Chapter 2

This chapter presents the Purnell Model for Cultural Competence, its organizing framework, and the assumptions upon which the model is based. In addition, American cultural values, practices, and beliefs are presented to assist non–native American health-care providers to understand American ways. The American references are meant to describe, not prescribe or predict, behaviors and practices. Although the authors recognize that Canada and Mexico are part of North America, American, as used in this chapter, refers to the dominant middle-class values of citizens of the mainland United States. Owing to space limitations, this chapter deals not with the objective culture—arts, literature, humanities, and so on—but rather with the subjective culture. Many Americans are not aware of the subjective culture because they identify differences as individual personality traits and disregard political and social origins of culture. Many view culture as something that belongs only to foreigners or disadvantaged groups. However, when Americans travel abroad, their host country inhabitants many times stereotypically identify them as Americans because of their values, beliefs, attitudes, behaviors, speech patterns, and mannerisms. Some feel that Americans are “fun lovers” and that, for some Americans, violence is a way of life. However, “the right to bear arms” is guaranteed by the Constitution. Most likely, the United States is not any more violent than, or even as violent as, many other societies, but American media coverage may be better than other countries, thereby giving the impression that the United States is more violent than it actually is. Accordingly, these stereotypes are not always accurate or desirable. Western academic and health-care organizations stress structure, systematization, and formalization when

studying complex phenomena such as culture and ethnicity. Given the complexity of individuals, the Purnell Model for Cultural Competence provides a comprehensive, systematic, and concise framework for learning and understanding culture. The empirical framework of the model can assist health-care providers, managers, and administrators in all health disciplines to provide holistic, culturally competent therapeutic interventions; health promotion and wellness; illness, disease, and injury prevention; health maintenance and restoration; and health teaching across educational and practice settings. The purposes of this model are to

1. Provide a framework for all health-care providers to learn concepts and characteristics of culture. 2. Deﬁne circumstances that affect a person’s cultural worldview in the context of historical perspectives. 3. Provide a model that links the most central relationships of culture. 4. Interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent health care. 5. Provide a framework that reﬂects human characteristics such as motivation, intentionality, and meaning. 6. Provide a structure for analyzing cultural data. 7. View the individual, family, or group within their unique ethnocultural environment.

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Assumptions Upon Which the Model Is Based

The major explicit assumptions upon which the model is based are 1. All health-care professions need similar information about cultural diversity. 2. All health-care professions share the metaparadigm concepts of global society, family, person, and health. 3. One culture is not better than another culture; they are just different. 4. Core similarities are shared by all cultures. 5. Differences exist within, between, and among cultures. 6. Cultures change slowly over time. 7. The primary and secondary characteristics of culture (see Chapter 1) determine the degree to which one varies from the dominant culture. 8. If clients are coparticipants in their care and have a choice in health-related goals, plans, and interventions, their compliance and health outcomes will be improved. 9. Culture has a powerful inﬂuence on one’s interpretation of and responses to health care. 10. Individuals and families belong to several subcultures. 11. Each individual has the right to be respected for his or her uniqueness and cultural heritage. 12. Caregivers need both culture-general and culture-speciﬁc information in order to provide culturally sensitive and culturally competent care. 13. Caregivers who can assess, plan, intervene, and evaluate in a culturally competent manner will improve the care of clients for whom they care. 14. Learning culture is an ongoing process that develops in a variety of ways, but primarily through cultural encounters (CampinhaBacote, 2006). 15. Prejudices and biases can be minimized with cultural understanding. 16. To be effective, health care must reﬂect the unique understanding of the values, beliefs, attitudes, lifeways, and worldview of diverse populations and individual acculturation patterns. 17. Differences in race and culture often require adaptations to standard interventions. 18. Cultural awareness improves the caregiver’s self-awareness. 19. Professions, organizations, and associations have their own culture, which can be analyzed using a grand theory of culture. 20. Every client encounter is a cultural encounter.

Overview of the Theory, the Model, and Organizing Framework

The Purnell model has been classiﬁed as holographic and complexity theory because it includes a model and organizing framework that can be used by all health-care providers in various disciplines and settings. The model is a circle, with an outlying rim representing global society, a second rim representing community, a third rim representing family, and an inner rim representing the person (Fig. 2–1). The interior of the circle is divided into 12 pieshaped wedges depicting cultural domains and their concepts. The dark center of the circle represents unknown phenomena. Along the bottom of the model, a jagged line represents the nonlinear concept of cultural consciousness. The 12 cultural domains (constructs) provide the organizing framework of the model. A box following the discussion of each domain provides statements that can be adapted as a guide for assessing patients and clients in various settings. Accordingly, health-care providers can use these same questions to better understand their own cultural beliefs, attitudes, values, practices, and behaviors.

MACRO ASPECTS OF THE MODEL The macro aspects of this interactional model include the metaparadigm concepts of a global society, community, family, person, and conscious competence. The theory and model are conceptualized from biology, anthropology, sociology, economics, geography, history, ecology, physiology, psychology, political science, pharmacology, and nutrition as well as theories from communication, family development, and social support. The model can be used in clinical practice, education, research, and the administration and management of health-care services or to analyze organizational culture. Phenomena related to a global societyinclude world communication and politics; conﬂicts and warfare; natural disasters and famines; international exchanges in education, business, commerce, and information technology; advances in health science; space exploration; and the expanded opportunities for people to travel around the world and interact with diverse societies. Global events that are widely disseminated by television, radio, satellite transmission, newsprint, and information technology affect all societies, either directly or indirectly. Such events create chaos while consciously and unconsciously forcing people to alter their lifeways and worldviews.

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Think of a recent event that has affected global society, such as conﬂict or war, health advances in technology, or recent travel and possible environmental exposure to health problems. How did you become aware of this event? How has this event altered your views and other people’s views of worldwide cultures?



In the broadest deﬁnition, community is a group of people having a common interest or identity and goes beyond the physical environment. Community includes the physical, social, and symbolic characteristics that cause people to connect. Bodies of water, mountains, rural versus urban living, and even railroad tracks help people deﬁne their physical concept of community.

Today, however, technology and the Internet allow people to expand their community beyond physical boundaries. Economics, religion, politics, age, generation, and marital status delineate the social concepts of community. Symbolic characteristics of a community include sharing a speciﬁc language or dialect, lifestyle, history, dress, art, or musical interest. People actively and passively interact with the community, necessitating adaptation and assimilation for equilibrium and homeostasis in their worldview. Individuals may willingly change their physical, social, and symbolic community when it no longer meets their needs. 22•CHAPTER 2

personal health status or the health status of the nation or community. Health can also be subjective or objective in nature.

How do you deﬁne your community in terms of objective and subjective cultural characteristics? How has your community changed over the last 5 to 10 years? The last 15 years? The last 20 years? If you have changed communities, think of the community in which you were raised.

Whom do you consider family? How have they inﬂuenced your culture and worldview? Who else has helped instill your cultural values?

A family is two or more people who are emotionally connected. They may, but do not necessarily, live in close proximity to each other. Family may include physically and emotionally close and distant consanguineous relatives as well as physically and emotionally connected and distant non–blood-related signiﬁcant others. Family structure and roles change according to age, generation, marital status, relocation or immigration, and socioeconomic status, requiring each person to rethink individual beliefs and lifeways.

A person is a biopsychosociocultural being who is constantly adapting to her or his community. Human beings adapt biologically and physiologically with the aging process; psychologically in the context of social relationships, stress, and relaxation; socially as they interact with the changing community; and ethnoculturally within the broader global society. In Western cultures, a person is a separate physical and unique psychological being and a singular member of society. The self is separate from others. However, in Asian and some other cultures, the individual is deﬁned in relation to the family or other group rather than a basic unit of nature.

In what ways have you adapted (1) biologically and physiologically to the aging process, (2) psychologically in the context of social relationships, (3) socially in your community, and (4) ethnoculturally within the broader society?

Health, as used in this book, is a state of wellness as deﬁned by the individual within his or her ethnocultural group. Health generally includes physical, mental, and spiritual states because group members interact with the family, community, and global society. The concept of health, which permeates all metaparadigm concepts of culture, is deﬁned globally, nationally, regionally, locally, and individually. Thus, people can speak about their

How do you deﬁne health? Is health the absence of illness, disease, injury, and/or disability? How does your profession deﬁne health? How does your nation or community deﬁne health? How do these deﬁnitions compare with your original ethnic background?

MICRO ASPECTS OF THE MODEL On a micro level, the model’s organizing framework comprises 12 domains and their concepts, which are common to all cultures. These 12 domains are interconnected and have implications for health. The utility of this organizing framework comes from its concise structure, which can be used in any setting and applied to a broad range of empirical experiences and can foster inductive and deductive reasoning in the assessment of cultural domains. Once cultural data are analyzed, the practitioner can fully adopt, modify, or reject health-care interventions and treatment regimens in a manner that respects the client’s cultural differences. Such adaptations improve the quality of the client’s health-care experiences and personal existence.

The Twelve Domains of Culture

The 12 domains essential for assessing the ethnocultural attributes of an individual, family, or group are 1. Overview, inhabited localities, and topography. 2. Communication. 3. Family roles and organization. 4. Workforce issues. 5. Biocultural ecology. 6. High-risk behaviors. 7. Nutrition. 8. Pregnancy and childbearing practices. 9. Death rituals. 10. Spirituality. 11. Health-care practices. 12. Health-care practitioners.

