimize conflict. Nurses must understand how the reactions of practitioners influence labeling of clients' behaviors and, therefore, eventually influence nurse–client interactions (Anderson, 1987, 1990; Gutierrez & Rogoff, 2003).

There is one very important caveat for the educator to remember when conducting a cultural assessment of any client:

> *Nurses must be especially careful not to overgeneralize or stereotype clients on the basis of their ethnic heritage. Just because someone belongs to a particular subculture does not necessarily mean they adhere to all the beliefs, values, customs, and practices of that ethnic group. Nurses should never assume a client's learning needs or preferences for treatment will be alike simply based on the individual's ethnicity.*

As Andrews and Boyle (1995) so aptly explained, "Sometimes cultural stereotyping may be perpetuated when a recipe-like approach to clients from specific cultural groups is used: i.e., there is a tendency by the nurse to view all members of a group homogenously and to expect certain beliefs or practices because of presumptions that may or may not apply to the client" (p. 50). Knowledge of cultural variations should serve only as background cues for obtaining additional information through assessment.

General Assessment and Teaching Interventions

As a first step in the teaching process, assessment should determine health beliefs, values, and practices. The nurse in the role of educator must implement successful teaching interventions using the universal skills of establishing rapport, assessing readiness to learn, and using active listening to understand problems. Nurses need to be aware of the established customs that influence the behavior one is attempting to change (Tripp-Reimer & Afifi, 1989). The nurse should, however, keep in mind that belonging to an ethnic group does not always mean a person follows or buys into all of the traditions or customs of the group to which they belong. Given that culture affects the way someone perceives a health problem and understands its course and possible treatment options, it is essential to carry out a thorough assessment prior to establishing a plan of action for long-term behavioral change.

Different cultural backgrounds not only create different attitudes and reactions to illness, but also can influence how people express themselves, both verbally and nonverbally, which may prove difficult to interpret. For example, asking a patient to explain what they believe to be the cause of a problem will help to reveal whether the patient thinks it is due to a spiritual intervention, a hex, an imbalance in nature, or other culturally based beliefs. The nurse should accept the client's explanation (most likely reflecting the beliefs of the support system as well) in a nonjudgmental manner.

Culture also guides the way an ill person is defined and treated. For example, some cultures believe that once the symptoms disappear, illness is no longer present. This belief can be

problematic for individuals suffering from an acute illness, such as a streptococcal infection, when a 1- or 2-day course of antibiotic therapy relieves the soreness in the throat. This belief also can be a problem for the individual afflicted with a chronic disease that is manifested by periods of remission or exacerbation.

In addition, readiness to learn must be assessed from the standpoint of a person's culture. Patients and their families, for instance, may believe that behavior change is context specific, such that they will adhere to a recommended medical regimen while in the hospital setting but fail to follow through with the guidelines once they return to the home setting. Also, the nurse and other healthcare providers must be cautious not to assume that the values adhered to by professionals are equally important or cherished by the patient and significant others. Consideration, too, must be given to barriers that might exist, such as time, financial, and environmental variables, which may hinder readiness to learn (see Chapter 4). Finally, the client needs to believe that new behaviors are not only possible, but also beneficial if the new information is to be remembered and interpreted correctly for behavioral change to be maintained over the long term (Kessels, 2003).

The following specific guidelines for assessment should be used regardless of the particular cultural orientation of the client (Anderson, 1987; Uzundede, 2006):

1. **Observe the interactions between client and his/her family members as well as among family members**. Determine who makes the decisions, how decisions are made, who is the primary caregiver, what type of care is given, and what foods and other objects are important to the them.
2. **Listen to the client**. Find out what the person wants, how his/her wants differ from what the family wants, and how they differ from what you think is appropriate.
3. **Consider communication abilities and patterns**. Identify the client's primary language (which may be different from your own). Also, note manners of speaking (rate of speech, expressions used) and nonverbal cues that can enhance or hinder understanding. In addition, be aware of your own nonverbal behaviors and etiquettes of interaction that may be acceptable or unacceptable to the client and family members.
4. **Explore customs or taboos**. Observe behaviors and clarify beliefs and practices that may interfere with care or treatment.
5. **Determine the notion of time**. Become oriented to the individual's and family members' sense of time and importance of time frames.
6. **Be aware of cues for interaction**. Determine which communication approaches are appropriate with respect to what is the most comfortable way to address the person(s) with whom you are interacting. Also, find out the symbolic objects or the activities that provide comfort and security.

These guidelines will assist in the exchange of information between the educator and client. The nurse/client role is a mutual one in which the nurse is both learner and teacher and the client is also both learner and teacher. The goal of negotiation is to arrive at ways of working together to solve a problem or to determine a

course of action (Anderson, 1987, 1990). The objective is not to take a totally fact-centered approach or pretend you are completely color blind, but to recognize each person as an individual and that differences exist within ethnic and racial groups as well as between these groups.

Use of Translators

If the client speaks a foreign language, the nurse should use the client's primary language whenever possible. When the nurse does not fluently speak the same language, it is necessary to secure the assistance of a translator. Translators may be family members, neighbors and friends, other healthcare staff, or professional interpreters.

For many reasons, the use of family or friends for translation of communication is not as desirable as using professionally trained interpreters. First, family members and friends may not be sufficiently fluent to assume the role. Second, they may choose to omit portions of the content they believe to be unnecessary or unacceptable. Third, their presence may inhibit peer communication and violate the patient's right to privacy and confidentiality (Baker et al., 1996; Poss & Rangel, 1995), especially in light of the recent HIPAA (Health Information Portability and Accountability Act) regulations.

Thus it is optimal if professionally trained interpreters can be used. They can translate instructional messages verbatim, and they work under an established code of ethics and confidentiality. If there is no bilingual person available to facilitate communication, the AT&T Language Line provides 24-hour access to translators who are fluent in 144 languages (Duffy & Snyder, 1999).

In teaching clients who are only partially fluent in English, the following strategies are recommended (Poss & Rangel, 1995; Stanislav, 2006; Tripp-Reimer & Afifi, 1989) to help the nurse alter the style of interaction when no translator is used:

- Speak slowly and distinctly, allowing for twice as much time as a typical teaching session would take.
- Use simple sentences, relying on an active rather than a passive voice.
- Avoid technical terms (e.g., use *heart* rather than *cardiac*, or *stomach* rather than *gastric*). Also avoid medical jargon (e.g., use blood pressure rather than BP) and American idioms (e.g., *it's just red tape you have to go through* or *I heard it straight from the horse's mouth*).
- Organize instructional material in the sequence in which the plan of action should be carried out.
- Make no assumptions that the information given has been understood. Ask for clients to explain in their own words what they heard, and, if appropriate, request a return demonstration of a skill that has been taught.

The Four Major Ethnic Groups

The U.S. Census Bureau (2000) defines the major ethnic groups in this country as follows: Black/African American (of African, Haitian, and Dominican Republic descents), Hispanic/Latino (of Mexican, Cuban, Puerto Rican, and other Latin descents), Asian/Pacific Islander (of Japanese, Chinese, Filipino, Korean, Vietnamese, Hawaiian, Guamian, Samoan, and Asian Indian descents), and American Indian/Alaskan Native (descen-

dents of hundreds of tribes of Native Americans and of Eskimo descent).

Given the fact that there are many ethnic groups (subcultures) in the United States, and hundreds worldwide, it is impossible to address the cultural characteristics of each one of them. The following is a review of the beliefs and health practices of the four major ethnic groups in this country as identified by the U.S. Census Bureau. These groups, who have been historically underrepresented, account for almost one third (28.7%) of the total U.S. population. These groups are recognized by the U.S. government as disadvantaged due to low income, low education, and/or sociocultural deprivation. The Hispanic/Latino and Asian/Pacific Islander groups are the fastest growing ethnic subcultures in this country (U.S. Census Bureau, 2006).

It must be remembered that one of the most important roles of the nurse as educator is to serve as an advocate for clients—as a representative of their interests. If nurses are to assume this role, then their efforts should be directed at making the healthcare setting as similar to the client's natural environment as possible. To do so, they must be aware of clients' customs, beliefs, and lifestyles.

In addition to information provided below on the four major ethnic groups, the following references are recommended as sources of additional information on particular tribes or subcultures specifically not addressed: Purnell and Paulanka (2003), Kelly and Fitzsimons (2000), Vivian & Dundes (2004), Chideya (1999), Chachkes and Christ (1996), Cantore (2001), Lowe and Struthers (2001), Parker and Kiatoukaysy (1999), Young, McCormick and Vitaliano (2002), Cohen (1991), Kniep-Hardy and Burkhardt (1977), Pang (2007), Horton and Freire (1990), and Smolan, Moffitt, and Naythons (1990).

Hispanic/Latino Culture

According to the U.S. Census Bureau (2006), the Hispanic/Latino group is the largest and the fastest-growing subculture in the United States. As of the last full census survey of 2000, they represent 11.9% of the total population of the United States. The number of Hispanic Americans has increased significantly since 1970 as a result of a higher birth rate in this group than the rest of the population, an increase in immigration, as well as improved census procedures.

