**Chapter** 1

Transcultural Diversity and Health Care



**The Need for Culturally**

**Competent Health Care**

Cultural competence has become one of the most im- portant initiatives in health care in the United States and throughout most of the world. Diversity has in- creased in many countries due to wars, discrimination, political strife, worldwide socioeconomic conditions, and the creation of the European Union. Some of the diversity is driven by actual numbers of immigrants, but other dimensions come from the visibility of the “new ethnics” and the waning of the social ideology of the “melting pot” (O’Neil, 2008). Instead of the term *melting pot*, meaning everyone is expected to blend, many believe the term *salad bowl* is more ap- propriate because people can stand out and be seen as individuals. Health ideology and health-care providers have learned that it is just as important to understand the patient’s culture as it is to understand the physio- logical responses in illness, disease, and injury. The health-care provider may be very knowledgeable about laboratory values and standard treatments and interventions for diabetes mellitus, heart disease, and asthma, but if the recommendations are not compat- ible with the patient’s own health beliefs, dietary prac- tices, and views toward wellness, the treatment plan is less likely to be followed (Giger et al., 2007). To this end, a number of worldwide initiatives have addressed cultural competence as a means for improving health and health care, decreasing disparities, and increasing patient satisfaction. These initiatives come from the U.S. Office of Minority Health, the Institute of Med- icine, *Healthy People 2020*, the National Quality Forum, the Joint Commission, The American Medical Association, the American Association of Colleges of Nursing, and other professional organizations. Educational institutions—from elementary schools to colleges and universities—are also addressing cultural

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diversity and cultural competency as they relate to disparities; health promotion and wellness; illness, dis- ease, and injury prevention; and health maintenance and restoration.

Many countries are now recognizing the need for addressing the diversity of their societies. Societies that used to be rather homogeneous, such as Portugal, Norway, Sweden, Korea, and selected areas in the United States and the United Kingdom, are now fac- ing significant internal and external migration, result- ing in ethnic and cultural diversities that did not previously exist, at least not to the degree they do now. Several European countries, such as Denmark, Italy, Poland, the Czech Republic, Latvia, the United Kingdom, Sweden, Norway, Finland, Italy, Spain, Portugal, Hungary, Belgium, Greece, Germany, the Netherlands, and France, either have in place or are developing national programs to address the value of cultural competence in reducing health disparities (Judge, Platt, Costongs, & Jurczak, 2005).

Whether people are internal migrants, immigrants, or vacationers, they have the right to expect the health-care system to respect their personal beliefs, values, and health-care practices. Culturally compe- tent health care from providers and the system, regardless of the setting in which care is delivered, is becoming a concern and expectation among con- sumers. Diversity also includes having a diverse workforce that more closely represents the popula- tion the organization serves. Health-care personnel provide care to people of diverse cultures in long- term-care facilities, acute-care facilities, clinics, communities, and patients’ homes. All health-care providers—physicians, nurses, nutritionists, thera- pists, technicians, home health aides, and other caregivers—need similar culturally specific information. For example, all health-care providers communicate,

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both verbally and nonverbally; therefore, all health- care providers and ancillary staff need to have similar information and skill development to com- municate effectively with diverse populations. The manner in which the information is used may differ significantly based on the discipline, individual expe- riences, and specific circumstances of the patient, provider, and organization. If providers and the system are competent, most patients will access the health-care system when problems are first recog- nized, thereby reducing the length of stay, decreasing complications, and reducing overall costs.

A lack of knowledge of patients’ language abilities and cultural beliefs and values can result in serious threats to life and quality of care for all individuals (Joint Commission, 2010). Organizations and indi- viduals who understand their patients’ cultural val- ues, beliefs, and practices are in a better position to be co-participants with their patients in providing culturally acceptable care. Having ethnocultural- specific knowledge, understanding, and assessment skills to work with culturally diverse patients ensures that the health-care provider can conduct a more tar- geted assessment. Providers who know culturally specific aggregate data are less likely to demonstrate negative attitudes, behaviors, ethnocentrism, stereo- typing, and racism. The onus for cultural compe- tence is on the health-care provider and the delivery system in which care is provided. To this end, health- care providers need both general and specific cultural knowledge when conducting assessments, planning care, and teaching patients about their treatments and prescriptions.

**World Diversity and Migration**

As of January 2011, the world’s population estimate reached 6.8 billion people, with a median age of 27.7 years. The population is expected to approach 7.6 billion by 2020 and 9.3 billion by 2050. The esti- mated population growth rate remains relatively stable at 1.13 percent, with 19.86 births per 1000 population; 8.7 deaths per 1000 population; and an infant mortal- ity rate of 44.13 per 1000 population, down from 48.87 in 2005. Worldwide life expectancy at birth is currently 66.12 years, up from 64.77 years in 2005 (*CIA World Factbook,* 2011). The ten largest urban pop- ulations where significant migration occurs are Tokyo, Japan with 36.7 million; Delhi, India with 22.2 million; São Paulo, Brazil with 20.3 million; Mexico City, Mexico with 19 million; New York–Newark, United States with 19.4 million; Shanghai, China with 16.6 million; Kolata, India with 15.6 million; Dhaka, Bangladesh with 14.7 million; and Karachi, Pakistan with 13.1 million (*CIA World Factbook,* 2011).