OVERVIEW, INHABITED LOCALITIES, AND TOPOGRAPHY This domain, overview, inhabited localities, and topography, includes concepts related to the country of origin, the current residence, the effects of the topography of the country of origin and current residence on health, economics, politics, reasons for migration, educational status, and occupations. These concepts are interrelated. For example, economic and political conditions may affect one’s reason for migration, and educational attainment is

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usually interrelated with employment choices and opportunities. Sociopolitical and socioeconomic conditions inﬂuence individual behavioral responses to health and illness. Learning about a culture includes becoming familiar with the heritage of its people and understanding how discrimination, prejudice, and oppression inﬂuence value systems and beliefs used in everyday life. Given the primary and secondary characteristics of diversity (see Chapter 1), cultural speciﬁc generalizations may not be part of a particular individual’s beliefs or value system. For most Americans, dominant cultural values and beliefs include individualism, free speech, rights of choice, independence and self-reliance, conﬁdence, “doing” rather than “being,” egalitarian relationships, nonhierarchal status of individuals, achievement status over ascribed status, “volunteerism,” friendliness, openness, futuristic temporality, ability to control the environment, and an emphasis on material things and physical comfort. These concepts are more fully described in other sections of this chapter. Given the size, population density, and diversity of the United States, one cannot generalize too much about American culture. Every generalization in this chapter is subject to exceptions, although most people will agree with the descriptions to some degree and on some level. Moreover, we believe the descriptions about the dominant American culture are true for white middle-class European Americans (and many other groups as well) who hold the majority of prestigious positions in the United States. The degree to which people conform to this dominant culture depends on the primary and secondary characteristics of culture discussed in Chapter 1 as well as individual personality differences. We recognize that some Americans do not think there is an American culture and resent any attempt at generalizations. Many foreigners believe that all Americans are rich, everyone lives in fancy apartments or houses, crime is everywhere, everyone drives an expensive gasoline-inefﬁcient car, and there is little or no poverty. For the most part, these misconceptions come from the media and Americans who travel overseas.

Heritage and Residence The United States comprises 3.5 million square miles and a population of nearly 300 million people, making it the world’s third most populous country (CIA Factbook, 2006). The United States is mostly temperate but tropical in Hawaii and Florida, arctic in Alaska, semiarid in the great plains west of the Mississippi River, and arid in the Great Basin of the southwest. Low winter temperatures in the northwest are ameliorated in January and February by warm Chinook winds from the eastern slopes of the Rocky Mounatins. There is a vast central plain; mountains in the west; hills and low mountains in the east; rugged mountains and broad river valleys in Alaska; and rugged, volcanic topography in Hawaii. When Europeans began settling the United States in the 16th century, approximately 2 million American Indians, who mostly lived in geographically isolated tribes, populated the land. The ﬁrst permanent European

settlement in the United States was St. Augustine, Florida, which was settled by the Spanish in 1565. The ﬁrst English settlement was Jamestown, Virginia, in 1607. By 1610, the nonnative population in the United States was only 350 people. By 1700, the population increased to 250,900; by 1800, to 5.3 million; and by 1900, to 75.9 million (Time Almanac, 2001). From 1607 until 1890, most immigrants to the United States came from Europe and essentially shared a common European culture. The plantation economy of the South paid for the forced relocation of natives from (primarily Western) Africa beginning in 1619 and ending with the American Civil War (1861–1865). This group did not share the common culture, and their acculturation was strongly inﬂuenced by their status as slaves. In the 1830s, a war with Mexico resulted in the annexation of greater Texas. From 1860 until 1865, the North and South fought over the issue of slavery, which resulted not only in the elimination of slavery but also in the industrialization of the North and the establishment of the United States as a major military power. The SpanishAmerican War (1898) resulted in the United States becoming a colonial power, with the annexation of Spain’s last colony in the Western Hemisphere, Cuba, and also its colony in the Philippines. World War I (1914–1918) established the United States as one of the world’s superpowers, and World War II (1939–1945) signiﬁcantly extended U.S. military power. In the postwar period, the ideological differences between the United States and the USSR resulted in the Cold War, which lasted until 1989. Today, U.S. military, cultural, and economic power affect almost every other country on the planet. The American colonies broke with the parent country, Britain, on July 4, 1776, and were recognized as the new nation of The United States of America with the original 13 colonies following the Treaty of Paris in 1783. During the 19th and 20th centuries, 37 new states were added to the original 13 as the nation expanded across the North American continent and acquired a number of overseas possessions. The Constitution of the Untied States was ratiﬁed in 1789 and included seven articles, which laid the foundation for an independent nation. The Bill of Rights, the ﬁrst 10 amendments to the Constitution, guarantees freedom of religion, speech, and the press; the right to petition, bear arms; and the right to a speedy trial. Only 17 additional amendments have been made to the Constitution. The 13th Amendment in 1865 prohibited slavery; the 14th Amendment in 1868 deﬁned citizenship and privileges of citizens; the 15th Amendment in 1870 gave suffrage rights regardless of race or color; and the 19th Amendment in 1920 gave women the right to vote. The United States is the world’s oldest constitutional democracy with three branches of government: (1) the executive branch, which includes the Ofﬁce of the President and the administrative departments; (2) the legislative branch, Congress, which includes both the Senate and the House of Representatives; and (3) the judicial branch, which includes the Supreme Court and the lesser federal courts. The Supreme Court has nine members appointed by the President and approved by Congress. The Justices serve a life term if they so choose. The THE PURNELL MODEL FOR CULTURAL COMPETENCE •23

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President serves a 4-year term and can be reelected only one time. The President is the Commander-in-Chief of the Armed Forces and oversees the executive departments. The members of the House of Representatives are divided among the states based on the population of each state. Members of the House of Representatives serve 2year terms. Each state has two senators, regardless of the population of the state. Senators serve 6-year terms. Each of the 50 states has its own constitution establishing, for the most part, a parallel structure to the federal government, with the executive branch headed by a governor, a state congress with representatives and senators, and a state court system. No limitations were placed on immigrants from Europe until the late 1800s. From 1892 to 1952, most European immigrants to America came through Ellis Island, New York, where they had to prove to ofﬁcials that they were ﬁnancially independent. More severe restrictions were placed on other immigrant groups, particularly those from Asia. In the 1960s, immigration policy changed to allow immigrants from all parts of the world without favoritism to or restrictions on ethnicity. Today, the United States includes immigrants or descendents from immigrants from almost every nation and culture of the world and is the world’s premier international nation. The United States admitted 52,868 refugees during ﬁscal year 2003–2004, including 13,331 from Somalia, 6000 from Laos, 3482 from Ukraine, 2959 from Cuba, and 1787 from Iran. As of June 2005, 32,229 refugees had been admitted (CIA Factbook, 2006). The United States has the largest and most technologically powerful economy in the world, with a per capita gross domestic product (GDP) of $42,000. In this marketoriented economy, private individuals and business ﬁrms make most of the decisions, and the federal and state governments buy needed goods and services predominantly in the private marketplace. U.S. business ﬁrms enjoy greater ﬂexibility than their counterparts in Western Europe and Japan in decisions to expand capital plant, to lay off surplus workers, and to develop new products. At the same time, they face higher barriers to enter their rivals’ home markets than foreign ﬁrms face entering U.S. markets. U.S. ﬁrms are at or near the forefront in technological advances, especially in computers and in medical, aerospace, and military equipment; their advantage has narrowed since the end of World War II. The on-rush of technology largely explains the gradual development of a “two-tier labor market,” in which those at the bottom lack the education and the professional/ technical skills of those at the top and, more and more, fail to get comparable pay raises, health insurance coverage, and other beneﬁts. Since 1975, practically all the gains in household income have gone to the top 20 percent of households. The response to the terrorist attacks of September 11, 2001, showed the remarkable resilience of the economy. The war in March–April 2003 between a U.S.-led coalition and Iraq, and the subsequent occupation of Iraq, required major shifts in national resources to the military. The rise in GDP in 2004 and 2005 was supported by substantial gains in labor productivity. Hurricane Katrina caused extensive damage in the Gulf Coast region in August 2005

but had a small impact on overall GDP growth for the year. Soaring oil prices in 2005 and 2006 threatened inﬂation and unemployment, yet the economy continued to grow through mid 2006. Imported oil accounts for about two-thirds of U.S. consumption. Long-term problems include inadequate investment in economic infrastructure, rapidly rising medical and pension costs of an aging population, sizable trade and budget deﬁcits, and stagnation of family income in the lower economic groups (CIA Factbook, 2006). People have been attracted to immigrate to the United States because of its vast resources and economic and personal freedoms, particularly the dogma that “all men are created equal.” Immigrants and their descendants achieved enormous material success, which further encouraged immigration.

Reasons for Migration and Associated Economic Factors The United States has a very large middle-class population and a small, but growing, wealthy population. Approximately 12.7 percent of the population lives in poverty, with higher rates among children (17.8 percent), older persons (20.5 percent), blacks (24.7 percent), and nonwhite Hispanics (21.9 percent) (U.S. Bureau of the Census: Poverty Rates, 2006c). The social, economic, religious, and political forces of the country of origin play an important role in the development of the ideologies and the worldview of individuals, families, and groups and are often a major motivating force for emigration. The earlier settlers in the United States came for better economic opportunities, because of religious and political oppression and environmental disasters such as earthquakes and hurricanes in their home countries, and by forced relocation such as slaves and indentured servants. Others have immigrated for educational opportunities and personal ideologies or a combination of factors. Most people immigrate in the hope of a better life; however, the individual or group personally deﬁnes this ideology. A common practice for many immigrants is to relocate to an area that has an established population with similar ideologies that can provide initial support, serve as cultural brokers, and orient them to their new culture and health-care system. For example, most people of Cuban heritage live in New York and Florida; French Canadians are concentrated in the Northeast; and the Amish are concentrated in Pennsylvania, Indiana, and Ohio. When immigrants settle and work exclusively in predominantly ethnic communities, primary social support is enhanced, but acculturation and assimilation into the wider society may be hindered. Groups without ethnic enclaves in the United States to assist them with acculturation may need extra help in adjusting to their new homeland’s language, access to health-care services, living accommodations, and employment opportunities. People who move voluntarily are likely to experience less difﬁculty with acculturation than people who are forced to emigrate. Some individuals immigrate with the intention of remaining in this country only a short time, making money, and returning home, whereas others immigrate with the intention of relocating permanently.