Hispanic or Latino Americans derive from diverse origins. This heterogeneous group of Americans with varied backgrounds in culture and heritage are of Latin American or Spanish origin who use Spanish (or a related dialect) as their dominant language. Those of Mexican heritage comprise the largest number of people (approximately 60%) of this subculture, followed by Puerto Rican, Central and South American, and Cuban Americans. They are found in every state but are concentrated in just nine states. California and Texas together have one half of the Hispanic population, but other large concentrations are found in New York, New Jersey, Florida, Illinois, Arizona, New Mexico, and Colorado (U.S. Census Bureau, 2006). Nurse educators who practice in the Southwestern states are most likely to encounter clients of Mexican heritage, those practicing in the Northeast states will most likely be caregivers of clients of Puerto Rican heritage, and nurses in Florida will be delivering care to a large number of Cuban Americans. Also, Hispanic people are more likely to live in metropolitan or rural areas than are non-Hispanic Americans (Purnell & Paulanka, 2003). While Hispanic

Americans have many common characteristics, each subgroup has unique characteristics.

The people of Hispanic heritage have particular healthcare needs that must be addressed. They are disproportionately affected by certain cancers, alcoholism, drug abuse, obesity, hypertension, diabetes, adolescent pregnancy, dental disease, and HIV/AIDS. Unlike in non-Hispanic Whites, homicide, AIDS, and perinatal conditions rank in the top 10 as causes of mortality. Hispanics are more prone to certain diseases, are less likely to receive preventive care, often lack health insurance, and have less access to health care than Whites living in the United States (Fernandez & Hebert, 2000; Hebert & Fernandez, 2000; Pacquiao, Archeval, & Shelley, 2000; Purnell & Paulanka, 2003; U.S. DHHS, 2000).

Unfortunately, both the curricula in nursing schools nationwide and the literature in nursing with respect to patient education efforts geared toward Hispanic Americans have paid little attention to the healthcare needs of this minority group. Although Hispanics are a culturally diverse group of people with varying health needs, avenues for including Hispanic healthcare issues in nursing curricula have been minimal and especially need to be developed in schools located in areas with high population concentrations of this ethnic group (Kelley & Fitzsimons, 2000; Sullivan & Bristow, 2007).

Fluency in Spanish as a foreign language is a necessity, or at least highly recommended, when practitioners are responsible for delivering care to this growing, underserved, culturally diverse ethnic group. Spanish-speaking people represent 54% of all non–English–speaking persons in the United States (U.S. Census Bureau, 2006). In proportion to the U.S. population, those of Hispanic heritage are underrepresented in nursing education. Only 1.7 % of all graduates of basic nursing programs are of Hispanic descent (see **Figure 8–6**). Far too few graduates are available to satisfy the increasing need for Hispanic healthcare professionals. The lack of representation of people from this subculture in the health professions is not thought to result from low aspirations on their part. Indeed, many Hispanic high school students rank health/medical services among their top 10 career choices. Unfortunately, the often poor academic achievement of Hispanic students in high schools and colleges is associated with a number of factors related to socioeconomic and educational disadvantages (Educating the Largest Minority Group, 2003).

Access to health care by Hispanics is limited both by choice and by unavailability of health services. Only one fifth of Puerto Rican, one fourth of Cuban, and one third of Mexican/Americans see a physician during the course of a year. Even when Hispanic people have access to the healthcare system, they may not receive the care they need. Difficulty in obtaining services, dissatisfaction with the care provided, and inability to afford the rising costs of medical care are major factors that discourage them from using the healthcare system (Fernandez & Hebert, 2000; Purnell & Paulanka, 2003).

Approximately 23% of Hispanic families live below the poverty line; members of this ethnic group are 2.5 times more likely to be below the poverty level than members of other subcultural groups in the United States. Economic disadvantage leaves little disposable income for paying out-of-pocket expenses for health care. When they do seek a regular source of care, many people of this minority group rely on public health facilities, hospital outpatient clinics, and emergency rooms (Fernandez & Hebert,

2000; Purnell & Paulanka, 2003). Also, they are very accepting of health care being delivered in their homes, where they feel a sense of control, stability, and security (Pacquiao et al., 2000).

The health beliefs of Hispanic people also affect their decisions to seek traditional care. Many studies dating back to the 1940s on Hispanic health beliefs and practices stressed exotic folklore practices, such as their use of herbs, teas, home remedies, and over-the-counter drugs for treating symptoms of acute and chronic illnesses. In addition, they place a high degree of reliance on health healers, known as *curenderos* or *esperitistas*, for health advice and treatment (Fernandez & Hebert, 2000; Purnell & Paulanka, 2003). For example, illnesses of Mexican Americans as an Hispanic subgroup could be organized into the following categories (Caudle, 1993; Markides & Coreil, 1986; Purnell & Paulanka, 2003):

1. Diseases of hot and cold, believed to be due to an imbalanced intake of foods or ingestion of foods at extreme opposites in temperature. In addition, cold air was thought to lead to joint pain, and a cold womb resulted in barrenness in women. Heating or chilling was the cure for parts of the body afflicted by disease.
2. Diseases of dislocation of internal organs, cured by massage or physical manipulation of body parts.
3. Diseases of magical origin, caused by *mal ojo*, or evil eye, a disorder of infants and children as a result of a woman's looking admiringly at someone else's child without touching the child, resulting in crying, fitful sleep, diarrhea, vomiting, and fever.
4. Diseases of emotional origin, attributed to sudden or prolonged terror called *susto.*
5. Folk-defined diseases, such as *latido*.
6. Standard scientific diseases.

Recent research reveals that overall health status of Hispanic Americans is determined by key health indicators on infant mortality, life expectancy, and mortality from cardiovascular disease, cancer, and measures of functional health. This research concludes that the health of people of Hispanic heritage is much closer to that of White Americans than to African Americans, even though the Hispanic and Black populations share similar socioeconomic conditions. Concerning the incidence of diabetes and infectious and parasitic diseases, however, Hispanic people are clearly at a disadvantage in relation to White people.

Possible explanations for the relative advantages and disadvantages in health status of Hispanic Americans involve such factors as the following, which were outlined by Purnell and Paulanka (2003):

- cultural practices favoring reproductive success
- early and high fertility contributing to low breast cancer but high cervical cancer rates
- dietary habits linked to low cancer rates but high prevalence of obesity and diabetes
- genetic heritage
- extended family support reducing the need for psychiatric services
- low socioeconomic status that contributes to increased infectious and parasitic diseases

Alcoholism also represents a serious health problem for many Hispanic Americans. Furthermore, as the Hispanic population becomes more acculturated, certain risk factors conducive to cardiovascular disease and certain cancers are expected to play larger roles in this group (Markides & Coreil, 1986; Purnell & Paulanka, 2003).

Today, the literature disagrees about the extent and frequency to which Hispanic people use home remedies and folk practices. In the southwestern United States, the Hispanic population has been found to use herbs and other home remedies to treat illness episodes—twice the proportion reported in the total U.S. population. Other studies claim that the use of folk practitioners has declined and practically disappeared in some Hispanic subgroups (Purnell & Paulanka, 2003).

Knowing where people get their health information can provide clues to practitioners as to how to reach particular population groups. For example, Mexican Americans receive almost as much information from mass media sources (TV, magazines, and newspapers) as they do from physicians and nurses. As a consequence, mass media could play an important role in disseminating information to a large portion of the Mexican American population (Purnell & Paulanka, 2003).

Because of the centrality of the family in Hispanic peoples' lives, the extended family serves as the single most important source of social support to its members. This culture is characterized by a pattern of respect and obedience to elders as well as a pattern of male dominance. Caregivers' focus, therefore, needs to be on the family rather than on the individual. It is likely, for example, that a woman would be reluctant to make a decision about her or her child's health care without consulting her husband first (Purnell & Paulanka, 2003).

Gender and family member roles are changing, however, as Hispanic women are taking jobs outside the home. Also, children are picking up the English language more quickly than their parents and are ending up in the powerful position of acting as interpreters for their adult relatives. The heavy reliance on family has been linked to this minority group's low utilization of healthcare services. In addition, levels of education correlate highly with access to health care. That is, as clearly depicted in Figure 8–1, the less education members within a household have, the poorer the family's health status and access to health care (Purnell & Paulanka, 2003; U.S. DHHS, 2000). Hispanic Americans are more likely than the general U.S. population to read English below the basic health literacy level (National Center for Education Statistics, 2006) and to have lower educational attainment than non-Hispanic Whites (Massett, 1996).

Teaching Strategies

Only about 40% of the Hispanic population has completed 4 years of high school or more, and only 10% have completed college, as compared with approximately 80% and 20%, respectively, of the rest of the non-Hispanic population (Purnell & Paulanka, 2003; Educating the Largest Minority Group, 2003). Both the educational level and the primary language of Hispanic clients need to be taken into consideration when selecting instructional materials (Massett, 1996; National Center for Education Statistics, 2006). Sophisticated teaching methods and tools would be inappropriate for those who have minimal levels of education.