As a first language, Mandarin Chinese is the most popular, spoken by 12.65 percent of the world’s pop- ulation, followed by Spanish at 4.93 percent, English

at 4.91 percent, Arabic at 3.1 percent, Hindi at 2.73 percent, Portuguese at 2.67 percent, Bengali at 2.71 percent, Russian at 2.16 percent, Japanese at 1.83 percent, and Standard German at 1.35 percent. Only 82 percent of the world population is literate. When technology is examined, more people have a cell phone than a landline—with a ratio of 3:1. Over 1.6 billion people are Internet users, up by 62 percent from 2005 (*CIA World Factbook,* 2011). Language literacy has serious implications for im- migration. Over two-thirds of the world’s 785 million illiterate adults are found in only eight countries: Bangladesh, China, Egypt, Ethiopia, India, Indonesia, Nigeria, and Pakistan. Of all the illiterate adults in the world, two-thirds are women; extremely low literacy rates are concentrated in three regions: the Arab states, South and West Asia, and Sub-Saharan Africa, where around one-third of the men and half of all women are illiterate (2005 est.) (*CIA World Factbook,* 2011).

The United Nations High Commissioner for Refugees estimated in December 2006, the latest year for which figures are available, a global population of 8.8 million registered refugees, the lowest number in 30 years, and as many as 24.5 million internally dis- placed persons in more than 50 countries. The actual global population of refugees is probably closer to 10 million given the estimated 1.5 million Iraqi refugees displaced throughout the Middle East. Migrants represent approximately 190 million people or 2.9 percent of the world population, up from 175 million in the year 2000. Moreover, international migration is decreasing, while internal migration is increasing, especially in Asian countries (U.N. Refugee Agency, 2009).

In 1997, the International Organization for Migra- tion studied the costs and benefits of international migration. A comprehensive update has not been un- dertaken since that time. According to the report, ample evidence exists that migration brings both costs and benefits for sending and receiving countries, al- though these are not shared equally. Trends suggest a greater movement toward circular migration with sub- stantial benefits to both home and host countries. The perception that migrants are more of a burden on than a benefit to the host country is not substantiated by research. For example, in the Home Office Study (2002) in the United Kingdom, migrants contributed US$4 billion more in taxes than they received in ben- efits. In the United States, the National Research Council (1998) estimated that national income had expanded by US$8 billion because of immigration. Thus, because migrants pay taxes, they are not likely to put a greater burden on health and welfare services than the host population. However, undocumented migrants run the highest health risks because they are less likely to seek health care. This not only poses risks

for migrants but also fuels sentiments of xenophobia and discrimination against all migrants.

◗ *What evidence do you see in your community that migrants have added to the economic base of the community? Who would be doing their work if they were not available? If migrants (legal or undocumented) were not picking veg- etables (just one example), how much more do you think you would pay for the vegetables?*

**U.S. Population and Census Data**

As of 2010, the U.S. population was over 308 million, an increase of 16 million since the 2000 census. The 2010 census data include changes designed to more clearly distinguish Hispanic ethnicity as not being a race. In addition, the Hispanic terms have been mod- ified to include *Hispanic* (used more heavily on the East Coast), *Latino* (used more heavily in California and the West Coast), and *Spanish*. The most recent census data estimate that 65.1 percent of the U.S. population are white, 15.8 percent are Hispanic/ Latino, 12.9 percent are black, 4.6 percent are Asian, 1.0 percent are American Indian or Alaskan Native, and 0.2 percent are Native Hawaiian or other Pacific Islander. These groupings will be more specifically re- ported as the census data are analyzed. The categories as used in the 2010 U.S. Census are as follows:

1. *White* refers to people having origins in any of the original peoples of Europe and includes Middle Easterners, Irish, German, Italian, Lebanese, Turkish, Arab, and Polish.
2. *Black,* or *African American,* refers to people hav- ing origins in any of the black racial groups of Africa and includes Nigerians and Haitians or any person who self-designates this category regardless of origin.
3. *American Indian* and *Alaskan Native* refer to people having origins in any of the original peo- ples of North, South, or Central America and who maintain tribal affiliation or community attachment.
4. *Asian* refers to people having origins in any of
the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This category includes the terms *Asian Indian*, *Chinese*, *Filipino*, *Korean*, *Japanese*, *Vietnamese*, *Burmese*, *Hmong*, *Pakistani*, and *Thai*.
5. *Native Hawaiian* and *other Pacific Islander* refer to people having origins in any of the original peoples of Hawaii, Guam, Samoa, Tahiti, the Mariana Islands, and Chuuk.
6. *Some other race* was included for people who are unable to identify with the other categories.
7. In addition, the respondent could identify, as a write-in, with two races (U.S. Census Bureau, 2010).

The Hispanic/Latino and Asian populations con- tinue to rise in numbers and in percentage of the overall population; however, although the black/ African American, Native Hawaiian and Pacific Islanders, and American Indian and Alaskan Natives groups continue to increase in overall numbers, their percentage of the population has decreased. Of the Hispanic/Latino population, most are Mexicans, fol- lowed by Puerto Ricans, Cubans, Central Americans, South Americans, and Dominicans. Salvadorans are the largest group from Central America. Three- quarters of Hispanics live in the West or South, with 50 percent of the Hispanics living in just two states: California and Texas. The median age for the entire U.S. population is 41.8 years, and the median age for Hispanics is 27.2 years (U.S. Census Bureau, 2010). The young age of Hispanics in the United States makes them ideal candidates for recruitment into the health professions, an area with crisis-level shortages of personnel, especially of minority representation.