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Educational Status and Occupations The value placed on formal education differs among cultural and ethnic groups and is often related to their socioeconomic status in their homeland and their abilities and reasons for emigrating. The United States places a high value on education, which has recently become a major issue in federal and state elections. Some groups, however, do not stress formal education because it is not needed for employment in their homeland. Consequently, they may become engulfed in poverty, isolation, and enclave identity, which may further limit their potential for formal educational opportunities and planning for the future. In the United States, preparation in elementary and secondary education varies widely. There is no national curriculum that each school is expected to follow, although there is standardized testing at a national level, which is used in the selection process for admission to institutions of higher education. Most states require children to attend school until the age of 16, although the child can drop out of school at a younger age with parents’ signed permission. Overall, the United States has the goal of producing a well-rounded individual with a variety of courses and 100 percent literacy. Theoretically, people have the freedom to choose a profession, regardless of gender and background. Educational attainment in the United States varies by race, gender, and region of the country. Eighty-seven percent of all adults age 25 years and older have completed high school, and 27 percent have completed a bachelor’s degree or higher. Of Asians, 87.6 percent have completed high school and 49.8 percent have a bachelor’s degree or higher. Of blacks, only 80 percent have completed high school and 17.3 percent have a bachelor’s degree or higher. Of Hispanics, only 57 percent have completed high school and only 1.4 percent have a bachelor’s degree or higher (U.S. Bureau of the Census, 2006b). In regard to learning styles, the Western system places a high value on the student’s ability to categorize information using linear, sequential thought processes. However, not everyone adheres to this pattern of thinking. For example, many Native Americans, Asians, and others have spiral and circular thought patterns that move from concept to concept without being linear or sequential; therefore, they may have difﬁculty placing information in a stepwise methodology. When someone is unaware of the value given to such behaviors, she or he may see such individuals as disorganized, scattered, and faulty in their cognitive patterns, resulting in increased difﬁculty with written and verbal communications. The American educational system stresses application of content over theory. Most European educational programs emphasize theory over practical application, and Arab education emphasizes theory with little attention

given to practical application. As a result, Arab students are more proﬁcient at tests requiring rote learning than at those requiring conceptualization and analysis. Being familiar with the individual’s personal educational values and learning modes allows health-care providers, educators, and employers to adjust teaching strategies for clients, students, and employees. Educational materials and explanations must be presented at a level consistent with clients’ educational capabilities and within their cultural framework and beliefs. THE PURNELL MODEL FOR CULTURAL COMPETENCE •25

What is your cultural heritage? How might you ﬁnd out more about it? Does your cultural heritage inﬂuence your current beliefs and values about health and wellness? What brought you/your ancestors to your current country of residence? Why did you/your ancestors emigrate?

How strongly do you believe in the value of education? Who in your life is responsible for instilling this value? Do you consider yourself to be a more linear/sequential learner or a random-patterned learner?

Immigrants bring job skills from their native homelands and traditionally seek employment in the same or similar trades. Sometimes, these job skills are inadequate for the available jobs in the new society; thus, immigrants are forced to take low-paying jobs and join the ranks of theworking poor and economically disadvantaged. Immigrants to America are employed in a broad variety of occupations and professions; however, limited experiential, educational, and language abilities of more recent immigrants often restrict employment possibilities. More importantly, experiential backgrounds sometimes encourage employment choices that are identiﬁed as high risk for chronic diseases, such as exposure to pesticides and chemicals. Others may work in factories that manufacture hepatotoxic chemicals, in industries with pollutants that increase the risk for pulmonary diseases, and in crowded conditions with poor ventilation that increase the risk for tuberculosis or other respiratory diseases. Understanding clients’ current and previous work background is essential for health screening. For example, newer immigrants who worked in malaria-infested areas in their native country, such as Egypt, Italy, Turkey, and Vietnam to name a few, may need health screening for malaria. Those who worked in mining, such as in Ireland and Poland, may need screening for respiratory diseases. Those who lived in overcrowded and unsanitary conditions, such as refugees and migrant workers, may need to be screened for infectious diseases such as tuberculosis, parasitosis, and respiratory diseases. Box 2–1 identiﬁes guidelines for assessing the cultural domain overview, inhabited localities, and topography.

COMMUNICATION Perhaps no other domain has the complexities of communication. Communication is interrelated with all other domains and depends on verbal language skills that include the dominant language, dialects, and the contextual use of the language as well as paralanguage variations, such as voice volume, tone, intonations, reﬂections, and willingness to share thoughts and feelings. Other important communication characteristics include nonverbal communications such as eye contact, facial

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expressions, use of touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, or future orientation of worldview; clock versus social time; and the degree of formality in theuse of names. Communication styles may vary between insiders (family and close friends) and outsiders (strangers and unknown health-care providers). Hierarchical relationships, gender, and some religious beliefs affect communication.

Dominant Language and Dialects The health-care provider must be aware of the dominant language and the difﬁculties that dialects may cause when communicating in the client’s native language. American English is a monochromic, low-contextual language in which most of the message is in the verbal mode, and verbal communication is frequently seen as being more important than nonverbal communication. Thus, Americans are more likely to miss the more subtle nuances of communication. Accordingly, if a misunderstanding occurs, both the sender and the receiver of the message take responsibility for the miscommunication. Americans speak American English, which differs somewhat in its pronunciation, spelling, and choice of words from English spoken in Great Britain, Australia, and other English-speaking countries. Within the United States, several dialects exist, but generally the differences do not cause a major concern with communications. Aside from people with foreign accents, in certain areas of the United States people speak with a dialect; these include the South and Northeast, in addition to local dialects such as “Elizabethan English” and “western drawl.” For the most part, these dialects and accents are not as different as in

some other countries; for example, the English spoken in Glasgow, Scotland, is utterly unlike the English spoken in Central London. The Spanish spoken in Spain differs from the versions spoken in Puerto Rico, Panama, or Mexico, which has as many as 50 different dialects within its borders. In such cases, dialects that vary widely may pose substantial problems for health-care providers and interpreters in performing health assessments and in obtaining accurate health data, in turn increasing the difﬁculty of making accurate diagnoses. Of the nearly 300 million people in the United States, almost 250 million were born in the United States. When language ability is looked at, 217 million speak only English, 23 million speak English less than very well, and 52 million speak a language other than English (CIA Factbook, 2006).

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BOX 2.1 Overview, Inhabited Localities, and Topography Overview, Inhabited Localities, and Topography 1. Identify the part of the world from which this cultural or ethnic group originates and describe the climate and topography of the country. Heritage and Residence 2. Identify where this group predominantly resides and include approximate numbers. Reasons for Migration and Associated Economic Factors 3. Identify major factors that motivated this group to emigrate. 4. Explore economic or political factors that have inﬂuenced this group’s acculturation and professional development in America. Educational Status and Occupations 5. Assess the educational attainment and value placed on education by this ethnic group. 6. Identify occupations that individuals in this group predominantly seek on immigration.

What is your dominant language? Do you have difﬁculty understanding other dialects of your dominant language? Have you traveled abroad where you had difﬁculty understanding the dialect or accent? What other languages beside your dominant language do you speak?

When speaking in a nonnative language, health-care providers must select words that have relatively pure meanings, be certain of the voice intonation, and avoid the use of regional slang and jargon to avoid being misunderstood. Minor variations in pronunciation may change the entire meaning of a word or a phrase and result in inappropriate interventions. Given the difﬁculty of obtaining the precise meaning of words in a language, it is best for health-care providers to obtain someone who can interpret the meaning and message, not just translate the individual words. Remember, translation refers to the written word and interpretation refers to the spoken word. Children should never be used as interpreters for their family members. Not only does it have a negative bearing on family dynamics, but sensitive information may not be transmitted. California’s law Government Code 7290 et seq. prohibits using children as interpreters. Here are some guidelines for communicating with non–English-speaking clients: 1. Use interpreters who can decode the words and provide the meaning behind the message. 2. Use dialect-speciﬁc interpreters whenever possible. 3. Use interpreters trained in the health-care ﬁeld. 4. Give the interpreter time alone with the client. 5. Provide time for translation and interpretation. 6. Use same-gender interpreters whenever possible. 7. Maintain eye contact with both the client and the interpreter to elicit feedback: read nonverbal cues. 8. Speak slowly without exaggerated mouthing, allow time for translation, use the active rather than the passive tense, wait for feedback, and

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restate the message. Do not rush; do not speak loudly. 9. Use as many words as possible in the client’s language and nonverbal communication when unable to understand the language. 10. Use phrase charts and picture cards if available. 11. During the assessment, direct your questions to the patient, not to the interpreter. 12. Ask one question at a time and allow interpretation and a response before asking another question. 13. Be aware that interpreters may affect the reporting of symptoms, insert their own ideas, or omit information. 14. Remember that clients can usually understand more than they can express; thus, they need time to think in their own language. They are alert to the health-care provider’s body language, and they may forget some or all of their English in times of stress. 15. Avoid the use of relatives, who may distort information or not be objective. 16. Avoid using children as interpreters, especially with sensitive topics. 17. Avoid idiomatic expressions and medical jargon. 18. If a certiﬁed interpreter is unavailable, the use of a translator may be acceptable. The difﬁculty with translation is omission of parts of the message, distortion of the message, including transmission of information not given by the speaker and messages not being fully understood. 19. If available, use an interpreter who is older than the patient. 20. Review responses with the patient and interpreter at the end of a session. 21. Be aware that social class differences between the interpreter and the client may result in the interpreter’s not reporting information that he or she perceives as superstitious or unimportant. Those with limited English ability may have inadequate vocabulary skills to communicate in situations in which strong or abstract levels of verbal skills are required, such as in the psychiatric setting. Helpful communication techniques with diverse clients include tact, consideration, and respect; gaining trust by listening attentively; addressing the client by preferred name; and showing genuine warmth and openness to facilitate full information sharing. When giving directions, be explicit. Give directions in sequential procedural steps (e.g., ﬁrst, second, third). Do not use complex sentences with conjunctions or contractions.

Before trying to engage in more sensitive areas of the health interview, the health-care practitioner may need to start with social exchanges to establish trust, use an openended format rather than yes or no closed-response questions, elicit opinions and beliefs about health and symptom management, and focus on facts rather than feelings. An awareness of nonverbal behaviors is essential to establishing a mutually satisfying relationship. The context within which a language is spoken is an important aspect of communication. The German, English, and French languages are low in context, and most of the message is explicit, requiring many words to express a thought. Chinese and Native American languages are highly contextual, with most of the information either in the physical context or internalized, resulting in the use of fewer words with more emphasis on unspoken understandings. Voice volume and tone are important paralanguage aspects of communication. Americans and people of African heritage may be perceived as being loud and boisterous because their volume carries to those nearby. Compared with Chinese and Hindus, Americans and African Americans generally talk loudly. Their loud voice volume may be interpreted by Chinese or Hindus as reﬂecting anger, when in fact a loud voice is merely being used to express their thoughts in a dynamic manner. In contrast, Westerners witnessing impassioned communication among Arabs may interpret the excited speech pattern and shouting as anger, but emotional communication is part of the Arab culture and is usually unrelated to anger. Thus, health-care providers must be cautious about voice tones when interacting with diverse cultural groups so their intentions are not misunderstood. In addition, the speed at which people speak varies by region; for example, in parts of Appalachia and the South, people speak more slowly than do people in the northeastern part of the United States. THE PURNELL MODEL FOR CULTURAL COMPETENCE •27

Give some examples of problems communicating with patients who did not speak or understand English. What did you do to promote effective communication?