The age of the population also can affect health and client education efforts. According to the

U.S. Census Bureau (2006), the Hispanic population is young as a total group (30% are younger than 20 years of age). Thus, the school system is an important setting for educating members of the Hispanic community. Education programs in the school system for Hispanic students on alcohol and drug abuse and on cardiovascular disease risk reduction proved successful if:

- cultural beliefs were observed.
- the educator was first introduced by an individual accepted and respected by the learners.
- family members were included.
- the community was encouraged to take responsibility for resolving the health problems discussed.

Morbidity, mortality, and risk factor data also provide clues to the areas in which patient education efforts should be directed. As mentioned earlier, Hispanic people have higher rates of diabetes, AIDS, obesity, alcohol-related illnesses, and mortality from homicide than the general population. All of these topics should be targeted for educational efforts at disease prevention and health promotion (Caudle, 1993).

Until recently, little data existed regarding patient education for Hispanic Americans. Purnell and Paulanka (2003), Fernandez and Hebert (2000), Hebert and Fernandez (2000), Pacquiao and others, 2000, and Caudle (1993) have contributed significantly to our understanding of the traditions and practices surrounding health and illness in the various Hispanic subgroups. The following general suggestions are useful when designing and implementing education programs for Hispanic Americans:

1. Identify the Hispanic American subgroups (e.g., Mexican, Cuban, and Puerto Rican) in the community whose needs differ in terms of health beliefs, language, and general health status. Design education programs that can be targeted to meet their distinct ethnic needs.
2. Be aware of individual differences within subgroups as to age, years of education, income levels, job status, and degree of acculturation.
3. Take into account the special health needs of Hispanic Americans with respect to incidences of diseases and risk factors to which they are vulnerable—breast cancer in women (Borrayo, 2004), diabetes, AIDS, obesity, alcohol-related illnesses, homicide, and accidental injuries.
4. Be aware of the importance of the family so as to direct education efforts to include all interested members. Remember that Hispanic families on the whole are very supportive of each other, and decision making rests with the male and elder authority figures in the traditional families.
5. Provide adequate space for teaching to accommodate family members who typically accompany patients seeking health care.
6. Be cognizant of the importance of the Roman Catholic religion in the lives of the Hispanic people when dealing with such issues as contraception, abortion, and family planning.
7. Demonstrate cultural sensitivity to health beliefs by respecting ethnic values and taking time to learn about Hispanic beliefs.

8. Consider other sources of care that this ethnic group might be using, such as home remedies, before they enter or while they are within the healthcare system.
9. Be aware of the modesty felt by some Hispanic women and girls, who may be particularly uncomfortable in talking about sexual issues in mixed company.
10. Display warmth, friendliness, and tactfulness when developing a relationship with people of Hispanic heritage because they expect healthcare providers to be informal and interested in their lives.
11. Determine whether Spanish is the language by which the client best communicates. Many Hispanic Americans prefer to speak Spanish, but they are not always literate in reading their native language.
12. Speak slowly and distinctly, avoiding the use of technical words and slang if the client has limited proficiency in the English language.
13. Do not assume that a nod of the head or a smile indicates understanding of what has been said. Even if Hispanic clients are not familiar with English, they respect authority and, therefore, it is not uncommon for them to display nonverbal cues that may be misleading or misinterpreted by the nurse. Ask clients to repeat in their own words what they have been told or use the teach back method to determine their level of understanding (Weiss, 2003).
14. If interpreters are used, be sure they speak the dialect of the learner. Be certain that the interpreter interprets instructions, rather than just translates them so that the real meaning gets conveyed. Also, be sure to talk to and with the client, not to the interpreter. If an interpreter is not available, use the AT&T hotline telephone number for a direct link to Spanish-speaking interpreters.
15. Provide written and audiovisual materials in Spanish that reflect linguistic appropriateness and cultural sensitivity. An increasing number of health education materials are available in Spanish (Borrayo, 2004).

Much more must be learned by nurse educators about the Hispanic American population with respect to their cultural beliefs and their health and education needs. It is evident that many members of this cultural group are not receiving the kind and amount of health services they desire and deserve. Nurses need to extend themselves to Hispanics in a culturally sensitive manner to effectively and efficiently address the needs of this rapidly growing segment of the U.S. population (Borrayo, 2004).

Black/African American Culture

According to the 2000 U.S. Census, members of the Black/African American culture make up the largest ethnic group in the United States. Currently, Black Americans constitute 12.2% of the U.S. population as compared with 11.9% for Hispanics. However, the most recent 2004 statistics indicate that the Hispanic population has surpassed this group in population growth (U.S. Census Bureau, 2006).

The cultural origins and heritage of Black Americans are quite diverse. Their roots are mainly from Africa and the Caribbean Islands.

They speak a variety of languages, including French, Spanish, African dialects, and various forms of English. Depending on the age cohort group to which they belong, African Americans may prefer to identify themselves differently as a racial group. For example, the youngest generation often refers to themselves (and likes to be referred by others) by the term *African American*. By contrast, middle-aged members of this ethnic group may prefer the term Black or Black American. Either designation is politically correct according to the U.S. Census Bureau's identification of this ethnic group as Black/African American. However, because the diversity of cultural heritage varies within the many Black subgroups, healthcare providers need to be aware of intraethnic differences in cultural beliefs, customs, and traditions (Purnell & Paulanka, 2003).

The one distinguishing factor of this ethnic group, in comparison to other subcultures, is that quite a few Black families have ancestry dating back to the early colonization of America in the 1600s when millions of Africans were brought forcibly to this country as slaves. The rich history of African heritage and American slavery has been passed on from generation to generation (Purnell & Paulanka, 2003).

The majority of this ethnic population resides in the South (54%). Approximately 19% live in the Midwest, 18% in the Northeast, and 9% in the West. The greatest concentration resides in large metropolitan areas, such as New York City, Chicago; Atlanta, Georgia; Washington, D.C.; Baltimore, Detroit, Michigan; and New Orleans, Lousiana (U.S. Census Bureau, 2006).

Unfortunately, African Americans have suffered a long history of inequality in educational opportunity. They were victims of school segregation and inferior facilities until the 1954 Supreme Court decision, *Brown v. Board of Education of Topeka*, outlawed the separation of Blacks and Whites in the public school systems. However, this educational deprivation has had long-term consequences, such as unequal access to higher paying and higher status job opportunities, which has led to low wages and a disproportionate number (approximately one third) of African Americans living at or below the poverty level (U.S. Census Bureau, 2006). In turn, poverty has resulted in low educational attainment, high rates of school dropout, drug and alcohol abuse, decreased health status, and a lower quality of life altogether (Forrester, 2000; Purnell & Paulanka, 2003). Nevertheless, many African Americans value education, which they see as the means to raise their standard of living by being able to secure better jobs and a higher social status.

Black Americans constitute a large segment of blue-collar workers and are not well represented in managerial and professional positions of employment. Discrimination in employment and job advancement is thought to be a major variable contributing to problems with career mobility. The government has taken major steps in the past 30 years to reverse discrimination in social and employment settings so as to give Black Americans more equal opportunities, but the majority of working-class Black people still do not typically advance to higher-level occupations.

Also, poverty and low educational attainment have had major consequences for the Black American community in terms of social and medical issues. Although Black families value education highly, there continues to be a greater than average high school dropout rate among Blacks, and many individuals remain poorly educated with concomitant literacy problems. Low educational levels and socioeconomic deprivation are strongly correlated with higher incidences of

disease, poor nutrition, lower survival rates, and a decreased quality of life in general. Increased exposure to hazardous working conditions in low paying, manual labor jobs has also resulted in a greater incidence of occupation-related diseases and illnesses among this population (Dignam, 2000; Machenbach et al., 2000; Monden et al., 2006; Rognerud & Zahl, 2005). In addition, the majority of Blacks reside in inner-city areas where exposure to violence and pollution puts them at greater risk for disease, disability, and death. The average life span of Black Americans is shorter than that of White Americans due to high death rates from cancer, cardiovascular disease, cirrhosis, diabetes, accidents, homicides, and infant mortality (Anderson et al., 2000; Dignam, 2000; Forrester, 2000; Holt, Kyles, Wiehagen, & Casey 2003; Keyserling et al., 2000; Samuel-Hodge, Keyserling, France, Ingram, Johnston, Davis et al., 2006; Yanek, Becker, Moy, Gettelsohn & Koffman, 2001). Also, Blacks are at higher risk for drug addiction, teenaged pregnancy, and sexually transmitted diseases (Purnell & Paulanka, 2003).

Purnell & Paulanka (2003) reported findings that African Americans are pessimistic about human relationships and their belief system emphasizes three major themes:

1. The world is a hostile and dangerous place to live.
2. The individual is vulnerable to attack from external forces.
3. The individual is considered helpless with few internal resources to combat adversity.

Because many African Americans tend to be suspicious of Western ethnomedical practitioners, they often seek the assistance of physicians and nurses only when absolutely necessary (Purnell & Paulanka, 2003). Instead, folk practitioners are held in higher esteem than the Western biomedical healthcare team.