Before 1940, most immigrants to the United States came from Europe, especially Germany, the United Kingdom, Ireland, the former Union of Soviet Social- ist Republics, Latvia, Austria, and Hungary. Since 1940, immigration patterns to the United States have changed: Most are from Mexico, the Philippines, China, India, Brazil, Russia, Pakistan, Japan, Turkey, Egypt, and Thailand. People from each of these coun- tries bring their own culture with them and increase the cultural mosaic of the United States. Many of these groups have strong ethnic identities and main- tain their values, beliefs, practices, and languages long after their arrival. Individuals who speak only their indigenous language are more likely to adhere to traditional practices and live in ethnic enclaves and are less likely to assimilate into their new society. The inability of immigrants to speak the language of their new country creates additional challenges for health- care providers working with these populations. Other countries in the world face similar immigration chal- lenges and opportunities for diversity enrichment. However, space does not permit a comprehensive analysis of migration patterns.

**Racial and Ethnic Disparities**

**in Health Care**

A number of organizations have developed docu- ments addressing the need for cultural competence as one strategy for eliminating racial and ethnic dis- parities. In 2005, the Agency for Healthcare Research and Quality (AHRQ) released the “Third National

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◗ *What changes in ethnic and cultural diversity have you seen in your community over the last 5 years? Over the last 10 years? Have you had the opportunity to interact with these newer groups?*

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Healthcare Disparities Report” (AHRQ, 2005), which provided a comprehensive overview of health dispar- ities in ethnic, racial, and socioeconomic groups in the United States. This report was a companion doc- ument to the “National Healthcare Quality Report” (2006), which was an overview of quality health care in the United States. *Healthy People 2010*’s (www. healthypeople.gov) goals were to increase the quality and the length of a healthy life and to eliminate health disparities. Healthy People provided science- based, 10-year national objectives for improving the health of all Americans. For 3 decades, Healthy People has established benchmarks and monitored progress over time in order to (1) encourage collabo- rations across communities and sectors, (2) empower individuals toward making informed health decisions, and (3) measure the impact of prevention activities (http://www.healthypeople.gov/2020/about/ default.aspx).

The *Healthy People 2020* (www.healthypeople2020. gov) report had a renewed focus on identifying, measuring, tracking, and reducing health disparities through determinants of health such as the social and economic environment, the physical environ- ment, and the person’s individual characteristics and behaviors.

Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent among different populations, a disparity exists. Race or ethnicity, sex, sexual identity, age, dis- ability, socioeconomic status, and geographic location all contribute to an individual’s ability to achieve good health. During the past two decades, one of *Healthy People’s* overarching goals focused on disparities. In- deed, in *Healthy People 2000,* the goal was to reduce health disparities among Americans; in *Healthy Peo- ple 2010,* it was to completely eliminate, not just reduce, health disparities; and in *Healthy People 2020,* the goal was expanded to achieve health equity, eliminate disparities, and improve the health of all groups.

*Healthy People 2020* defines a *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.” Health disparities adversely affect groups of people who have systematically experi- enced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sen- sory, or physical disability; sexual orientation or gender identity; geographic location; or other char- acteristics historically linked to discrimination or exclusion. In addition, powerful, complex relation- ships exist among health and biology, genetics, and individual behavior, and among health and

health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influ- ence an individual’s or population’s health, are known as determinants of health (*Healthy People 2020*)*.*

More specific data on ethnic and cultural groups are included in individual chapters. As can be seen by the overwhelming data, much more work needs to be done to improve the health of the nation. Space does not permit an extensive discourse on racial and ethnic disparities in other countries, but documents with frequent updates that include other countries, conditions, and policies are listed as a resource on DavisPlus.

**Culture and Essential Terminology**

Culture Defined

Anthropologists and sociologists have proposed many definitions of *culture*. For the purposes of this book, which is primarily focused on individual cultural com- petence instead of the culturally competent organiza- tion, **culture** is defined as the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision mak- ing. Health and health-care beliefs and values are as- sumed in this definition. These patterns may be explicit or implicit, are primarily learned and trans- mitted within the family, are shared by most (but not all) members of the culture, and are emergent phenomena that change in response to global phe- nomena. Culture, a combined anthropological and social construct, can be seen as having three levels: (1) a tertiary level that is visible to outsiders, such as things that can be seen, worn, or otherwise observed; (2) a secondary level, in which only members know the rules of behavior and can articulate them; and (3) a primary level that represents the deepest level in which rules are known by all, observed by all, implicit, and taken for granted (Koffman, 2006). Culture is largely unconscious and has powerful influences on health and illness.

An important concept to understand is that cultural beliefs, values, and practices are learned from birth: first at home, then in the church and other places where people congregate, and then in educational settings. Therefore, a 3-month-old female child from Russian Ashkenazi Jewish heri- tage who is adopted by a European American



◗ *What health disparities have you observed in your community? To what do you attribute these disparities? What can you do as a professional to help decrease these disparities?*

family and reared in a dominant European American environment will have a European American world- view. However, if that child’s heritage has a tendency toward genetic/hereditary conditions, they would come from her Russian Jewish ancestry, not from European American genetics.

◗ *Who in your family had the most influence in teaching you cultural values and practices? Out- side the family, where else did you learn about your cultural values and beliefs? What cultural practices did you learn in your family that you no longer practice?*

When individuals of dissimilar cultural orienta- tions meet in a work or a therapeutic environment, the likelihood for developing a mutually satisfying relationship is improved if both parties attempt to learn about one another’s culture. Moreover, race and culture are not synonymous and should not be confused. For example, most people who self- identify as African American have varying degrees of dark skin, but some may have white skin. How- ever, as a cultural term, *African American* means that the person takes pride in having ancestry from both Africa and the United States; thus, a person with white skin could self-identify as African American.