On a scale of 1 to 10, with 1 low and 10 high, where do you place yourself in the scale of highcontextual versus low-contextual communication? Do you tend to use a lot of words to express a thought? Do you know family members/friends/ acquaintances who are your opposite in terms of low-contextual versus high-contextual communication? Does this sometimes cause concerns in communication? Do you think biomedical language is high or low context?

Cultural Communication Patterns Communication includes the willingness of individuals to share their thoughts and feelings. Many Americans are willing to disclose very personal information about themselves, including information about sex, drugs, and family problems. In fact, personal sharing is encouraged in a wide variety of topics, but not religion as in Central America, politics as in Spain, or philosophical things as discussed in most of Europe. In the United States, having

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well-developed verbal skills is seen as important, whereas in Japan, the person who has very highly developed verbal skills is seen as having suspicious intentions. Similarly, among many Appalachians, the person who has welldeveloped verbal skills may be seen as a “smooth talker”; and therefore, her or his actions may be suspect. In some cultural groups, such as many Asian cultures, individuals are expected to be shy, withdrawn, and difﬁdent—at least in public—whereas in other cultures, such as Jewish and Italian, individuals are expected to be more ﬂamboyant and expressive. Most Appalachians and Mexicans willingly share their thoughts and feelings among family members and close friends, but they may not easily share thoughts, feelings, and health information with “outside” health-care providers until they get to know them. By engaging in small talk and inquiring about family members before addressing the client’s health concerns, health-care providers can help establish trust and, in turn, encourage more open communication and sharing of important health information.

fortable standing closer to each other than Americans; in fact, they interpret physical proximity as a valued sign of emotional closeness. Middle Eastern clients, who stand very close and stare during a conversation, may offend health-care practitioners. These clients may interpret American health-care providers as being cold because they stand so far away. An understanding of personal space and distancing characteristics can enhance the quality of communication among individuals.

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How willing are you to share personal information about yourself? How does it differ with family, friends, or strangers? Do you tend to speak faster, slower, or about the same rate as the people around you? What happens when you meet someone who speaks much more rapidly or much more slowly than you do? Do you normally speak in a loud or low voice volume? How do you respond when someone speaks louder or softer than you do?

Touch, a method of nonverbal communication, has substantial variations in meaning among cultures. For the most part, America is a low-touch society, which has recently been reinforced by sexual harassment guidelines and policies. For many, even casual touching may be seen as a sexual overture and should be avoided whenever possible. People of the same sex (especially men) or opposite sex do not generally touch each other unless they are close friends. However, among most Asian cultures, two people of the same gender can touch each other without it having a sexual connotation. Among Egyptian Americans, touch between opposite sexes is accepted in private and only between husband and wife, parents and children, and adult brothers and sisters; it is less readily accepted from strangers. Mexican Americans, even though they frequently touch family members and friends, tend to be modest during health-care examinations by the opposite gender. Always explain the necessity and ask permission before touching a client for a health examination. Being aware of individual practices regarding touch is essential for effective health assessments. Personal space needs to be respected when working with multicultural clients and staff. American, Canadian, and British conversants tend to place at least 18 inches of space between themselves and the person with whom they are talking. Arabs require less personal space when talking with each other (Hall, 1990). They are quite com

How comfortable are you being touched on the arm or shoulder by friends? By people who know you well? Do you consider yourself to be a “person who touches frequently” or do you rarely touch friends? Can you think of groups in the clinical setting for whom therapeutic touch is not appropriate?

Regardless of class or social standing of the conversants, Americans are expected to maintain direct eye contact without staring. A person who does not maintain eye contact may be perceived as not listening, not being trustworthy, not caring, or being less than truthful. Among traditional Mexicans, Cubans, Puerto Ricans, Iranians, Egyptians, Italians, and Greeks, sustained eye contact between a child and an older adult may bring on the “evil eye” or “bad eye.” In many Asian cultures, a person of lower social class or status should avoid eye contact with superiors or those with a higher educational status. Thus, eye contact must be interpreted within its cultural context to optimize relationships and health assessments. The use of gestures and facial expressions varies among cultures. Most Americans gesture moderately when conversing and smile easily as a sign of pleasantness or happiness, although one can smile as a sign of sarcasm. A lack of gesturing can mean that the person is too stiff, too formal, or too polite. However, when gesturing to make, emphasize, or clarify a point, one should not raise one’s elbows above the head unless saying hello or good-bye. Americans, unlike the Japanese and Chinese, do not normally smile as a form of embarrassment, confusion, or not understanding. For the Japanese and Chinese, happiness hides behind a straight face; if you are truly happy, you do not need to smile.

What are your spatial distancing practices? How close do you stand to family? Friends? Strangers? Does this distancing remain the same with the opposite gender? Do you maintain eye contact when speaking with people? Is it intense? Does it vary with the age or gender of the person with whom you are conversing? What does it mean when someone does not maintain eye contact with you? How do you feel in this situation?

Preferred greetings and acceptable body language also vary among cultural groups. An expected practice for

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American men and women in business is to extend the right hand when greeting someone for the ﬁrst time. In northern European countries, it is considered rude and impolite to converse with one’s hands in the pockets. In the United States, conﬁdence and competence are associated with a relaxed posture; however, in Korea and Japan, conﬁdence and competence are more closely associated with slightly tense postures (Krebs & Kunimoto, 1994). More elaborate greeting rituals occur in Asian, Arab, and Latin American countries and are covered in individual chapters. Although many people consider it impolite or offensive to point with one’s ﬁnger, many Americans do so, and do not see it as impolite. In Iran, beckoning is done by waving the ﬁngers with the palm down, whereas extending the thumb, like thumbs-up, is considered a vulgar sign. Among the Vietnamese, signaling for someone to come by using an upturned ﬁnger is a provocation, usually done to a dog. Among the Navajo, it is considered rude to point; rather, the Navajo shift their lips toward the desired direction.

iting friends or meeting for strictly social engagements, punctuality is less important, but one is still expected to appear within a “reasonable” time frame. In the healthcare setting if an appointment is made for 9 a.m., the person is expected to be there at 8:45 a.m. so she or he is ready for the appointment and does not delay the healthcare provider. Some organizations refuse to see the patient if they are more than 15 to 30 minutes late for an appointment; a few charge a fee, even though the patient was not seen, giving the impression that money is more important than the person. In other cultures, patients are seen whenever they arrive. For immigrants from rural settings, time may be even less important. These individuals may not even own a timepiece or be able to tell time. Expectations for punctuality can cause conﬂicts between health-care providers and clients, even if one is cognizant of these differences. These details must be carefully explained to individuals when such situations occur. Being late for appointments should not be misconstrued as a sign of irresponsibility or not valuing one’s health. THE PURNELL MODEL FOR CULTURAL COMPETENCE •29

Do you tend to use your hands a lot when speaking? Can people tell your emotional state by your facial expressions?

Temporal Relationships Temporal relationships, people’s worldview in terms of past, present, and future orientation, vary among individuals and among cultural groups. The American culture is future-oriented, and people are encouraged to sacriﬁce for today and work to save and invest in the future. The future is important in that people can inﬂuence it. Americans generally see fatalism, the belief that powers greater than humans are in control, as negative; but to many others, it is seen as a fact of life not to be judged. For example, the German culture is regarded as a past-oriented society, in which laying a proper foundation by providing historical background information can enhance communication. Most people of Central American heritage are more present oriented, placing great importance on the here and now, not something that may occur in the future or has occurred in the past. However, for people in many societies, temporality is balanced among past, present, and future in the sense of respecting the past, valuing and enjoying the present, and saving for the future. Differences in temporal orientation can cause concern or misunderstanding among health-care providers. For example, in a future-oriented culture, a person is expected to delay purchase of nonessential items to afford prescription medications. However, in less future-oriented cultures, the person buys the nonessential item because it is readily available and defers purchasing the prescription medication. The attitude is, why not purchase it now— the prescription medication can be purchased mañana (tomorrow or later). Americans see time as a highly valued resource and do not like to be delayed because it “wastes time.” When vis

How timely are you with professional appointments? With social engagements? What does it mean to you when people are chronically late? Can you give examples indicating that you are past oriented? Present oriented? Future oriented? Do you consider yourself more one than the other?

Format for Names Names are important to individuals, and their format differs among cultures. The American name “David Thomas Jones” denotes a man whose ﬁrst name is “David,” middle name is “Thomas,” and family surname is “Jones.” Friends would call him by his ﬁrst name, “David.” In the formal setting, he would be called “Mr. Jones.” In addition, he could also have a “nickname” that would be used by family and close friends, for example, “Davy” from his ﬁrst name or “Tom” or “Tommy” from his middle name. Hispanics may have a more complex system for denoting their full name. For example, a married woman may take her husband’s surname while maintaining both of her parents’ last names, resulting in an extended name such as “La Senora Roberta Rodriguez de Malena y Perez.” In this example, Mrs. Rodriguez has the ﬁrst name of “Roberta,” her husband’s surname “Rodriguez,” her mother’s maiden name “Malena,” and her father’s surname “Perez.” Friends would address her as “Roberta,” whereas in the formal setting, she would be called “Mrs. Rodriguez.” This extended name format may become even more confusing because one’s last name can be, for example, “de la Caza.” Therefore, a single woman’s name might be “Angelica [ﬁrst name] Elena [middle name] de la Caza [family name] y de la Cruz [mother’s maiden name].” She may choose any name she wants for legal purposes. When in doubt, the health-care provider needs to ask which name is used for legal purposes. Such extensive naming formats can create a challenge for health-care

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workers keeping a medical record when they are unaware of differences in ethnic recording of names.