Common to the Black culture is the concept of extended family, consisting of several households, with the older adults often taking the leadership role within the family constellation. Respect for elders and ancestors is valued. They are held in high esteem because living a long life indicates that the individual had more opportunities to acquire much experience and knowledge. Decision making regarding healthcare issues is, therefore, often left to the elders. Family ties are especially strong between grandchildren and grandparents. It is not unusual for grandmothers to want to stay at the hospital bedside when their grandchildren are ill. This extended family network provides emotional, physical, and financial support to members during times of illness and other crises (Forrester, 2000; Purnell & Paulanka, 2003).

Single parenting within the African American culture is an accepted position without stigma attached to it. Becoming a mother at a young age, although not highly desirable or condoned by Black women, does have a fairly high level of tolerance in this cultural group (Purnell & Paulanka, 2003). In fact, Black women do not perceive negative sanctions within their culture if they do not meet the ideal norm of getting an education or job prior to marriage and children. Relatives are supportive each other if help is needed with childbearing.

Spirituality and religiosity are very much a prominent cultural component of this ethnic group's community. They are at the center of and are a defining feature of African American life and serve as a source of hope, renewal, liberation, and unity among its members. *Spirituality* is defined as a belief in a higher power, a sacred

force that exists in all things. *Religiosity* is defined as an individual's level of adherence to beliefs and ritualistic practices associated with religious institutions (Holt, Clark, & Kreuter, 2003; Mattis, 2000; Mattis & Jagers, 2001; Puchalski & Romer, 2000).

Both spirituality and religion play a role in the development and maintenance of social relationships throughout the developmental life span. Blacks, moreso than Whites, turn to religion to cope with health challenges. Religious practices also have been found to influence health beliefs and positively influence health status and outcomes in the African American community (Newlin, Knafl, & Melkus, 2002). These strong religious values and beliefs may extend to their feelings about illness and health. A majority of Black Americans find inner strength from their trust in God. Some believe that whatever happens is God's will. This belief has led to the perception that Black Americans have a fatalistic view of life (Purnell & Paulanka, 2003) and are governed by a relatively strong external locus of control (Holt, Clark et al., 2003).

A traditional folk practice, known as voodoo, consists of beliefs about good or evil spirits inhabiting the world. A religious leader or voodoo doctors have the power to appease or release hostile spirits. Illness, or disharmony, is thought to be caused by evil spirits because a person failed to follow religious rules or the dictates of ancestors. Curative measures involve finding the cause of an illness—a hex or a spell placed on a person by another or the breaking of a taboo—and then finding someone with magical healing powers or witchcraft to rid the afflicted individual of the evil spirit(s). Some Black American families also continue to practice home remedies such as the use of mustard plasters, taking of herbal medicines and teas, and wearing of amulets to cure or ward off a variety of illnesses and afflictions (Purnell & Paulanka, 2003).

Teaching Strategies

In teaching Black Americans preventive and promotion measures, as well as caring for them during acute and chronic illnesses, the nurse must explore the client's value systems. Generally, any folk practices or traditional beliefs should be respected and allowed (if they are not harmful) and incorporated into the recommended treatment or healthcare interventions used by western medicine. The following discussion offers more specific recommendations for rendering culturally appropriate care for Black Americans.

Black Americans tend to be very verbal, dynamic, animated, and interpersonal, whereby they express feelings openly to family and friends. However, they are much more private about family matters when in the company of strangers. Even though Black Americans are very informal when they interact among themselves, they prefer to be greeted in a more formal manner with the use of their surnames, which demonstrates the respect and pride they have in their family heritage.

Also, Black Americans tend to feel comfortable with less personal space than do some other ethnic groups. Humor, joking, and teasing one another are ways to reduce stress and tension, but these types of communication can be misinterpreted as aggressive behavior if not understood within the context of their culture (Purnell & Paulanka, 2003).

Generally, African Americans are also more present than past or future oriented. Thus, they tend to be more relaxed about specific time frames, evincing a more circular rather than lin-

ear sense of time, which is more characteristic of the dominant White culture. Health providers must be careful not to misinterpret nonverbal and verbal behaviors when delivering care and must be flexible in the timing of appointments, as Blacks will usually keep their appointments but may not always be on schedule.

Traditionally, the family structure has been matriarchal; this pattern persists to the present day due to a high percentage of households run by a female single parent. It is imperative that healthcare providers acknowledge the dominant role that Black women play in decision making and the importance of sharing health information directly with them. Grandmothers continue to play a central role in the Black American family and are often involved in providing economic support and child care for their grandchildren (Forrester, 2000).

With respect to prevalent diseases and health issues within this population group, diabetes and hypertension continue to be the most serious health problems. The group as a whole suffers higher morbidity and mortality rates from these diseases than do other Americans (Samuel-Hodge et al., 2006; Yanek et al., 2001). Also, Blacks are at higher risk for being victims of violence, accidents, disabilities, and cancer (Forrester, 2000; Purnell & Paulanka, 2003). Obesity is another major problem among Black Americans. Food to them is a symbol of health and wealth, and a higher than ideal body weight is viewed as positive by this ethnic group.

Nurse educators must concentrate on disease prevention measures, institute early screening for high blood pressure, cancer, and diabetes, as well as screening for signs and symptoms of other diseases common in this population, and provide culturally congruent health education to improve the overall health status of Black Americans (Bailey, Erwin, & Belin, 2000; Powe, Daniels, Finnie, & Thompson, 2005). Strong family ties encourage individuals to be treated by the family before seeking care from health professionals. This cultural practice may be a factor contributing to the delay or failure of Blacks to seek treatment of diseases at the early stages of illness. An effective approach to providing care can be to conduct health screening programs in conjunction with community and church activities (Samuel-Hodge et al., 2006). "The church is a viable health education venue for this population" (Holt, Kyles et al., 2003).

Due to economic factors, Black Americans are likely to have less ready access to healthcare services. Identified barriers to Black Americans seeking the health care they need include lack of culturally relevant care, perceptions of racial discrimination, and a general distrust of both healthcare professionals and the healthcare system. Establishing a trusting relationship, therefore, is an essential first step to be taken by healthcare professionals if Blacks are to receive and accept the health services they require and deserve. Recognizing their unique responses to health and illness based on their spiritual and religious foundations, their strong family ties, and other traditional beliefs is essential if therapeutic interventions developed by the healthcare team are to be successful. Efforts to recruit more Blacks into the nursing profession would help most assuredly to reduce some of the barriers to caring for this population of Americans.

Asian/Pacific Islander Culture

People from Asian countries and the Pacific Islands constitute the third major ethnic group. Many Southeast Asian refugees have come to the U.S. mainly as a result of World War II, the Korean War in the 1950s, the fall of the South

Vietnam government in 1975, and the successive disintegrations of the governments of Laos and Cambodia. Primarily, they have settled on the West Coast, particularly in the San Francisco Bay area of California and in Washington state (Villanueva & Lipat, 2000; Young et al., 2002). Also, the states of New York, New Jersey, and Texas have experienced a large influx of Asian peoples, particularly from China, the Philippines, and Japan. In the decades following political and social upheavals in Southeast Asia, almost three quarters of a million people of Asian/Pacific Islander origin immigrated into the United States. As of 2004, more than 12 million Asian/Pacific Islanders (3.8% of the total U.S. population) live in the country (U.S. Census Bureau, 2006).

Although Asian/Pacific Islander people have been classified as a single ethnic group by many researchers and census takers, the culture of all these people is not the same. In fact, a wide variety of cultural, religious, and language backgrounds are represented. Some similarities exist among members of the Asian/Pacific Islander group, but there are also many differences (Purnell & Paulanka, 2003). By understanding the basic beliefs of the Asian/Pacific Islander people, nurses and other healthcare practitioners can be better prepared to understand and accept their cultural differences and varied behavior patterns (Villanueva & Lipat, 2000; Young et al., 2002).

The major philosophical orientation of the Asian/Pacific Islander people is a blend of four philosophies—Buddhism, Confucianism, Taoism, and Phi. Four common values are strongly reflected in all of these philosophies:

1. Male authority and dominance
2. Saving face (behavior as a result of a sense of pride)
3. Strong family ties
4. Respect for parents, elders, teachers, and other authority figures

The following is a brief review of the beliefs and healthcare practices of the Asian/Pacific Islander people (Pang, 2007; Purnell & Paulanka, 2003).

Buddhism

The fundamental belief is that all existence is suffering. The continuation of life, and therefore suffering, arises from desires and passions. According to the Buddhist philosophy, no humans are limited to a single existence terminating in death. Instead, everyone is reincarnated. Cambodians, who are in particular strongly influenced by the Buddhist philosophy, strive to accumulate religious merits or good deeds to ensure a better life to come. They adhere to a deep belief in karma, whereby things done in this existence will help or hinder their ascension on the ladder to nirvana. Good deeds, sharing, donating, and being generous and kind are all ways to accumulate merits.

Confucianism

Moral values and beliefs are heavily influenced by this philosophy, which focuses on the moral aspects of one's personality. Two predominant moral qualities, developed through cultivation of the personality, include humaneness (the attitude shown toward others) and a sense of moral duty and obligation (attitudes persons display toward themselves). The principles that guide the social behavior of people who adhere to Confucianism are described as follows.