Important Terms Related to Culture

**Attitude** is a state of mind or feeling about some as- pect of a culture. Attitudes are learned; for example, some people think that one culture is better than another. No one culture is “better” than another; they are just different, and many different cultures share the same customs. A belief is something that is accepted as true, especially as a tenet or a body of tenets accepted by people in an ethnocultural group. A belief among some cultures is that if you go outside in the cold weather with wet hair, you will catch a cold. Attitudes and beliefs do not have to be proven; they are unconsciously accepted as truths. **Ideology** consists of the thoughts and beliefs that reflect the social needs and aspirations of an in- dividual or an ethnocultural group. For example, some people believe that health care is the right of all people, whereas others see health care as a privilege.

The literature reports many definitions of the terms *cultural awareness, cultural sensitivity,* and *cultural competence*. Sometimes, these definitions are used in- terchangeably, but each has a distinct meaning. **Cul- tural awareness** has to do with an appreciation of the external signs of diversity, such as the arts, music, dress, foods, and physical characteristics. **Cultural sen- sitivity** has to do with personal attitudes and not say- ing things that might be offensive to someone from a cultural or ethnic background different from the

health-care provider’s. **Cultural competence** in health care is having the knowledge, abilities, and skills to deliver care congruent with the patient’s cultural beliefs and practices. Increasing one’s consciousness of cultural diversity improves the possibilities for health-care practitioners to provide culturally compe- tent care.

One progresses from unconscious incompetence (not being aware that one is lacking knowledge about another culture), to conscious incompetence (being aware that one is lacking knowledge about another culture), to conscious competence (learning about the patient’s culture, verifying generalizations about the patient’s culture, and providing cultural- specific interventions), and, finally, to unconscious competence (automatically providing culturally congruent care to patients of diverse cultures). Un- conscious competence is difficult to accomplish and potentially dangerous because individual differ- ences exist within cultural groups. To be even mini- mally effective, culturally competent care must have the assurance of continuation after the original im- petus is withdrawn; it must be integrated into, and valued by, the culture that is to benefit from the interventions.

Developing mutually satisfying relationships with diverse cultural groups involves good interpersonal skills and the application of knowledge and tech- niques learned from the physical, biological, and social sciences as well as the humanities. An under- standing of one’s own culture and personal values and the ability to detach oneself from “excess bag- gage” associated with personal views are essential for cultural competence. Even then, traces of ethno- centrism may unconsciously pervade one’s attitudes and behavior. **Ethnocentrism**—the universal ten- dency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways (which most people prac- tice to some degree)—can be a major barrier to pro- viding culturally competent care. Ethnocentrism perpetuates an attitude in which beliefs that differ greatly from one’s own are strange, bizarre, or unen- lightened and, therefore, wrong. Values are princi- ples and standards that are important and have meaning and worth to an individual, family, group, or community. For example, the dominant U.S. cul- ture places high value on youth, technology, and money. The extent to which one’s cultural values are internalized influences the tendency toward ethnocentrism. The more one’s values are internal- ized, the more difficult it is to avoid the tendency toward ethnocentrism.

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◗ *What activities have you done to increase your cultural awareness and competence? How do you demonstrate that you are culturally sensitive?*

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◗ *Given that everyone is ethnocentric to some de- gree, what do you do to become less ethnocentric? With which groups are you more ethnocentric?
If you were to rate yourself on a scale of 1 to*

*10, with 1 being only a little ethnocentric and 10 being very ethnocentric, what score would you give yourself? What score would your friends give you? What score would you give your closest friends?*

The Human Genome Project (2003) determined that 99.9 percent of all humans share the same genes. One-tenth percent of genetic variations account for the differences among humans, although these differences may be significant when conducting health assessments and prescribing medications and treatments. Ignoring this small difference, however, is ignoring the beliefs, practices, and values of a small ethnic or cultural population to whom one provides care. However, the controversial term *race* must still be addressed when learning about culture. Race is genetic in origin and in- cludes physical characteristics that are similar among members of the group, such as skin color, blood type, and hair and eye color (Giger et al., 2007). People from a given racial group may, but do not necessarily, share a common culture. Race as a social concept is some- times more important than race as a biological con- cept. Race has social meaning, assigns status, limits or increases opportunities, and influences interactions be- tween patients and clinicians. Some believe that race terminology was invented to assign low status to some and privilege, power, and wealth to others (American Anthropological Association, 1998). Thus, perhaps the most significant aspect of race is social in origin. Moreover, one must remember that even though one might have a racist attitude, it is not always recognized because it is ingrained during socialization and leads to ethnocentrism.

◗ *How do you define race? What other terms do you use besides race to describe people? In what category did you classify yourself on the last census? What categories would you add to the current census classifications?*

**Worldview** is the way individuals or groups of peo- ple look at the universe to form basic assumptions and values about their lives and the world around them. Worldview includes cosmology, relationships with na- ture, moral and ethical reasoning, social relationships, magicoreligious beliefs, and aesthetics.

Any **generalization**—reducing numerous character- istics of an individual or group of people to a general form that renders them indistinguishable—made about the behaviors of any individual or large group of people is almost certain to be an oversimplification. When a generalization relates less to the actual observed behavior than to the motives thought to

underlie the behavior (i.e., the *why* of the behavior), it is likely to be oversimplified. However, generalizations can lead to **stereotyping**, an oversimplified concep- tion, opinion, or belief about some aspect of an indi- vidual or group. Although generalization and stereotyping are similar, functionally, they are very dif- ferent. Generalization is a starting point, whereas stereotyping is an endpoint. The health-care provider must specifically ask questions to determine these values and avoid stereotypical views of patients. See the section on Variant Characteristics of Culture in this chapter.