FAMILY ROLES AND ORGANIZATION The cultural domain of family roles and organizationaffects all other domains and deﬁnes relationships among insiders and outsiders. This domain includes concepts related to the head of the household, gender roles, family goals and priorities, developmental tasks of children and adolescents, roles of the aged and extended family members, individual and family social status in the community, and acceptance of alternative lifestyles such as single parenting, nontraditional sexual orientations, childless marriages, and divorce. Family structure in the context of the larger society determines acceptable roles, priorities, and the behavioral norms for its members.

Head of Household and Gender Roles An awareness of family decision-making patterns (i.e., patriarchal, matriarchal, or egalitarian) is important for determining with whom to speak when health-care decisions have to be made. Among Americans, it is acceptable for women to have a career and for men to assist with child care, household domestic chores, and cooking responsibilities. Both parents work in many families, necessitating placing children in child-care facilities. In some families, fathers are responsible for deciding when to seek health care for family members, but mothers may have signiﬁcant inﬂuence on ﬁnal decisions. Among many Hispanics, the decisions may be egalitarian, but the male’s role in the family is to be the spokesperson for the family. The health-care provider, when speaking with parents, should maintain eye contact and direct questions about a child’s illness to both parents.

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How do you prefer to be addressed or greeted? Does this change with the situation? How do you normally address and greet people? Do your responses change with the situation?

BOX 2.2

Communications Dominant Language and Dialects 1. Identify the dominant and other languages spoken by this group. 2. Identify dialects that may interfere with communication. 3. Explore contextual speech patterns of this group. What is the usual volume and tone of speech? Cultural Communication Patterns 4. Explore the willingness of individuals to share thoughts, feelings, and ideas. 5. Explore the practice and meaning of touch in their society: within the family, between friends, with strangers, with members of the same sex, with members of the opposite sex, and with health-care providers. 6. Identify personal spatial and distancing characteristics when communicating on a one-to-one basis. Explore how distancing changes with friends versus strangers. 7. Explore the use of eye contact within this group. Does avoidance of eye contact have special meanings? How does eye contact vary among family, friends, and strangers? Does eye contact change among socioeconomic groups? 8. Explore the meaning of various facial expressions. Do speciﬁc facial expressions have special meanings? How are emotions displayed or not displayed in facial expressions? 9. Are there acceptable ways of standing and greeting outsiders? Temporal Relationships 10. Explore temporal relationships in this group. Are individuals primarily past, present, or future oriented? How do individuals see the context of past, present, and future? 11. Identify how differences in the interpretation of social time versus clock time are perceived. 12. Explore how time factors are interpreted by this group. Are individuals expected to be punctual in terms of jobs, appointments, and social engagements? Format for Names 13. Explore the format for a person’s names. 14. How does one expect to be greeted by strangers and health-care practitioners?

Box 2–2 identiﬁes guidelines for assessing the cultural domain communication.

How would you classify the decision making in your family—patriarchal, matriarchal, or egalitarian? Does it vary by what decision has to be made? Are gender roles prescribed in your family? Who makes the decisions about health and health care?

Prescriptive, Restrictive, and Taboo Behaviors for Children and Adolescents Every society has prescriptive, restrictive, and taboo practices for children and adolescents. Prescriptive beliefs are things that children or teenagers should do to have harmony with the family and a good outcome in society. Restrictive practices are things that children and teenagers should not do to have a positive outcome. Taboo practices are those things that, if done, are likely to cause signiﬁcant concern or negative outcomes for the child, teenager, family, or community at large. For most Americans, a child’s individual achievement is valued over the family’s ﬁnancial status. This is different from non-Western cultures in which attachment to family may be more important and the need for children to excel individually is not as important. In most middleand upper-class American families, children have their own room, television, and telephone, and in many

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homes, their own computer. At younger ages, rather than having group toys each child has his or her own toys and is taught to share them with others. Americans encourage autonomy in children, and after completing homework assignments (with which parents are expected to help), children are expected to contribute to the family by doing chores such as taking out the garbage, washing dishes, cleaning their own room, feeding and caring for pets, and helping with cooking. They are not expected to help with heavy labor at home except in rural farm communities. Children are allowed and encouraged to make their own choices, including managing their own money allowance and deciding who their friends might be, although parents may gently suggest one friend might be a better choice than another. American children and teenagers are permitted and encouraged to have friends of the same and opposite gender. They are expected to be well behaved, especially in public. They are taught to stand in line—ﬁrst come, ﬁrst served—and to wait their turn. As they reach the teenage years, they are expected to refrain from premarital sex, smoking, using recreational drugs, and drinking alcohol until they leave the home. However, this does not always occur and teenage pregnancy and use of recreational alcohol and drugs remains high. When children become teenagers, most are expected to get a job, such as baby sitting, delivering newspapers, or doing yard work to make their own spending money, which they manage as a way of learning independence. The teenage years are also seen as a time of natural rebellion. In American society, when young adults become 18 or complete their education, they usually move out of their parents’ home (unless they are in college) and live independently or share living arrangements with nonfamily members. More single males (59 percent) than single females (48 percent) over the age of 18 years elect to live with their parents (U.S. Bureau of the Census, 2006a). If the young adult chooses to remain in the parents’ home, then she or he might be expected to pay room and board. However, young adults are generally allowed to return home when they are needed or for ﬁnancial or other purposes. Individuals over the age of 18 are expected to be self-reliant and independent, which are virtues in the American culture. This differs from other cultures, such as the Japanese and some Hispanic cultures, in which children are expected to live at home with their parents until they marry, because dependence, not independence, is the virtue. Adolescents have their own subculture, with its own values, beliefs, and practices that may not be in harmony with those of their major ethnic group. Being in harmony with peers and conforming to the prevalent choice of music, clothing, hairstyles, and adornment may be especially important to adolescents. Thus, role conﬂicts can become considerable sources of family strain in many more-traditional families who may not agree with the American values of individuality, independence, selfassertion, and egalitarian relationships. Many teens may experience a cultural dilemma with exposure outside the home and family. As outsiders, health-care practitioners in school health can have a signiﬁcant role in providing factual informa

tion regarding issues related to sexuality. Expressing an openness to discuss these sensitive issues in a group or one-on-one format within their cultural context may assist teenagers to learn more about sexuality and primary prevention. Health-care providers can assist adolescents and family members to work through these cultural differences by helping them resolve personal conﬂicts in ways that convey respect for the family’s culture. However, in some religions, parental permission may be needed to discuss sexual issues with their children. Discussing personal parenting practices and providing information about disease, illness, and treatment in culturally congruent ways encourage individuals to explore alternative beliefs while continuing to value their own culture. THE PURNELL MODEL FOR CULTURAL COMPETENCE •31

Were you taught to be independent and autonomous or dependent in your family? Was there more emphasis on the individual or on the group?

Family Goals and Priorities American family goals and priorities are centered on raising and educating children. During this stage in the American culture, young adults make a personal commitment to a spouse or signiﬁcant other and seek satisfaction through productivity in career, family, and civic interests. In most societies, young adulthood is the time when individuals work on Erikson’s developmental tasks of intimacy versus isolation and generativity versus stagnation. The median age at ﬁrst marriage and unwed pregnancy in the United States has changed signiﬁcantly over the last century and varies by the part of the country. In the 1890s, the median age at ﬁrst marriage for men was 21.6 years, and for women, 22.0 years. By the 1920s, the median age at ﬁrst marriage for men increased to 22.8 years, while it remained relatively stable for women at 20.3 years. By 2004, the age at ﬁrst marriage for men increased to 26.7 years, and to 25.1 years for women (U.S. Bureau of the Census, 2006a). Southern states and the District of Columbia also tend to have a higher percentage of unwed mothers with infants compared with the national average. These include the District of Columbia, 53.4 percent; Mississippi, 45.7 percent; and Louisiana, 40.2 percent of all mothers. The states with the lowest percentages of unwed mothers with infants were Utah, 14.7 percent; Minnesota, 20.6 percent; and Idaho, 21.6 percent (U.S. Bureau of the Census, 2006a). The American culture places a high value on children, and many laws have been enacted to protect children who are seen as the “future of the society.” In most Asian cultures, children are desirable and highly valued as a source of family strength, and family members are expected to care for each other more so than in the American culture. The United States has seen an explosion in its older population during the 20th century, up from 3.1 million in 1900 to over 47 million in 2006 being over the age of 65 years. This population is expected to increase by

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74 percent by 2030 (U.S. Bureau of the Census, 2006a). The American culture, which emphasizes youth, beauty, thinness, independence, and productivity, contributes to some societal views of the aged as less important members and tends to minimize the problems of older people. A contrasting view among some Americans emphasizes the importance of older people in society. Chinese and Appalachian cultures have great reverence for the wisdom of older people, and families eagerly make space for them to live with extended families. Children are expected to care for elders when the elders are unable to care for themselves. A great embarrassment may occur to family members when they cannot take care of their older family members. Helping the ethnic family to network and ﬁnd social support, resources, or acceptable long-term-care facilities within the community is a useful strategy for the health-care provider. The concept of extended family membership varies among societies. The extended family is extremely important in the Hispanic/Latino/Spanish cultures, and healthcare decisions are often postponed until the entire family is consulted. The extended family may include biological relatives and nonbiological members who may be considered brother, sister, aunt, or uncle. In some Asian cultures, the inﬂuence of grandparents in decision making is considered more important than that of the parents. An accepted practice among Filipinos is for the grandparents to raise the grandchildren so that the parents can work. Grandparents, aunts, and cousins often assume the parental role in African American families, and fellow church members are frequently considered important members of the extended family. A common practice in such cultures is for several generations of a family to live in the same household, providing an ideal situation for health teaching. The health-care provider can have a signiﬁcant impact on the health status of the extended family in primary care, home health, acute care, or longterm care. Americans also place a high value on egalitarianism, nonhierarchical relationships, and equal treatment regardless of their race, color, religion, ethnicity, educational or economic status, sexual orientation, or country of origin. However, these beliefs are theoretical and notalways seen in practice. For example, women still have a lower status than men, especially when it comes to prestigious positions and salaries. Most top-level politicians and corporate executive ofﬁcers are white men. Subtle classism does exist, as evidenced by comments referring to “working-class men and women.” Despite the current inequities, Americans value equal opportunities for alland signiﬁcant progress has been made since about 1980. Americans are known worldwide for their informality and for treating everyone the same. They call people by their ﬁrst names very soon after meeting them, whether in the workplace, in social situations, in classrooms, in restaurants, or in places of business. Americans readily talk with waitstaff and store clerks and call them by their ﬁrst names. Most Americans consider this respectful behavior. Formality can be communicated by using the person’s last (family) name and title such as Mr., Mrs., Miss, Ms., or Dr. To this end,