Patterns of Authority The following five relationships run from inferior to superior to

form a pattern of obligation and authority in the family as well as in social and political realms:

1. Son (child) to father
2. Wife to husband
3. Younger brother to older brother
4. Friend to friend
5. Subject to ruler

These patterns of authority and obligation influence decision making and social interactions. For example, a friend is to regard a friend as a younger or older brother. Women's subservience to men is reflected in a woman's behavior to always seek the advice of her husband when making decisions. This authority needs to be respected by nursing staff when, for instance, a woman refuses to choose a contraceptive method until she asks for her husband's advice and permission.

Man in Harmony With the Universe In the Confucian system, people are seen as being between heaven and earth, and life has to be in harmony with the universe. An example of this principle in action is when an Asian responds passively to new information, quietly accepting it rather than actively seeking to clarify it. Given this perspective, it is important for the nurse when instructing the client to ask for an explanation of the information to ascertain if it was understood.

Ancestor Worship Concern for the moral order of relationships is reflected in a deep reverence for tradition and prescribed rites. Great emphasis is placed on funerals, etiquette for mourning, and the sharing of a communal meal with the dead.

The Asian/Pacific Islander culture values harmony in life and a balance of nature. Shame is something to be avoided, families are the center of life, elders are respected, and ancestors are worshiped and remembered. Children are highly valued because they carry on the family name and are expected to care for aging parents. The woman's role is one of subservience throughout her entire life—she will follow the advice of parents while unmarried, the husband's advice while married, and the children's advice when widowed. This subservient role is in direct conflict with U.S. social and family values, which expect women to take a more independent, assertive, and self-determined role.

TAOISM

The Tao philosophy has its roots in the belief of two opposing magical forces in nature, the negative (yin) and the positive (yang), which affect the course of all material and spiritual life. The basic concepts of Chinese philosophy, the beliefs in tao (the way of nature) and yin and yang (the principle of balance), stress that human achievement in harmony with nature should be accomplished through nonaction.

Common also is the idea that good health depends on the balance between hot and cold. Equilibrium of hot and cold elements produces good health. Drugs, natural elements, and foods are classified as either hot or cold. It is believed that sickness can be caused by eating too much hot or cold food. Hot foods include meats, sweets, and spices. Cold foods include rice and vegetables.

The Chinese people believe in strong family ties, respect for elders, and the authority of men as the head of the household. As a consequence, sons are highly valued. Illness is believed to result from an imbalance in the forces of nature. Ill health is believed to be a curse from heaven, with mental illness being the worst possible

curse, because the individual was irresponsible in not obtaining the right amount of rest, food, and work.

Phi

Phi worship is a belief in the spirits of dead relatives or the spirits of animals and nature. Phi ranges from bad to good. If a place has a strong phi, the individual must make an offering before doing anything in that place, such as building a house or tilling the land. If someone violates a rule of order, an atmosphere of bad phi can result in illness or death. Redemption can be sought from a phi priest as a hope of getting relief from suffering. Offerings are made and special rites are performed to rid the person of a bad phi.

Worshipers of this philosophy respect elders and avoid conflict by doing things in a pleasant manner. Those who adhere to the phi philosophy are hospitable and generous. They show respect to others by the way a person is addressed, and tend to prize hard work and ambition.

For people of the Asian/Pacific Islander ethnic group, marked cultural differences confront them when they live in the United States with respect to ways of life, ways of thinking, values orientation, social structure, and family interactions (Chao, 1994; Young et al., 2002). Children may adapt quickly, but the older generations tend to have difficulty acculturating.

Their medical practices, like their other unique cultural practices, differ significantly from Western ways. The health-seeking behaviors of immigrants tend to be crisis oriented, following the pattern in their homelands where medical care was not readily available. They are likely to seek health care only when seriously ill. Reinforcement is needed to encourage them to come for follow-up visits after an initial encounter with the healthcare system. Sometimes they are viewed by practitioners as noncompliant when they do not do exactly what is expected of them, when they withdraw from follow-up treatments, or when they do not keep prearranged appointments.

Asian people make great use of herbal remedies to treat various ills, such as fevers, diarrhea, and coughs. Dermabrasion, often misunderstood by U.S. practitioners, is a home remedy to cure a wide variety of problems such as headaches, cold symptoms, fever, and chills. In their traditional healthcare system, Asian individuals rely on folk medicines from healers, sorcerers, and monks.

Western medicine is thought to be "shots that cure," and Asian patients expect to get some form of medicine (injections or pills) whenever they seek medical help in the United States. If no medication is prescribed, the person, if not given an explanation, may feel that care is inadequate and fail to return for future care.

Common to many Southeast Asians is the idea that illnesses, just like foods, are classified as hot and cold. This belief coincides with the yin and yang philosophy of the principles of balance. If a disease is considered hot in origin, then giving cold foods is believed to be the proper treatment.

Conflict and fear are the most likely responses to laboratory tests and having blood drawn. It is the belief of this ethnic group that removing blood makes the body weak and that blood is not replenished. Fear of surgery may result from the conviction that souls inhabit the body and may be released. Another major fear is the loss of privacy leading to extreme embarrassment and humiliation.

Teaching Strategies

Respect is automatically endowed on most healthcare providers and teachers because they

are seen as knowledgeable. Asians are sensitive and formal people, so making a friendly and nonthreatening approach to them is necessary before giving care. They must be given permission to ask a question but are not offended by questions from others.

One salient characteristic to be noted of the Japanese subculture is a childlike dependency known as *amae,* which continues through adulthood but is especially evident when people are ill or going through hardships. This behavior conflicts with the Western nursing philosophy of helping those they care for to become independent in self-care. Awareness of this characteristic dependent behavior will allow American nurses to approach clients of Japanese heritage in a culturally relevant and tolerant manner (Hisama, 2000).

Language barriers are usually the first and biggest obstacle to overcome in working with people of Asian/Pacific Islander descent. The learning style of Asians is essentially passive—no personal opinions, no confrontations, no challenges, and no outward disagreements. Nurses and other healthcare practitioners should be aware that in the Asians' wish to save face for themselves and others, they avoid being disruptive and will agree to what is said so as not to be offensive.

The approach to learning is done primarily by repetition and rote memorization of information. It must be remembered that decision making is a family affair. Consequently, family members need to be included, especially the male authority figure, in the process of deciding the best solution for a situation. They are easily shamed, so clients must be reassured and told what is considered acceptable behavior by Western moral and legal standards. Nods of the head do not necessarily mean agreement or understanding. Questions directed to them need to be asked in several ways to confirm that they understand any instructional messages given.

American Indian/Alaskan Native Culture

The U.S. Census Bureau (2006) has identified more than 2.8 million people (almost 1% of the U.S. population) who are of this ethnic group living in the United States. There are more than 500 distinct tribes of American Indians and Native Alaskans, including Eskimo and Aleut tribes (Lowe & Struthers, 2001). The largest of these tribes is the Cherokee. Other tribes of significant size are the Navaho, Sioux, Chippewa, Choctaw, Pueblo, and the Latin American Indian. These tribes reside primarily in the Northwestern, Central, and Southwestern regions of the United States (U.S. Census Bureau, 2006). The term Native American will be used throughout this section of the chapter to include both the American Indian and Native Alaskan people.

Of these people, approximately one half are eligible for health services provided by the federal government. Medical care to American Indian people has a long history. As far back as 1832, the War Department undertook a smallpox vaccination campaign for tribes of American Indian people, largely to protect military troops from infection. In 1849, healthcare responsibility was transferred to the newly created Bureau of Indian Affairs. In 1954, the Department of Health, Education, and Welfare of the U.S. Public Health Service (USPHS) took over jurisdiction. Today, the Indian Health Service (IHS) of the USPHS maintains responsibility for providing health care to members of this ethnic group (Mail, McKay, & Katz, 1989).

The current challenge to healthcare practitioners is to integrate Western medicine with traditional non-Western tribal folk medicine to provide cross-cultural health education to Native Americans in reservation-based communities across the nation. To do so, nurses must understand contemporary Native American cultural patterns, including theories of disease causality and associated therapies. It is also essential for nursing professionals to become focused on a more ethnomedical orientation. This means delineating the nature and consequences of illness problems and disease interventions from the ethnic group's perspective, rather than adhering to the biomedical orientation of defining diseases and illness interventions from only a Western perspective.

In the ethnomedical context, the concept of health and illness incorporates the relationship of humans with their universe—a concept that bridges culture with a sensitivity toward the daily practices inherent within specific ethnic groups. The challenge for the nurse educator is to understand the world perspective of contemporary American Indian and Native Alaskan people that sets them apart from non–Native Americans (Cantore, 2001; Lowe & Struthers, 2001; Mail et al.,1989).