Within all cultures are subcultures and ethnic groups whose values/experiences differ from those of the dominant culture with which they identify. Indeed, subcultures share beliefs according to the *variant characteristics* of culture, as described later in this chapter. In sociology, anthropology, and cultural studies, a **subculture** is defined as a group of people with a culture that differentiates them from the larger culture of which they are a part. Subcultures may be distinct or hidden (e.g., gay, lesbian, bisexual, and transgendered populations). If the subculture is char- acterized by a systematic opposition to the dominant culture, then it may be described as a counterculture. Examples of subcultures are Goths, punks, and ston- ers, although popular lay literature might call these groups cultures instead of subcultures. A countercul- ture would include cults (Merriam Webster Online Dictionary, 2010).

The terms *transcultural* versus *cross-cultural* have been hotly debated among experts in several countries but especially in the United States. Specific definitions of these terms vary. Some attest that they are the same, whereas others say they are different. Histori- cally, nursing seems to favor the word *transcultural*. Indeed, the term has been credited to a nurse anthro- pologist, Madeleine Leininger, in the 1950s (Leininger & McFarland, 2006), and it continues to be popular in the United States, the United Kingdom, and many European countries. The term *cross-cultural* can be traced to anthropologist George Murdock in the 1930s and is still a popular term used in the social sciences, although the health sciences have used it as well. The term implies comparative interactivity among cultures.

**Cultural humility**, another term found in cultural literature, focuses on the process of intercultural exchange, paying explicit attention to clarifying

◗ *Everyone engages in stereotypical behavior to some degree. We could not function otherwise. If someone asks you to think of a nurse, what image do you have? Is the nurse male or female? How old is the nurse? How is the nurse dressed? Is the nurse wearing a hat? How do you distin- guish a stereotype from a generalization?*

the professional’s values and beliefs through self- reflection and incorporating the cultural characteris- tics of the professional and the patient into a mutually beneficial and balanced relationship (Trevalon & Murray-Garcia, 1998). This term appears to be most popular with physicians and some professionals from the social sciences.

**Cultural safety** is a popular term in Australia, New Zealand, and Canada, although it is used else- where. Cultural safety expresses the diversity that exists within cultural groups and includes the social determinants of health, religion, and gender, in ad- dition to ethnicity (*Guidelines for Cultural Safety,* 2005). **Cultural leverage** is a process whereby the principles of cultural competence are deliberately invoked to develop interventions. It is a focused strategy for improving the health of racial and eth- nic communities by using their cultural practices, products, philosophies, or environments to facilitate behavioral changes of the patient and professional (Fisher et al., 2007).

**Acculturation** occurs when a person gives up the traits of his or her culture of origin as a result of con- tact with another culture. Acculturation is not an ab- solute, and it has varying degrees. Traditional people hold onto the majority of cultural traits from their culture of origin, which is frequently seen when people live in ethnic enclaves and can get most of their needs met without mixing with the outside world. Bicultural acculturation occurs when an individual is able to function equally in the dominant culture and in one’s own culture. People who are comfortable working in the dominant culture and return to their ethnic en- clave without taking on most of the dominant cul- ture’s traits are usually bicultural. Marginalized individuals are not comfortable in their new culture or their culture of origin. **Assimilation** is the gradual adoption and incorporation of characteristics of the prevailing culture (Portes, 2007).

**Enculturation** is a natural conscious and uncon- scious conditioning process of learning accepted cul- tural norms, values, and roles in society and achieving competence in one’s culture through socialization. Enculturation is facilitated by growing up in a partic- ular culture, and it can be through formal education, apprenticeships, mentorships, and role modeling (Clarke & Hofsess, 1998).

**Individualism, Collectivism,**

**and Individuality**

All cultures worldwide vary along an individualism and collectivism scale and are subsets of broad world- views. A continuum of values for individualistic and collectivistic cultures includes orientation to self or group, decision making, knowledge transmission, individual choice and personal responsibility, the

concept of progress, competitiveness, shame and guilt, help-seeking, expression of identity, and interaction/ communication style (Hofstede, 1991; Hofstede & Hofstede, 2005).

Elements and the degree of individualism and col- lectivism exist in every culture. People from an indi- vidualist culture will more strongly identify with the values at the individualistic end of the scale. More- over, individualism and collectivism fall along a con- tinuum, and some people from an individualistic culture will, to some degree, align themselves toward the collectivistic end of the scale. Some people from a collectivist culture will, to some degree, hold values along the individualistic end of the scale. Accultura- tion is a key component of adopting individualistic and collectivistic values. Those who live in ethnic en- claves usually, but not always, adhere more strongly to their dominant cultural values, sometimes to such a degree that they are more traditional than people in their home country. Acculturation and the variant characteristics of culture determine the degree of ad- herence to traditional individualistic and collectivist cultural values, beliefs, and practices (Hofstede, 1991; Hofstede & Hofstede, 2005).

Communicating, assessing, counseling, and educat- ing a person from an individualistic culture, where the most important person in society is the individual, may require different techniques than for a person in a collectivist culture where the group is seen as more important than the individual (Hofstede & Hofstede, 2005). The professional must not confuse individual- ism with individuality—the degree that varies by cul- ture and is usually more prevalent in individualistic countries. **Individuality** is the sense that each person has a separate and equal place in the community and where individuals who are considered “eccentrics or local characters” are tolerated (Purnell, 2010).