Alternative Lifestyles The traditional American family is nuclear, with a married man and woman living together with one or more unmarried children. The American family is becoming a more varied community, including (1) unmarried people, both women and men, living alone; (2) single people of the same or different genders living together with or without children; (3) single parents with children; (4) and blended families consisting of two parents who have remarried, with children from their previous marriages and additional children from their current marriage. However, in some cultures, the traditional family is extended, with parents, unmarried children, married children with their children, and grandparents all sharing the same living space or at least living in very close proximity. The newest category of family, domestic partnerships, is sanctioned by many cities or counties in the United States and grants some of the rights of traditional married couples to unmarried heterosexual, homosexual, older people, and disabled couples who share the traditional bond of the family. Courts in some states allow gay and lesbian couples to adopt children. Among more rural subcultures, same-sex couples living together may not be as accepted or recognized in the community as they are in larger cities. As gay parents have become more visible, lesbian and gay parenting groups have started in many cities across the United States to offer information, support, and guidance, resulting in more lesbians and gay men considering parenthood through adoption and artiﬁcial insemination. Social attitudes toward homosexual activity vary widely, and homosexual behavior occurs in societies that deny its presence. Homosexual behavior carries a severe stigma in some societies. To discover that one’s son or daughter is homosexual is akin to a catastrophic event for Egyptian Americans. In Iran and in some provinces of

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achieved status is more important than ascribed status. What one has accumulated in material possessions, where one went to school, and one’s job position and title are more important than one’s family background and lineage. However, in some families in the South and the Northeast, one’s ascribed status has equal importance to achieved status. The United States does not have a caste or class system, and theoretically, one can move readily from one socioeconomic position to another. To many Americans, if formality is maintained, it may be seen as pompous or arrogant, and some even deride the person who is very formal. However, formality is a sign of respect in many other cultures and is also valued by older Americans.

What were prescriptive behaviors for you as a child? As a teenager? As a young adult? What were restrictive behaviors for you as a child? As a teenager? As a young adult? What were taboo behaviors for you as a child? As a teenager? As a young adult? How are elders regarded in your culture? In your family?

Alternative Lifestyles The traditional American family is nuclear, with a married man and woman living together with one or more unmarried children. The American family is becoming a more varied community, including (1) unmarried people, both women and men, living alone; (2) single people of the same or different genders living together with or without children; (3) single parents with children; (4) and blended families consisting of two parents who have remarried, with children from their previous marriages and additional children from their current marriage. However, in some cultures, the traditional family is extended, with parents, unmarried children, married children with their children, and grandparents all sharing the same living space or at least living in very close proximity. The newest category of family, domestic partnerships, is sanctioned by many cities or counties in the United States and grants some of the rights of traditional married couples to unmarried heterosexual, homosexual, older people, and disabled couples who share the traditional bond of the family. Courts in some states allow gay and lesbian couples to adopt children. Among more rural subcultures, same-sex couples living together may not be as accepted or recognized in the community as they are in larger cities. As gay parents have become more visible, lesbian and gay parenting groups have started in many cities across the United States to offer information, support, and guidance, resulting in more lesbians and gay men considering parenthood through adoption and artiﬁcial insemination. Social attitudes toward homosexual activity vary widely, and homosexual behavior occurs in societies that deny its presence. Homosexual behavior carries a severe stigma in some societies. To discover that one’s son or daughter is homosexual is akin to a catastrophic event for Egyptian Americans. In Iran and in some provinces of China, a lesbian or gay man may be killed. In February 2001, a judge in Somalia sentenced two Somali lesbians to death for “exercising unnatural behavior” (Judge orders Executions, 2001).

Do you consider your family nuclear or extended? How close are you to your extended family? How is status measured in your family? By money or by some other attribute? What are your personal views of two people of the same gender living together in a physical relationship? What about heterosexual couples? Does divorce cause a stigma in your culture? In your family?

When the health-care provider needs to provide assistance and make a referral for a person who is gay, lesbian, bisexual, or transsexual, a number of options are available. Some referral agencies are local, whereas others are national, with local or regional chapters. Many are ethnically or religiously speciﬁc. Some national groups that have links to local and regional organizations include the following: Gay, Lesbian, and Straight Education Network, http://www.glsen.org National Latino(a) Lesbian, Gay, Bisexual, and Trans-gender Organization, http://www.lego.org Parents, Families, and Friends of Lesbians and Gays, http://www.pﬂag.org National Center for Lesbian Rights, http://www.info @nclrights.org Log Cabin Republicans, http://www.lcr.org National Stonewall Democratic Federation, http:// www.stonewalldemocrats.org National Youth Advocacy Coalition, http://www.nyacyouth.org Family Pride Coalition, http://www.familypride.org It’s Time, America, http://www.gender.org BINET U.S., http://www.binetUS.org National Black, Lesbian, and Gay Leadership Forum, http://www.nblglf.org Box 2–3 identiﬁes guidelines for assessing the cultural domain family roles and organization.

Family Roles and Organization Head of Household and Gender Roles 1. Identify which family members make which types of decisions in the household. Is the overall decisionmaking pattern patriarchal, matriarchal, or egalitarian? 2. Describe gender-related roles of men and women in the family system. Prescriptive, Restrictive, and Taboo Behaviors 3. Identify prescriptive, restrictive, and taboo behaviors for children. 4. Identify prescriptive, restrictive, and taboo behaviors for adolescents. Family Roles and Priorities 5. Describe family goals and priorities emphasized by this culture. 6. Explore developmental tasks in this group. 7. Explore the status and role of the aged in the family. 8. Explore the roles and importance of extended family members. 9. Describe how one gains social status in this cultural system. Is there a caste system? Alternative Lifestyles 10. Describe how alternative lifestyles and nontraditional families, such as single parents, blended families, communal families, same-sex families, are viewed by this society.

WORKFORCE ISSUES

Culture in the Workplace A fourth domain of culture is workforce issues. Differences and conﬂicts that exist in a homogeneous culture may be intensiﬁed in a multicultural workforce. Factors that affect these issues include language barriers, degree of assimilation and acculturation, and issues related to autonomy. Moreover, concepts such as gender roles, cultural communication styles, health-care practices of the country of origin, and selected concepts from all other domains affect workforce issues in a multicultural work environment. Americans are expected to be punctual on their job, with formal meetings, and with appointments. If one is more than a minute or two late, an apology is expected, and if one is late by more than ﬁve or 10 minutes, a more elaborate apology is expected. When people know they are going to be late for a meeting, the expectation is that they call or send a message indicating that they will be late. The convener of the meeting or teacher in a classroom is expected to start and stop on time out of respect for the other people in attendance. This is in contrast to practices in many other cultures, for example, Panama, where a meeting or class starts when the majority of people arrive. However, in social situations in the United States, a person can be 15 or more minutes late, depending on the importance of the gathering. In this instance, an apology is not really necessary or expected; however, most Americans will politely provide a reason for the tardiness. The American workforce stresses efﬁciency (time is money), operational procedures on how to get things done, task accomplishment, and proactive problem solving. Intuitive abilities and common sense are not usually valued as much as technical abilities. The scientiﬁc method is valued, and everything has to be proven. Americans want to know why, not what, and will search for a single factor that is the cause of the problem and the reason why something is to be done in a speciﬁc way. Many are obsessed with collecting facts and ﬁgures before they make decisions. Pragmatism is valued. In the United States, everyone is expected to have a job description, meetings are to have a predetermined agenda (although items can be added at the beginning of the meeting), and the agenda is followed throughout the meeting. Americans prefer to vote on almost every item on an agenda, including approving the agenda itself. Everything is given a time frame, and deadlines are expected to be respected. In these situations, American values expect that the needs of individuals are subservient to the needs of the organization. However, with the postmodernist movement, greater credibility and recognition have been given to approaches other than the scientiﬁc method.

These unskilled and semiskilled positions are among the most attainable for new immigrants. Minority groups employed as professionals are underrepresented among all health-care professions. According to the American Physical Therapy Association, only 0.5 percent of U.S. physical therapists are American Indian or Alaskan Native, 4.6 percent are African American or black,1.8 percent are Hispanic/Latino, 3.3 percent are Asian/Paciﬁc Islander, and the remainder (81.8 percent) are white (American Physical Therapy Association, 2006). The American Nurses Association found that only 0.5 percent of U.S. registered nurses are Native American or Alaskan Native, 4.2 percent are black, 1.6 percent are Hispanic/Latino, 3.4 percent are Asian/Paciﬁc Islander, and the remainder (89.7 percent) are white (National Sample Survey of Registered Nurses, 2006). According to the American Medical Association (2006), of physicians in the United States, 0.7 percent are Native American or Alaskan Native, 7.9 percent are black, 6.9 percent are Hispanic, 19.4 percent are Asian/Paciﬁc Islander, and 65 percent are white. The educational preparation of health-care professionals in some countries is not comparable with that in the United States. The vast array of health-care providers in the United States—radiology technicians, physical therapists, occupational therapists, social service workers, electrocardiogram technicians, respiratory therapists, and so on— may not exist in other countries. In Mexico, some Latin American countries, and some other developing countries, nursing education is offered primarily at the high school level. Concerns surface about the amount of additional training needed for some emigrating foreign graduates before sitting for American licensing examinations. During nursing workforce shortages, American healthcare facilities rely on emigrating nurses from the Philippines, Canada, England, Ireland, and other countries to supplement their numbers. Some foreign nurses, such as British and Australian, culturally assimilate into the workforce more easily than others but still have difﬁculty with defensive charting as is required in the United States. In their socialized health-care system, clients are not likely to initiate litigation (Purnell & Galloway, 1995). Others may have difﬁculty with the assertiveness expected from American nurses. Timeliness and punctuality are two culturally based attitudes that can create serious problems in the multicultural workforce. In some situations, conﬂicts may arise over the issue of reporting to work on time or on an assigned day. The lack of adherence to meeting time demands in other countries is often in direct opposition to the American ethic for punctuality.