As outlined by Purnell and Paulanka (2003), Lowe and Struthers (2001), Harding (1998), Scharnberg (2007), Joho and Ormsby (2000), and Cantore (2001), Native American culture has the following major characteristics:

1. A spiritual attachment to the land and harmony with nature
2. An intimacy of religion and medicine
3. Emphasis on strong ties to an extended family network, including immediate family, other relatives, and the entire tribe
4. The view that children are an asset, not a liability
5. A belief that supernatural powers exist in animate as well as in inanimate objects
6. A desire to remain Native American and avoid acculturation, thereby retaining one's own culture and language
7. A lack of materialism, lack of time consciousness, and a desire to share with others

Unless the awareness of non-Native American healthcare workers is raised, these common characteristics can easily be overlooked by them when care is being provided to clients of this ethnic group. Although Anglo-American culture and Western healthcare practices have been integrated to some extent into the Native American way of life, the preceding characteristics still predominate today to set this subculture apart as a unique entity.

Native Americans see a close connection between religion and health. When a family member becomes ill, witchcraft is still perceived by some tribes as the real cause of illness. In traditional societies, witchcraft functions to supply answers to perplexing or disturbing questions. It also explains personal insecurities, intragroup tensions, fears, and anxieties.

Witches, with their supernatural powers, have served as convenient scapegoats on which to blame the misfortunes in life and provided tribes with a mechanism for social control. It is hypothesized that as the cultural practices of witchcraft were increasingly denigrated by missionaries and bureaucrats, substitutions such as compulsive drinking and frequent use of narcotics (peyote) emerged as culturally sanctioned outlets for aggressive impulses and frustrations.

These behaviors were seen as less disruptive than demonstrating overt hostilities. This hypothesis has been proposed as an explanation of the high prevalence of substance abuse by Native Americans.

Some Native American tribes still practice witchcraft but tend to deny it as a reality because of the negative stereotype and stigma attached to it by outsiders. Nevertheless, the intimacy between religion and medicine persists and is exhibited in the form of "sing" prayers and ceremonial cure practices. However, few nurses would think of providing space and privacy for several relatives to be able to conduct a ceremony for a hospitalized family member.

Some Native American tribal beliefs also require incorporating the medicine man (shaman) into the system of care given to patients. The central and formal aspects of Native American medicine are ceremonial, embracing the notion of a supernatural power. Although the ceremonies vary from tribe to tribe, the ideas of causation and cure are common to all Native Americans. The ritual performed is determined by the signs and symptoms of an illness. Sometimes rituals are conducted by family members. Cornmeal, from the sacred food of corn, is one item that is frequently used in a variety of curative ceremonies. Herbal remedies have for generations served native healers as their pharmacopoeia. The nurse must demonstrate legitimate respect for such ritualistic symbols and ceremonial activities.

To be considered really poor in the Native American world is to be devoid of relatives. The family and tribe are of utmost importance, which is a belief that children learn from infancy. It is not unusual for many family members—sometimes large groups of 10 to 15 people—to arrive at the hospital and camp out on the hospital grounds to be with their sick relative. Talking is unnecessary, but simply being there is highly important for everyone concerned. Hospital personnel have often labeled this behavior as useless and disruptive and deem the patient and family to be uncooperative.

Grandmothers, in particular, have great importance to a sick child, and they frequently must give permission for a child to be hospitalized and treated. The Native American kinship system, in fact, allows for a child to have several sets of grandparents, aunts, uncles, cousins, brothers, and sisters. Sometimes a number of women substitute as a mother figure for a child, which may cause role confusion for the non-Native American healthcare provider.

Children are given a great deal of freedom and independence to learn by their decisions and live by the consequences of their actions. Their entire childhood years consist of experiential learning to develop skills and self-confidence to function as adults. They may appear spoiled, but in fact they are taught self-care and respect for others at a very early age. Children are doted on by family members, and, in turn, they have high regard for their elders. In fact, the older adults in Native American communities are highly respected and looked to for advice and counsel. Outside of their private domain, such as in the public school system, Native American children tend not to be seen as very competitive or assertive. However, to call attention to oneself is interpreted by Native Americans as showy and inappropriate.

Another characteristic of Native Americans is that they generally are not very future oriented; they take one day at a time and do not feel they have control over their own destiny. Time is seen as being on a continuum with no beginning and no end. Native Americans tend not to live by clocks and schedules. In fact,

many of their homes do not have clocks, and family members eat meals and do other activities when they please.

Members of this ethnic group tend to be more casual in their approach to life than many non-Native American people. This lack of time consciousness and pressure is a crucial factor to be remembered by healthcare providers when a prescribed regimen calls for the patient to follow a medication, exercise, or dietary schedule. This attitude or way of thinking also has proved to be a significant obstacle when health educators have attempted to provide preventive care. Inattention to time, in addition, can interfere with their keeping scheduled appointments, although lack of funds rather than time seems to be the main cause of missed appointments.

Another aspect of time is reflected in their belief that death is just a part of the life cycle—a much healthier and more accepting attitude toward dying than that held by most White Americans. Their grief process is culturally very different. Funerals are accompanied by large feasts and the sharing of gifts with relatives of the deceased. There is no belief in a life hereafter as a reward for a lifetime of good deeds while on earth. Life after death is, instead, viewed as an opportunity to join the world of long-ago ancestors. Their view of death is closely related to their opinion about the appropriate disposal of amputated limbs. Because diabetes is so prevalent in the Native American population, it is important to know that they usually want to reclaim an amputated body part for proper burial.

Sharing is another core value of Native Americans. The concept of *being* is fundamental, and there is little stress on achievement or the worth of material wealth. Individuals are valued much more highly than material goods. Overall, Native Americans are a proud, sensitive, cooperative, passive people, devoted to tribe and family, and willing to share possessions and self with others. They are very vulnerable when it comes to their pride and dignity. They can be easily offended by nonsensitive caregivers.

In terms of human relationships, it is important to note that Native Americans believe that to look someone in the eye is considered disrespectful. Some tribes feel that looking into the eyes of another person reveals and may even steal someone's soul. As a friendly handshake and eye contact are acceptable and even expected in the Anglo-American culture, it must be acknowledged that these gestures do not have the same meaning for the Native American. In fact, eye contact by White American definition is interpreted to mean that someone is paying attention, is interested, or understands. Non-Native American healthcare workers, therefore, may consider lack of eye contact to mean that these patients are shiftless, shifty, uninterested in learning, or inattentive, when in fact all along they were taking in the message of instruction being given. If asked, they can often repeat verbatim what someone just said to them.

The type and incidence health problems faced by Native Americans have undergone significant change over the years. In the first half of the twentieth century, acute and infectious diseases were prevalent and were the principal cause of death. Today, as a result of increased life expectancy, Native Americans are succumbing to many lifestyle diseases and chronic conditions. Chief among the causes of morbidity and mortality are heart disease, cancer, diabetes, and drug and alcohol abuse—all of which to some extent are amenable to educational intervention.

Teaching Strategies

Nurse educators need to focus on giving information about these diseases and risk factors,

emphasize the teaching of skills related to changes in diet and exercise, and help clients to build positive coping mechanisms to deal with emotional problems. For the most part, acute and infectious diseases, with the exception of a recurrence in tuberculosis, are no longer a major cause of illness and death among Native Americans. This is due to modern drug therapy, early case findings, improved sanitary conditions, and better provision of health education.

Another positive influence has been the greater availability of community health representatives (CHRs). These indigenous community outreach workers have played a significant role in case finding, early diagnosis, and reinforcement of patient and other health education recommendations. As Mail and others (1989) stated: "Involving the CHR in patient education is an important cross-cultural consideration, because this is the individual who will reinforce behavior changes with the community and home" (p. 97).

Although all Native Americans share some of the core beliefs and practices of their culture, each tribe is unique in its customs and language. Finding the ways and means to integrate Western medicine with the traditional Native American folk medicine in caring for the varied needs of this population group presents a challenge to the nurse educator. It also presents a learning opportunity for the recipient of these health education services.

Preparing Nurses for Diversity Care

America is no longer the homogeneous melting pot society it once was. Today, myriad cultures are present in the United States, and we face an increasing trend toward global migration of people and globalization of nursing practice. The delivery of appropriate health care now and in the future will depend on use of a culturally informed approach that goes beyond simple language translation and an understanding of the characteristics of different cultures. As caregivers, we must learn how to relate to people, both clients, fellow healthcare practitioners, and nursing students, who come from a variety of cultural backgrounds, and discover the cultural meaning of various health events (Career Directory, 2005).

The nursing profession must be prepared to pursue this relatively new paradigm for creating and managing diversity within our workforce as well as within the healthcare marketplace consisting of consumers and staff from multicultural backgrounds. Diversity has the potential to positively affect our profession by increasing organizational effectiveness, creating greater access to care, lifting morale of clients and staff, and enhancing productivity in the workforce (Cooper, Grywalski, Lamp, Newhouse, & Studlien, 2007; Marquand, 2001; Thomas & Ely, 1996).