Some highly individualistic cultures include tradi- tional European American (in the United States), British, Canadian, German, Norwegian, and Swedish, to name a few. Some examples of collectivist cultures include traditional Arabic, Amish, Chinese, Filipino, Korean, Japanese, Latin American, Mexican, Ameri- can Indians (and most other indigenous Indian groups), Taiwanese, Thai, Turkish, and Vietnamese. Far more world cultures are collectivistic than are in- dividualistic. It may be difficult for a nurse who is from a highly collectivist culture to communicate with patients and staff in highly individualistic cultures, such as the United States and Germany (Hofstede & Hofstede, 2005).

Cultures differ in the extent to which health and in- formation are explicit or implicit. In low-context cul- tures, great emphasis is placed on the verbal mode, and many words are used to express a thought. Low- context cultures are individualistic. In high-context cultures, much of the information is implicit where

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fewer words are used to express a thought, resulting in more of the message being in the nonverbal mode. Great emphasis is placed on personal relationships. High-context cultures are collectivistic (Hofstede, 1991; 2001).

Consistent with individualism, individualistic cul- tures encourage self-expression. Adherents to individ- ualism freely express personal opinions, share many personal issues, and ask personal questions of others to a degree that may be seen as offensive to those who come from a collectivistic culture. Direct, straight forward questioning is usually appreciated with indi- vidualism. However, the professional should take cues from the patient before this intrusive approach is ini- tiated. Small talk before getting down to business is not always appreciated. Individualistic cultures usu- ally tend to be more informal and frequently use first names. Ask the patient by what name he or she prefers to be called. Questions that require a “yes” or “no” answer are usually answered truthfully from the pa- tient’s perspective. In individualistic cultures that value autonomy and productivity, one is expected to be a productive member of society. Among collectivistic cultures, people with a mental or physical disability are *more likely* to be hidden from society to “save face,” and the cultural norms and values of the family unit mean that the family provides care in the home (Purnell, 2001).

Indeed, it is absolutely imperative to include the family, and sometimes the community, in health care for effective counseling; otherwise, the treatment plan may falter. However, among many Middle Eastern and other collectivistic cultures, family members with mental or physical disabilities are hidden from the community for fear that children in the family might not be able to obtain a spouse if the condition is known. For other impairments, such as HIV, the con- dition may be kept from public view, not because of confidentiality rights but for fear that news of the con- dition will spread to other family members and the community.

The greater the perceived cultural stigma, the more likely the delay in seeking counseling, resulting in the condition being more severe at the time of treatment. Individualistic cultures socialize their members to view themselves as *independent*, separate, distinct individuals, where the most important per- son in society is self. A person feels free to change alliances and not feel bound by any particular group (shared identity). Although they are part of a group, they are still free to act independently within the group and less likely to engage in “groupthink.” In individualism, competition, whether individual or group, permeates every aspect of life. Separateness, independence, and the capacity to express one’s own views and opinions are both explicitly valued and implicitly assumed.

In individualistic cultures, a person’s identity is based mainly on one’s personal accomplishments, career, and challenges. A high standard of living supports self-efficiency, self-direction, self-advocacy, and independent living. Decisions made by elders and people in hierarchal positions may be questioned or not followed because the ideal is that all people expect to, and are expected to, make their own decisions about their lives. Moreover, people are personally re- sponsible and held accountable for their decisions. Improving self, doing “better” than others (frequently focused on material gains), and making progress on a community or national level are expected. If one fails, the blame and shame are on the individual alone.

In collectivistic cultures, people are socialized to view themselves as members of a larger group, family, school, church, educational setting, workplace, and so on. They are bound through the expectations of loy- alty and personal and familial lifetime protective ties. Children are socialized where priority is given to con- nections and interrelationship with others as the basis of psychological well-being. Older people and those in hierarchical positions are respected, and people are less likely to openly disagree with them. Parents and elders may have the final say in their children’s careers and life partners. The focus is not on the individual but on the group.

Collectivism is characterized by not drawing atten- tion to oneself, and people are not encouraged to ask controversial questions about themselves or others. When one fails, shame may be extended to the family, and external explanations, spiritual, superiors, or fate may be given. To avoid offending someone, people are expected to practice smooth interpersonal communi- cation by not openly disagreeing with anyone and being evasive about negative issues. Among most col- lectivist cultures, disagreeing with or saying “no” to a health-care professional is considered rude. In fact, in some languages, there is no word for “no.” If you ask a collectivist patient if she knows what you are asking, if she understands you, and if she knows how to do something, she will always answer “yes.” But “yes” could mean (a) I hear you, but I do not understand you; (b) I understand you, but I do not agree with what you are saying; and (c) I know how to do that, but I might not do it. Repeating what has been pre- scribed does not ensure understanding; instead, ask for a demonstration or some other response that is more likely to determine understanding.

**Variant Characteristics of Culture**

Great diversity exists within a cultural group. Major influences that shape people’s worldviews and the de- gree to which they identify with their cultural group of origin are called the “variant characteristics of culture.” Some variant characteristics cannot be

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REFLECTIVE EXERCISE 1.1

Does your cultural heritage primarily have a collectivistic or in- dividualistic cultural worldview? Rate your culture on a scale of 1 to 10 with 1 = collectivistic and 10 = individualistic. Is your culture tolerant of individuality? Are you consistent with your cultural heritage? Provide some specific behaviors to support your answer.