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How timely are you in reporting to work? Do you see others in the workforce who do not report to work on time? What problems does it cause if they are not on time? What would you do as a supervisor to encourage people to report to work on time?

Most Americans place a high value on “fairness” and rely heavily on procedures and policies in the decisionmaking process. However, Americans’ value for individualism, in which the individual is seen as the most important element in society, favors a person’s decision to further her or his own career over the needs or wants of the employer. Therefore, individuals frequently demonstrate little loyalty to the organization and leave one position to take a position with another company for a better opportunity. In organizations in which people generally conform because of the fear of failure, there is a hierarchical order for decision making, and the person who succeeds is the one with strong verbal skills who conforms to the hierarchy’s expectations. This person is well liked and does not stand out too much from the crowd. Frequently, others view as a threat the person with a high level of competence who stands out. Thus, to be successful in the highly technical American workforce, get the facts, control your feelings, have precise and technical communication skills, be informal and direct, and clearly and explicitly state your conclusion.

How important are technical skills and verbal skills in your work environment? Does your organization encourage more formal or more informal communication? Why? Do you believe that everything needs to be proven scientiﬁcally? Do you value a more direct or indirect style of communication?

Clinical professionals trained in their home countries now occupy a signiﬁcant share of technical and laboratory positions in U.S. health-care facilities. Service employees such as food preparation workers, nurse aides, orderlies, housekeepers, and janitors represent the most culturally diverse component of hospital workforces.

Does your workforce (class) reﬂect the ethnic and racial diversity of the community? Why? Why not? What might you do to increase this diversity?

Issues Related to Autonomy Cultural differences related to assertiveness inﬂuence how health-care practitioners view each other. Speciﬁcally,

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some Asian nurses may not be as assertive with physicians as American nurses are. The concept of nurses being dependent on physicians and male administrators is inseparable from the Muslim concept of women being subject to the authority of husbands, fathers, and elder brothers. Polish nursing is seen as a vocation; therefore, Polish nurses may be unprepared for the level of sophistication and autonomy of American nursing. Educational training for nurses in Pakistan is culturally different from training in America. The Commission on Graduates of Foreign Nursing Schools administers a screening examination for temporary work visas to foreign graduate nurses seeking work. This examination assesses the ability to write and comprehend the English language, but it cannot examine the speciﬁc nuances of selected language barriers that may cause difﬁculties in the workplace. One area in which problems typically develop is in taking physicians’ prescription instructions over the telephone. The newer immigrant health-care professional may have passed the state’s professional licensing examination but still need extra time in translating messages and formulating replies. When individuals speak in their native language at work, it may become a source of contention for both clients and health-care personnel. For example, most non–English-speaking employees do not want to exclude or offend others, but it is easier to speak in their native language to articulate ideas, feelings, and humor among themselves. Negative interpretations of behaviors can be detrimental to working relationships in the health-care environment. Some foreign graduates, with limited aural language abilities, may need to have care instructions written or procedures demonstrated.

5. Northern Ireland has now banned religious discrimination in employment, something the United States has done for many years. However, this does not mean that religious discrimination on an individual basis can not occur given the setting. 6. The Hispanic workforce in the United States is growing by almost 10 percent a year, while the non-Hispanic workforce is growing at a rate of only 1 percent a year. 7. Whereas 78 percent of people with a disability work at least part-time, 26% of them live in poverty. However, only 22 percent report experiencing discrimination. 8. Religious preferences and sexual orientation continue to cause discrimination, especially from religious groups whose beliefs reject homosexuality. 9. Acknowledging workers’ sexual orientation improves productivity because employees feel more comfortable knowing there is no criticism of their lifestyles. However, 22 percent of heterosexual employees admit being uncomfortable working with gay, lesbian, bisexual, or transgender individuals. 10. The European Union’s Equal Treatment Framework Directive (2000/78C) prohibits discrimination on the basis of age, religion, belief, disability, or sexual orientation, the latter of which has not yet occurred in the United States.

Generational Differences in the Workforce Not only is the U.S. workforce becoming more multicultural, but the last decade has seen an increase in the professional literature regarding generational differences in our workforce. Most of the literature on generational differences describes the dominant culture, with little mention as to how these differences might coincide with the multiethnic workforce. These authors believe that these descriptions do not “ﬁt” the generalizations as well as they do for the dominant, nonethnic, nonimmigrant populations. However, these descriptions do have value and are brieﬂy described here. For the ﬁrst time in U.S. history, we now have four generations working together, recognizing some general but overlapping differences among the groups. Much can be gained in teamwork when these four generations are working together, especially when it is combined with ethnic and cultural diversity. At the same time, if administration does not effectively manage these diverse groups, interpretations, misunderstandings, and potential uncontrolled conﬂict can occur in the work environment. These four groups are (1) traditionalists, (2) baby boomers, (3) generation Xers, and (4) millennials. Each group brings a different worldview, different perspectives, and varied strengths to the workforce. A brief description of each group follows. The traditionalists were born prior to 1945 and are characterized as being loyal, patriotic, and hard working. Many from this group worked under “control and command”

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Does your profession encourage autonomy in the workforce? Does your current work (class) encourage autonomy and independence? Do you see any cultural or gender differences in autonomy? Do people speak different languages at work? What difﬁculty does this cause?

Diversity and Inclusion in the Workforce Although many organizations focus on race and ethnicity, to these authors, diversity includes religion, gender, sexual orientation, and age. The Human Resource Institute (2005) addresses diversity and inclusion issues globally and reports the following global concerns: 1. In France, women’s salaries are 33 percent less than men’s salaries given the same employment characteristics. 2. Ethnic minorities in Wales are ﬁve times more likely to express workplace bullying resulting in burnout, increased stress, and depression and anxiety. 3. The Roma “gypsies” in Slovakia have an 87 percent unemployment rate. 4. In Canada, nearly 350,000 Aboriginals are slated to enter the workforce in the next few years.

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styles of management and may perceive changes in the health-care ﬁeld as being too radical. They are an invaluable resource with the history of the organization and the profession and have a wealth of practical expertise to share. Most have also developed conﬂict resolution and negotiation skills. Many who retired have now returned to new professions or returned to work part-time (Anthony, 2006; Kupperschmidt, 2006; Sherman, 2006, Weston, 2006). The baby boomers, born between 1945 and 1965, currently account for almost half the workforce. Most are seen as idealistic, optimistic, competitive, and community focused. They are also considered the “sandwich generation” because they are often caring for their children and their parents. They are also “sandwiched” between the traditionalist with whom they have worked for many years and the generation Xers. This group also has a wealth of practical expertise to share and has developed conﬂict resolution and negotiation skills (Anthony, 2006; Kupperschmidt, 2006; Sherman, 2006, Weston, 2006). Generation Xers, born between 1966 and 1980, compose about 30 percent of the workforce. They are characterized as being highly dependent and skeptical and have a “free-agent” mentality and will change jobs easily to meet family and personal needs. Most are looking for experience rather than job security (Anthony, 2006; Kupperschmidt, 2006; Sherman, 2006, Weston, 2006). Millennials, born between after 1981, compose only about 15 percent of the population. Born of the baby boomers, they like new ideas and change. Technology use is a given, and most are comfortable with diversity. This group has travel and educational experiences that previous generations did not have (Anthony, 2006; Kupperschmidt, 2006; Sherman, 2006, Weston, 2006).

require different assessment skills in dark-skinned people than in light-skinned people. To assess for oxygenation and cyanosis in dark-skinned people, the practitioner must examine the sclera, buccal mucosa, tongue, lips, nail beds, palms of the hands, and soles of the feet rather than relying on skin tone alone. Jaundice is more easily determined in Asians by assessing the sclera rather than relying on the overall change in skin color. Health-care providers must establish a baseline skin color (by asking a family member or someone known to the individual), use direct sunlight if possible, observe areas with the least amount of pigmentation, palpate for rashes, and compare skin in corresponding areas. With people who are generally fairskinned, such as Germans, Polish, Irish, and British, to name a few, prolonged exposure to the sun places them at an increased risk for skin cancer.

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How many generations are in your work group (class)? Are their beliefs and practices similar to or different from what is reported in the literature? Do the generational differences cause conﬂict? Which generation takes the lead in resolving conﬂicts when they arise?

Do you have difﬁculty assessing rashes, bruises, and sunburn in people with dark skin? Do you have difﬁculty assessing jaundice and oxygenation in people with dark skin? How does your assessment of skin differ between clients with light versus dark skin? Do you take precautions and protect yourself against the sun? Why? Why not?

Box 2–4 identiﬁes guidelines for assessing the cultural domain workforce issues.

BIOCULTURAL ECOLOGY The domain biocultural ecology identiﬁes speciﬁc physical, biological, and physiological variations in ethnic and racial origins. These variations include skin color and physical differences in body habitus; genetic, hereditary, endemic, and topographic diseases; psychological makeup of individuals; and differences in the way drugs are metabolized by the body. No attempt is made here to explain or justify any of the numerous, conﬂicting, and highly controversial views and research about racial variations in drug metabolism and genetics.

Skin Color and Other Biological Variations Skin coloration is an important consideration for healthcare providers because anemia, jaundice, and rashes

BOX 2.4

Workforce Issues Culture in the Workplace 1. Identify speciﬁc workforce issues affected by immigration, for example, education. 2. Describe speciﬁc multicultural considerations when working with this culturally diverse individual or group in the workforce. 3. Explore factors inﬂuencing patterns of acculturation in this cultural group. 4. Explore native health-care practices and their inﬂuence in the workforce. Issues Related to Autonomy 5. Identify cultural issues related to professional autonomy, superior or subordinate control, religious issues, and gender in the workforce. 6. Identify language barriers with concrete interpretations of the language.