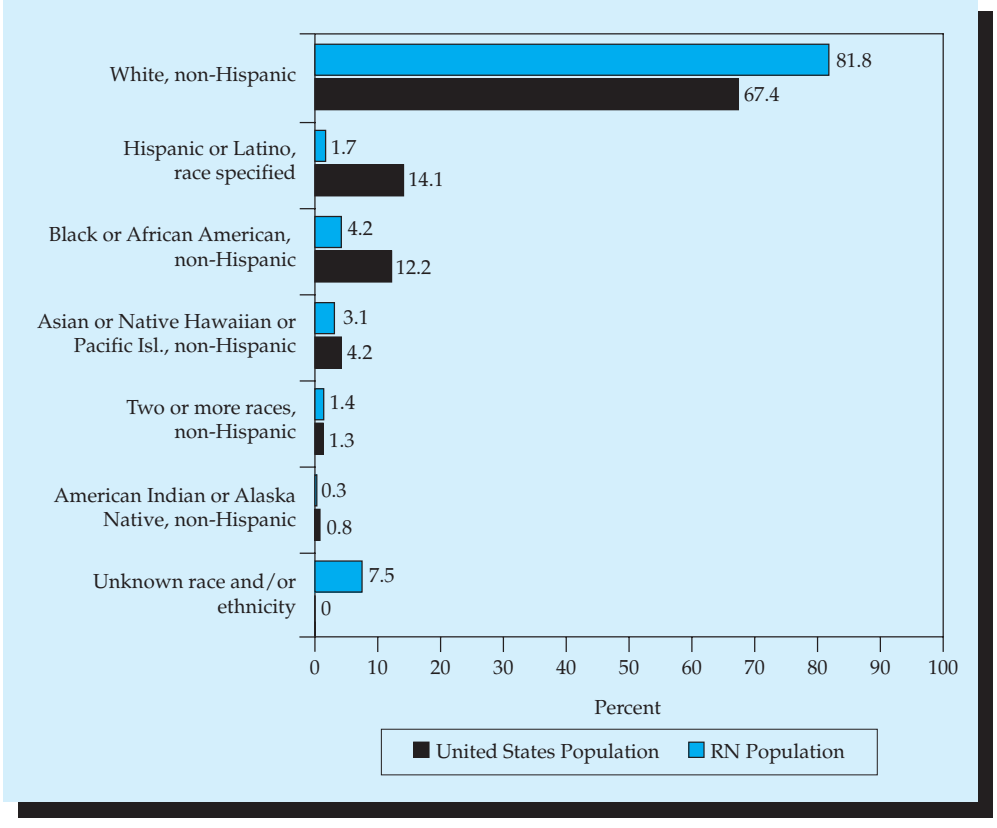
As a result of former President Clinton's national leadership to eliminate cultural disparities in health by the year 2010, the U.S. government introduced a series of initiatives put forth in the *Healthy People 2010* document. One goal of this 10-year plan was eliminate racial and ethnic disparities in health (U.S. DHHS, 2000). This current initiative is lauded as "the first explicit commitment by the government to achieve equity in health outcomes" (Jones, 2000, p. 214). The nursing profession has embraced this goal and its objectives to eradicate discrepancies in health outcomes among minority populations. The profession has begun contributing to this expectation by focusing on change in both the academic and the practice settings as well as through clinical research (Carol, 2001).

One important step to assure culturally competent nursing care in this new century is to

increase minority representation in nursing. The profession needs to recruit and retain more minority students and faculty to expand diversity within its ranks. Unfortunately, the nursing workforce comprises only 10% of people from minority groups (see **Figure 8–6**), whereas more than 28% of the total U.S. population belongs to a variety of cultural subgroups (Robinson, 2000).

Another initiative to break down cultural barriers to health care is to strengthen multicultural perspectives in the curriculum of nursing education programs (Bond, Kardong-Edgren, & Jones,

Figure 8–6 Distribution of Registered Nurses by Racial/Ethnic Background, March 2004



Source: U.S. Census Bureau (2006). Statistical abstract of the United States, resident population by sex, race, and Hispanic origin status: 2000 to 2004, Table 13. Retrieved from http://www.census.gov/prod/2005pubs/06statab/pop.pdf.

Note: Census reports that, of the 293,655,000 in the U.S. population for 2004, 197,841,000 are of White race, only, and non-Hispanic. Thus, while 67.4% of the U.S. population are White, non-Hispanic, 32.6% are non-White or Hispanic.

2001; Kelley & Fitzsimons, 2000). Innovative nursing education means incorporating social values that recognize diverse lifestyles and acknowledge multicultural and multiracial perspectives (Rew, Becker, Cookston, Khosropour, & Martinez, 2003). As these authors pointed out, nurses must not only better understand the cultural characteristics and traits of patients and families from different ethnic backgrounds, but also improve the relationship between nurses and clients from different cultural backgrounds.

Nurses must be able to create an environment in which people are encouraged to express themselves and freely describe their needs. As Dreher (1996) so aptly stated, "Transcending cultural differences is more than an appreciation of cultural diversity. It is transcending one's own investment in the social and economic system as one knows it and lives it" (p. 4). Nurse educators must concentrate on the cultural strategies that are needed to help individuals and groups negotiate the healthcare system.

Stereotyping: Identifying the Meaning, the Risks, and the Solutions

In addressing the diversity issues of gender, socioeconomics, and culture, one must acknowledge the risks of stereotyping inherent in discussing these three attributes of the learner. Throughout this chapter, it has been explicitly recognized that differences exist in learning based on gender, socioeconomics, and culture and often require alternative approaches to teaching. It is important to realize that differences should not be equated with judgments as to what is good or bad, right or wrong; rather, one should not ignore the need to attend to these differences in a sensitive, open, and fair manner.

Nurse educators must relate to each person as an individual. It is important to develop an awareness that although a person can be considered as a member—or may identify with members—of a certain ethnic group, the individual has his or her own abilities, experiences, preferences, and practices. Learning needs, learning styles, and readiness to learn are all factors that influence lifestyle behaviors.

Nevertheless, everyone has been socialized in subtle and not so subtle ways according to one's own diversity attributes, socioeconomic and political backgrounds, and other life exposures. It is imperative to acknowledge the prejudices, biases, and stereotypical tendencies that can come into play when dealing with others like or unlike ourselves. We must consciously attempt to recognize these possible attitudes and the effect they may have on others in our care. To address the dangers of stereotyping on more than just a superficial level, this section examines examples of what constitutes unacceptable forms of stereotyping, what common pitfalls can arise in dealing with diversity, and what can be done to avoid stereotypical behaviors in ourselves and others.

Stereotyping is defined by Purnell and Paulanka (2003) as "an oversimplified conception, opinion, or belief about some aspect of an individual or group of people" (p. 357). Exaggerated generalizations are commonly made about the characteristics, behaviors, and motives associated with any person or group of people. Actually, stereotyping can be positive or negative, depending on how, where, when, why, and about whom it is applied (Satel, 2002).

For example, stereotyping can be a useful and legitimate process to organize or classify people

if based on logical reasoning and accumulated facts. A system of organization and classification helps people to identify and understand information—for example, "he's Jewish," "she's Italian," or "they're Democrats." Conversely, stereotyping can be negative if it is used to place people in a mold or an artificial, unfair position based on oversimplification without true substantiation by facts. Negative stereotyping leads to disrespect, dehumanization, and denigration of others and serves as a barrier to equality and fairness toward others.

Stereotyping deserves a bad name when associated with bias or clichés. There is a huge emotional component to stereotyping. The language that we use, the attitudes that we project, the conclusions that we draw, and the context in which we employ stereotyping all determine its positive or negative quality.

Unfortunately, classification by association is often perfunctory and, therefore, laden with bias. Stereotyping in this sense is used to label someone. For example, we, as Americans, think of ourselves as the freedom fighters and liberty lovers of the world; in the same breath, we may describe members of other groups or nationalities as violators of human rights or terrorists. This threat of stereotyping is even greater in light of the infamous September 11, 2001, attack on our country. Simple appearance, such as a beard, attire, or form of speech, can be the basis of broad and deep prejudices.

People particularly tend to use an excuse to classify individuals when they do not like or respect others whose backgrounds, attitudes, abilities, values, or beliefs are different from or opposed to their own or are misunderstood or misinterpreted. Stereotyping, conscious or subconscious, results in intolerance toward others and engenders the belief that our way is the only way or the right way. Corley and Goren (1998) discuss the ways in which labeling, stereotyping, and stigmatizing responses by nurses tend to marginalize clients.

Attitudes toward sex-role competencies are considered a type of stereotyping. Gender bias has produced inequality in education, employment, and other social spheres. This is an especially relevant caveat for nurses in relating with colleagues as more and more men choose the nursing profession as a career (Coleman, 2002).

Research into gender stereotyping in the past 20 years has documented that elementary and secondary school teachers interact more actively with boys by asking them more questions, giving them more feedback (praise and positive encouragement), and providing them with more specific and valuable comments and guidance. In these subtle ways, these stereotypical expectations are reinforced (Snowman & Biehler, 2006).