Collectivism Individualism
1 2 3 4 5 6 7 8 9 10

changed, while others can. They include but are not limited to the following:

• *Nationality:* One cannot change his or her nation- ality, but over time many people have changed their names to better fit into society or to decrease discrimination. For example, many Jews changed the spelling of their last names during and after World War II to avoid discrimination.

• *Race:* Race cannot be changed, but people can and do make changes in their appearance, such as with of cosmetic surgery.

• *Color:* Skin color cannot usually be changed on a permanent basis.

• *Age:* Age cannot be changed, but many people go to extensive lengths to make themselves look younger. One’s worldview changes with age. In some cultures, older people are looked upon with reverence and increased respect. Age difference with the accompanying worldview is frequently called the *generation gap*.

• *Religious affiliation:* People can and do change their religious affiliations or self-identify as atheists. However, if someone changes his or her religious affiliation—for example, from Judaism to Pente- costal or Baptist to Islam—a significant stigma may occur within their family or community.

• *Educational status:* As education increases, people’s worldview changes and increases their knowledge base for decision making.

• *Socioeconomic status:* Socioeconomic status can change either up or down and can be a major de- terminant for access to and use of health care.

• *Occupation:* One’s occupation can change. Of course, an occupation can be a health risk if employment is in a coal mine, on a farm, or in a high-stress position. In addition, someone who is educated in the health professions would not have as much difficulty with health literacy.

• *Military experience:* People who have military ex- perience may be more accustomed to hierarchical decision making and rules of authority.

• *Political beliefs:* Political affiliation can change ac- cording to one’s ideology. One of the major reasons for migration is ideological and political beliefs.

• *Urban versus rural residence:* People can change their residence with concomitant changes in ideology with different health risks and access to health care.

• *Enclave identity:* For people who primarily live and work in an ethnic enclave where they can get their needs met without mixing with the world outside, they may be more traditional than people in their home country.

• *Marital status:* Married people and people with partners frequently have a different worldview than those without partners.

• *Parental status:* Often, when people become parents—having children, adopting, or taking responsibility for raising a child—their worldview changes, and they usually become more futuristic.

• *Sexual orientation:* Sexual orientation is usually stable over time, but some people are bisexual. In addition, people who are incarcerated may engage in same-sex activity but return to a heterosexual lifestyle when released from prison. Gender reas- signment is now a possibility for some, although a significant stigma may occur.

• *Gender issues:* Men and women may have different concerns in regards to type of work and work hours, pay scales, and health inequalities.

• *Physical characteristics:* One’s physical characteris- tics may have an effect on how people see them- selves and how others see them and can include such characteristics as height, weight, hair color and style, and skin color.

• *Immigration status (sojourner, immigrant, or undoc- umented status):* Immigration status and length of time away from the country of origin also affect one’s worldview. People who voluntarily immigrate generally acculturate and assimilate more easily. Sojourners who immigrate with the intention of remaining in their new homeland for only a short time on work assignments or refugees who think they may return to their home country may not have the need or desire to acculturate or assimilate. Additionally, undocumented individuals (illegal immigrants) may have a different worldview from those who have arrived legally. Many in this group remained hidden in society so they will not be discovered and returned to their home country.

• *Length of time away from the country of origin:* Usu- ally, the longer people are away from their culture
of origin, the less traditional they become as they acculturate and assimilate into their new culture.

REFLECTIVE EXERCISE 1.2

What are your variant characteristics of culture? How has each one influenced you and your worldview? How has your worldview changed as your variant characteristics have changed? How is each of these a culture or a subculture?



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Some examples of how variant cultural character- istics change one’s worldview follow.

Consider two people with the following variant characteristics. One is a 75-year-old devout Islamic female from Saudi Arabia, and the other is a 19-year- old African American fundamentalist Baptist male from Louisiana. Obviously, the two do not look alike, and they probably have very different worldviews and beliefs, many of which come from their religious tenets and country of origin.

The variant cultural characteristics of being a single transsexual urban business executive will most likely have a different worldview from that of a married het- erosexual rural secretary who has two teenagers. In another case, a migrant farm worker from the high- lands of Guatemala with an undocumented status has a different perspective than an immigrant from Mexico who has lived in New York City for 10 years.

**Ethics Across Cultures**

As globalization grows and population diversity with nations increases, health-care providers are increas- ingly confronted with ethical issues related to cultural diversity. At the extremes stand those who favor mul- ticulturalism and postmodernism versus those who favor humanism. Internationally, multiculturalism as- serts that no common moral principles are shared by all cultures. Postmodernism asserts a similar claim against all universal standards, both moral and im- moral. The concern is that universal standards provide a disguise, whereas dominant cultures destroy or erad- icate traditional cultures.

Humanism asserts that all human beings are equal in worth, that they have common resources and prob- lems, and that they are alike in fundamental ways (Macklin, 1999). Humanism does not put aside the many circumstances that make individuals’ lives dif- ferent around the world. Many similarities exist as to what people need to live well. Humanism says that cer- tain human rights should not be violated. Macklin (1998) asserts that universal applicability of moral principles is required, not universal acceptability. Beaucamp (1998) concurs that fundamental principles of morality and human rights allow for cross-cultural judgments of immoral conduct. Of course, there is a middle ground.

Throughout the world, practices are claimed to be cultural, traditional, and beneficial, even when they are exploitative and harmful. For example, female cir- cumcision, a traditional cultural practice, is seen by some as exploiting women. In many cases, the practice is harmful and can even lead to death. Although empirical, anthropological research has shown that different cultures and historical eras contain different moral beliefs and practices, it is far from certain that what is right or wrong can be determined only by the beliefs and practices within a particular culture or

subculture. Slavery and apartheid are examples of civil rights violations.

Accordingly, codes of ethics are open to interpre- tation and are not value-free. Furthermore, ethics be- long to the society, not to professional groups. Ethics and ethical decision making are culturally bound. The Western ethical principles of patient autonomy, self- determination, justice, do no harm, truth telling, and promise-keeping are highly valued, but not all cultures—non-Western societies—place such high regard on these values. For example, in Russia, the truth is optional, people are expected to break their promises, and most students cheat on examinations. Cheating on a business deal is not necessarily considered dishonorable (Birch, 2006).

In health organizations in the United States, ad- vance directives give patients the opportunity to de- cide about their care, and staff members are required to ask patients about this upon admission to a health- care facility. Western ethics, with its stress on individ- ualism, asks this question directly of the patient. However, in collectivist societies, such as among some ethnic Chinese and Japanese, the preferred person to ask may be a family member. In addition, translating health forms into other languages can be troublesome because a direct translation can be confusing. For ex- ample, “informed consent” may be translated to mean that the person relinquishes his or her right to decision making.

Some cultural situations occur that raise legal is- sues. For instance, in Western societies, a competent person (or an alternative such as the spouse, if the person is married) is supposed to sign her or his own consent for medical procedures. However, in some cul- tures, the eldest son is expected to sign consent forms, not the spouse. In this case, both the organization and the family can be satisfied if both the spouse and the son sign the informed consent.

Instead of Western ethics prevailing, some author- ities advocate for universal ethics. Each culture has its own definition of what is right or wrong and what is good or bad. Accordingly, some health-care providers encourage international codes of ethics, such as those developed by the International Council of Nurses (2010). These codes are intended to reflect the patient’s culture and whether the value is placed on individualism or collectivism. Most Western codes of ethics have interpretative statements based on the Western value of individualism. International codes of ethics do not contain interpretative statements but, rather, let each society interpret them according to its culture. As our multicultural society increases its di- versity, health-care providers need to rely upon ethics committees that include members from the cultures they serve.

As the globalization of health-care services increases, providers must also address very crucial issues, such as

cultural imperialism, cultural relativism, and cultural imposition. **Cultural imperialism** is the practice of ex- tending the policies and practices of one group (usually the dominant one) to disenfranchised and minority groups. An example is the U.S. government’s forced mi- gration of Native American tribes to reservations with individual allotments of lands (instead of group own- ership), as well as forced attendance of their children at boarding schools attended by white people. Proponents of cultural imperialism appeal to universal human rights values and standards (Purnell, 2001).

**Cultural relativism** is the belief that the behaviors and practices of people should be judged only from the context of their cultural system. Proponents of cultural relativism argue that issues such as abortion, euthanasia, female circumcision, and physical punish- ment in child rearing should be accepted as cultural values without judgment from the outside world. Opponents argue that cultural relativism may under- mine condemnation of human rights violations, and family violence cannot be justified or excused on a cul- tural basis (Purnell, 2001).

**Cultural imposition** is the intrusive application of the majority group’s cultural view upon individuals and families (Universal Declaration of Human Rights, 2001). Prescription of special diets without regard to patients’ cultures and limiting visitors to immediate family, a practice of many acute-care facilities, border on cultural imposition (Purnell, 2001).

Health-care providers must be cautious about forcefully imposing their values regarding genetic test- ing and counseling. No group is spared from genetic disease. Advances in technology and genetics have found that many diseases, such as Huntington‘s chorea, have a genetic basis. Some forms of breast and colon cancers, adult-onset diabetes, Alzheimer’s dis- ease, and hypertension are some of the newest addi- tions. Currently, only the well-to-do can afford broad testing. Advances in technology will provide the means for access to screening that will challenge genetic testing and counseling. The relationship of ge- netics to disability, individuals with a disability, and those with a potential disability will create moral dilemmas of new complexity and magnitude.

Many questions surround genetic testing. Should health-care providers encourage genetic testing? What is, or should be, done with the results? How do we approach testing for genes that lead to disease or

disability? How do we maximize health and well-being without creating a eugenic devaluation of those who have a disability? Should employers and third-party payers be allowed to discriminate based on genetic potential for illness? What is the purpose of prenatal screening and genetic testing? What are the assump- tions for state-mandated testing programs? Should parents and individuals be allowed to “opt out” of testing? What if the individual does not want to know the results? What if the results could have a deleterious outcome to the infant or the mother? What if the re- sults got into the hands of insurance companies that then denied payment or refused to provide coverage? Should public policy support genetic testing, which may improve health and health care for the masses of society? Should multiple births from fertility drugs be restricted because of the burden of cost, education, and health of the family? Should public policy encour- age limiting family size in the contexts of the mother’s health, religious and personal preferences, and the availability of sufficient natural resources (such as water and food) for future survival? What effect do these issues have on a nation with an aging popula- tion, a decrease in family size, and decreases in the numbers and percentages of younger people? What ef- fect will these issues have on the ability of countries to provide health care for their citizens? Health-care providers must understand these three concepts and the ethical issues involved because they will increasingly encounter situations in which they must balance the patient’s cultural practices and behaviors with health promotion and wellness, as well as illness, disease, and injury prevention activities for the good of the patient, the family, and society. Other international issues that may be less controversial include sustainable environ- ments, pacification, and poverty (Purnell, 2001).

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◗ *What practices have you seen that might be considered a cultural imposition?
What practices have you seen that might be considered cultural imperialism?*

*What practices have you seen that might be considered cultural relativism?
What have you done to address them when you have seen them occurring?*



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