Also, it used to be that an extensive list of personality differences between the sexes would be included in education and developmental psychology textbooks. However, recent psychology research has revealed that these sex-role lists are gender biased. Today, it is recognized that few personality characteristics associated with gender are consistent across cultures, except for aggression (Vander Zanden et al., 2007; Santrock, 2006; Snowman & Biehler, 2006)

As another example of gender bias, women have been labeled as attentive listeners and men as poor listeners when, in fact, listening behavior is not a measure of attentiveness but a matter of behavioral style. Men, when listening, move around and make sporadic eye contact, whereas women are likely to remain still and maintain steady eye contact with occasional nodding or smiling. As a result, the listening

style of men is often misinterpreted as inattentive or rude, and the style of females is often mistaken for encouragement or agreement with what is being said (Tear, 1995).

Interruptions when engaging in dialogue also have been noted as a misinterpretation of communication differences between the sexes. Men frequently speak in a steady flow and interrupt each other to take turns, whereas women tend to speak with frequent pauses to allow others to have their say. Pause-free male speech is often misinterpreted as a device to discourage females from participating and as an attempt to be pushy. The tendency for females to pause in speaking is seen as being timid or courteous. These misinterpretations reinforce stereotypes of men as dominating, insensitive, and controlling and women as unassertive, passive, and oversensitive (Tear, 1995).

Nurses must concentrate on treating the sexes equally when providing access to health education, delivering health and illness care, and designing health education materials that contain bias-free language. For example, they must avoid gender-specific terms and choose words that minimize ambiguity in gender identity, unless critical to the content. They should avoid using the pronouns *he* or *she* and instead use the plural pronoun *they*. If at all possible, nurses should avoid beginning or ending words with man or men, such as *man-made*, *mankind*, or *chairmen*. Do not specify marital status unless necessary by using Ms. instead of Mrs. Guidelines for nonsexist language can be found in *McGraw-Hill Guidelines for Bias-Free Publishing or The Bias-Free Word Finder*.

With respect to age, socioeconomics, culture and race, religion, or disabilities, stereotyping most definitely exists. Throughout this chapter, there are many cautions against stereotyping of individuals and groups. For example, just because someone belongs to a specific ethnic group does not necessarily mean that the individual adheres to all of the beliefs and practices of that particular culture.

A thorough and accurate assessment of the learner is the key to determining the particular abilities, preferences, and needs of each individual. The nurse educator should choose words that are accurate, clear, and free from bias whenever speaking or writing about various individuals or groups. Nurses should refer to someone's ethnicity, race, religion, age, and socioeconomic status only when it is essential to the content being addressed. For instance, it is more politically and socially correct to use the term *older adult* than the term *elderly* or *aged*. Do not label a member of a special population as a *disabled person* but rather as a *person with a disability*. Also, it is more appropriate and more acceptable to refer to a *person with diabetes* rather than a *diabetic* or to a *person with AIDS* rather than an *AIDS victim*.

To avoid stereotyping, nurses should ask themselves the following questions:

- Do I use neutral language when teaching clients and families?
- Do I confront bias when evidenced by other healthcare professionals?
- Do I request information equally from clients regardless of gender, socioeconomic status, age, or culture?
- Are my instructional materials free of stereotypical terminology and expressions?
- Am I an effective role model of equality for my colleagues?
- Do I treat all clients with fairness, respect, and dignity?
- Does someone's appearance influence (raise or lower) my expectations of that

person's abilities or affect the quality of care I deliver?
- Do I routinely assess the educational backgrounds, experiential backgrounds, personal attributes, and economic resources of clients to ensure appropriate health teaching?
- Am I knowledgeable enough of the cultural traditions of various groups to provide sensitive care in our multicultural, pluralistic society?

It is easy to stereotype someone, not of out of malice, but out of ignorance. Nurse educators have a responsibility to keep informed of the most current beliefs and facts about various gender attributes, socioeconomic influences, and cultural traditions that could impact positively or negatively on teaching and learning. Every day, research in nursing, social science, psychology, and medicine is yielding information that will assist in planning and revising appropriate nursing interventions to meet the needs of our diverse client populations.

State of the Evidence

It is essential that nurses base their practice on evidence from empirical studies and expert opinion to deliver the highest, most scientifically sound care to clients. Such evidence also is important as a basis for the educational preparation of staff nurses and future members of the nursing profession to give them the most up-to-date knowledge and skills needed to function competently and confidently in today's healthcare environment.

With respect to gender attributes of the learner, it is evident that understanding how the human brain works and the differences between the sexes in how they think, feel, and respond is still in its infancy. Neuroscience is just beginning to unravel the mysteries and discover the differences and similarities in the way male and female brains are wired. In the last 5–10 years, there has been an upsurge of interest and fascination with the discoveries in the field of neurobiology. New brain imaging instruments are beginning to reveal which individual portions of the brain are responsible for cognition, emotions, and tasks, but even more importantly is how the different parts of the brain operate or interact in concert with one another.

Brain research is an exciting, largely uncharted field, and some of the research findings are conflicting or inconclusive. Therefore, the challenge is to incorporate what is currently known for the refinement of our approaches to teaching and learning, but not to be too quick in jumping to assumptions or generalizations in the application of preliminary research findings before the evidence is conclusive.

Research into the impact of socioeconomics on health outcomes also needs to be further conducted. For example, currently, scant information is available about IQ and socioeconomics in relation to health status and health inequalities. The research of Batty et al. (2006) has shown that although cognitive abilities are related to health, the association between socioeconomic environment, social position, educational attainment, and employment status on the health inequalities in morbidity and mortality is still not altogether clear (Elstad & Krokstad, 2003; Singh-Manoux, et al., 2005). Much more research needs to be done to understand the impact of socioeconomic position in relation to the ability, preference, and motivation for learning.

Nursing research priorities on the influence of cultural diversity on the health of individuals

and groups must be identified and defined. Knowledge gaps remain despite the increase in the number of new studies being conducted. For example, the growing multicultural nature of our American society requires that we understand the impact of ethnic beliefs on the epidemiology of various diseases, on the effectiveness of health promotion efforts, on illness prevention measures, and on health maintenance and rehabilitation interventions. Bolton and colleagues (2001) posed the question: Are there ethnic variations in response to chronic illness and the performance in functional abilities of daily living? A need exists for funding to support research investigation into so many issues related to health, such as nutrition, mental status, social isolation, and prenatal to postmenopausal phases of women's lives.

Also, research is just in its initial stages in developing instruments that give insight into cultural effects of clients' perspectives on health and responses to illness. Harris, Belyea, Mishel, & Germino (2003) call for exploration into creating as well as adopting reliable and valid instruments to measure health beliefs, attitudes, customs, and patterns of behavior in males and females of different ethnic backgrounds. It is clear that health providers lack substantial evidence on how the context of culture impacts health and illness.

Summary

This chapter explored the influence of gender characteristics, socioeconomic status, and cultural beliefs on both the ability and willingness of clients to learn healthcare measures. The in-depth examination of these three factors serves as an explanatory model for certain behaviors observed or potentially encountered in a teaching–learning situation. Even though the emphasis of this chapter was on clients of diverse backgrounds with whom nurse educators interact, an understanding of gender, socioeconomic, and cultural characteristics also can be a useful source of information when teaching nursing students or staff who may come with a variety of experiences and orientations.

The most important message to remember from this chapter is the care one must take not to stereotype or generalize common characteristics of a group to all members associated with that particular group. For example, if the nurse does not know much about an ethnic subculture, he or she should ask clients about their beliefs rather than just assuming they abide by the tenets of a certain cultural group. In that way, nurses can avoid offending learners.

In their role as teachers, nurses must be cautious to treat each learner as an individual. They must determine the extent to which clients ascribe to, exhibit beliefs in, or adhere to ways of doing things that might affect their learning. Humans live in a double environment—an outer layer of social and cultural experiences and an inner layer of innate strengths and weaknesses—which influences how they perceive and respond to their world (Griffith, 1982).

Nurses, as professionals, should constantly strive to improve the delivery of care to all people regardless of their gender orientation, ethnic origin, creed, nationality, or socioeconomic background. There is much more for nurses to know about how these three factors of gender, socioeconomics, and culture affect the teaching–learning process before we can competently, confidently, and sensitively deliver care to satisfy the needs of our socially, intellectually, and culturally diverse clientele.

REVIEW QUESTIONS

1. What are five gender-related characteristics in cognitive functioning and personality behavior that affect learning?
2. How does the environment versus heredity influence gender-specific approaches to learning?
3. In what ways does SES negatively affect a person's health, and, conversely, how does illness impact an individual's socioeconomic well-being?
4. How does the SES of individuals influence the teaching–learning process?
5. What is meant by the term *poverty circle?*
6. What is the definition of each of the following terms: *assimilation, acculturation, culture, ethnic group,* and *ethnocentrism?*
7. How can the concept of transcultural nursing be applied to the assessment and teaching of clients from culturally diverse backgrounds?
8. What are the 12 cultural domains identified in Purnell's model of cultural competence that should be taken into account when conducting a nursing assessment?
9. What are the four major ethnic groups in the United States?
10. What are the salient characteristics of each of the four major ethnic groups?
11. Which teaching strategies are most appropriate to meet the needs of individuals from each of the four major ethnic groups?
12. What can the nurse do to avoid cultural stereotyping?

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