Variations in body habitus occur among ethnic and racially diverse individuals. For example, the long bones of many blacks are signiﬁcantly longer and narrower than those of whites (Giger & Davidhizar, 2004). Asians have narrower shoulders and wider hips than other ethnic/racial groups. Additional racial variations include ﬂat nose bridges among Asians, which may be overlooked by opticians when ﬁtting and dispensing eyeglasses. Many Vietnamese children are small by American standards and do not fall within normal ranges on standardized American growth charts. Mandibular tori occur more frequently among Asians, making ﬁtting dentures more

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difﬁcult. Bone density is greater in whites than in Chinese, Japanese, and Eskimos, whereas osteoporosis is lowest in black males and highest in white females. Other musculoskeletal variations such as the ulna and radius are equal among most Swedes. Other musculoskeletal variations such as the number of vertebrae, thickness of the frontal bone, and rotation of the humerus exist among ancestry groups and are listed in the Appendix. Such biocultural data provide important information for healthcare practitioners when assessing health problems geared to the unique attributes of people of diverse cultures. Given diverse gene pools, this type of information is often difﬁcult to obtain, and much of the research is inconclusive.

Diseases and Health Conditions Some diseases are more prevalent and endemic in certain racial or ethnic groups than in others. The incidence varies somewhat among the different ethnic groups. Speciﬁc health problems are covered in individual chapters in this book. Cardiovascular disease is the leading killer of both men and women in all racial and ethnic groups in the United States. The causative factors that contribute to the development of cardiovascular disease include obesity, 54.9 percent; lack of physical activity, 27.7 percent; and smoking, 22.9 percent (Centers for Disease Control and Prevention [CDC], 2006a). The leading sites for cancer for white male Americans are lung (74.2 percent), prostate (24.4 percent), colon and rectum (23.4 percent), pancreas (9.8 percent), and blood/ leukemia (8.6 percent). The most common sites for white female Americans are lung (32.9 percent), breast (27.7 percent), colon and rectum (15.6 percent), ovary (8.2 percent), and pancreas (7.0 percent). Although these same sites account for most cancers in other ethnic and racial groups, the order of occurrence differs. For example, prostate cancer is the highest reported cancer among American Indians, blacks, Filipinos, Japanese, and nonwhite Hispanic men. In women, breast cancer incidence rates are higher in all groups except Vietnamese, for whom cervical cancer rates rank highest. Stomach cancer appears in the top cancers for men and women in Asian populations except for Filipinos and Chinese women (National Cancer Institute 2006). A more thorough description of the variations in the sites and incidence of cancer among racial and ethnic groups in the United States can be obtained from the National Cancer Institute (CDC, 2006a) and the CDC. Almost 16 million Americans have been diagnosed with diabetes mellitus (DM), and the disease is undiagnosed in an additional 5.4 million people. More women than men suffer from DM. In addition, the prevalence of DM varies by race and ethnicity. The prevalence of DM among whites is 7.8 percent. However, blacks are 1.7 times as likely to have diabetes as whites; Mexican Americans, 1.9 times as likely; and American Indians and Alaskan Natives, 2.8 times as likely. Prevalence rates for Asian and Paciﬁc Islanders in the United States are limited, but DM among Native Hawaiians is twice that of white Americans in Hawaii (CDC, 2006b). HIV continues as a pandemic trend. An estimated 36million people are living with HIV/AIDS; 16.4 million

are women and 1.4 million are children under the age of 15years. Worldwide, HIV is increasingly affecting women. The overwhelming majority of people with HIV (95 percent) are from developing countries. Latin America accounts for 1.4 million people with HIV. Brazil has the highest rate in South America, and Honduras has the highest rate in Central America. Nearly 1 million people in the United States have HIV, with the highest concentration in large urban areas. The Caribbean has approximately 390,000 people with HIV; the most affected country is Haiti (CDC, 2006b). International health agencies, such as the World Health Organization (WHO), Pan American Health Organization (PAHO), CDC, and Joint United Nations Programme on HIV/AIDS (UNAIDS), have joined together in partnership for global HIV prevention efforts, with speciﬁc programs for selected countries, populations, and cultural groups. A number of world religions, among them Roman Catholicism and Islam, do not believe in the use of condoms because they are contraceptives and because they may encourage promiscuity and sex outside marriage. To them, abstinence is the only option for the control of HIV and AIDS. For more information on AIDS prevention, contact CDC National AIDS Hotline at 1-800342-AIDS; Spanish 1-800-344-SIDA; Deaf, 1-800-243-7889. The CDC National Prevention Information Network can be contacted at 1-800-458-5231. In the United States, more than 65 million people are currently living with an incurable sexually transmitted infection (STI). Although extremely common, STIs are difﬁcult to track, and many people are not aware they have these infections, resulting in hidden epidemics. Although syphilis is at an all-time low in the United States, other STIs such as gonorrhea, chlamydia, genital herpes, trichomoniasis, human papillomavirus, hepatitis B, and bacterial vaginosis continue to surge through the population. Women bear the greatest burden of STIs, suffering more frequent and more serious complications than men. Roughly one-fourth of these diseases occur in teenagers, with chlamydia and gonorrhea the most prevalent STIs among teenagers and young adults under the age of 25. STIs affect all racial, ethnic, and cultural groups. Each population needs culturally speciﬁc, relevant, and congruent education to decrease the incidence of these diseases. The middle socioeconomic white groups in the United States have responded favorably to educational programs geared to age-speciﬁc groups through media and school campaigns. Likewise, other communities have been successful with educational programs geared to the unique needs of the population. Some comparisons of each STI with ethnospeciﬁc populations, age groups, and gender can be obtained from the CDC (2006a) or the Institute of Medicine (2006). Illnesses and diseases with an increased incidence in white ethnic groups in the United States include appendicitis, diverticular disease, cancer of the colon, hemorrhoids, varicose veins, cystic ﬁbrosis, rosacea, osteoporosis and osteoarthritis, and phenylketonuria. Many immigrant groups have higher rates of some infectious diseases and illnesses that are not common in the United States. Accordingly, health-care providers should assess newer immigrants for diseases that are common in their homelands. An awareness of populations at risk for speciﬁc endemic diseases allows the health professional to THE PURNELL MODEL FOR CULTURAL COMPETENCE •37

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provide culturally appropriate screening and education for disease prevention and health promotion. See Appendix for illnesses and diseases and their causes for speciﬁc ethnic and cultural groups common in the United States. The topography of a given country or region may provide the health-care practitioner with essential clues to symptoms requiring investigation. People who have been working in coal mines are at inceased risk for pulmonary illnesses, even though they have been retired for many years. Thus, previous occupations should be included as part of the health assessment, not just indicating that they are retired. People who emigrate from mosquito-infested tropical areas such as Brazil, Mexico, Central America, Turkey, and Vietnam may present with chills, fever, lassitude, and splenic enlargement, which are consistent with malaria. Air pollution, which increases the risk for respiratory diseases, may be a signiﬁcant risk factor for any group who emigrates from or lives in a large city. Knowledge of speciﬁc risk factors related to the topography of the client’s country of origin and current residence enhances the diagnostic process and ensures accurate assessments.

effects of (1) smoking, which accelerates drug metabolism; (2) malnutrition, which affects drug response; (3) a high-fat diet, which increases absorption of antifungal medication, whereas a low-fat diet renders the drug less effective; (4) cultural attitudes and beliefs about taking medication; and (5) stress, which affects catecholamine and cortisol levels on drug metabolism, studies have identiﬁed some speciﬁc alterations in drug metabolism among diverse racial and ethnic groups. For instance, the Chinese are more sensitive to the cardiovascular effects of propranolol and have an increased absorption of antipsychotics, some narcotics, and antihypertensives than their white American counterparts. Eskimos, American Indians, and Hispanics have an increased risk for developing peripheral neuropathy while taking the drug isoniazid, compared with white Americans, who inactivate the drug more rapidly. African Americans respond better to diuretic therapy than do white ethnic groups (Aschenbrenner, 2005; GenSpec, 2006; Kudzma, 1999; Lavizzo-Mourey & Mackenzie, 2006; Levy, 1993; Munoz & Hilgenberg, 2005; Prows & Prows, 2004; U.S. Food and Drug Administration, 2006). The difference in the way physicians prescribe medications in various countries is an additional cultural consideration. For example, in most Asian countries and Great Britain, the preferred practice is to start out with low dosages of medicines and adjust upward until side effects or therapeutic responses are reached. In the United States, most clinicians start with the maximum dosage and adjust downward as side effects occur (Levy, 1993). Health-care providers need to investigate the literature for ethnic-speciﬁc studies regarding variations in drug metabolism, communicate these ﬁndings to other colleagues, and educate their clients regarding these side effects. Medication administration is one area in which health-care providers see the importance of culture, ethnicity, and race.

38•CHAPTER 2

What are the most common illnesses and diseases in your family? In your community? What might you do to decrease the incidence of illness and diseases in your family? In your community?

Are you aware of any outbreaks of new illnesses or diseases in your community? In other parts of the world? How might these outbreaks have been prevented?

Why is it important for health-care providers to be aware of variations in drug metabolism in the body? What conditions besides genetics have an inﬂuence on drug metabolism?

Since the late 1990s, every continent has had outbreaks of new or re-emerging diseases. North America has had outbreaks of bubonic plague, campylobacteria, cyclospora, salmonella, e coli in spinach, and Legionnaire’s disease. Central and South America have been particularly affected by cholera, yellow fever, malaria, dengue fever, and rabies. Europe has had outbreaks of shigella in Paris, Escherichia coli and mad cow disease in Great Britain, and leptospirosis in the Ukraine. Asia has had an increase in dengue fever; anthrax has been seen in Russia and the United States; and avian ﬂu has occurred in Hong Kong and other places. Africa has had meningitis in Chad, endemic rates of ebola in Zaire and Sudan, and bubonic plague in Malawi and Mozambique. To this end, educators in colleges and health-care organizations need to educate students, staff, and the community about new and re-emerging illnesses as a public health concern.

Variations in Drug Metabolism Information regarding drug metabolism among racial and ethnic groups has important implications for health-care practitioners when prescribing medications. Besides the

Box 2–5 identiﬁes guidelines for assessing and the cultural domain biocultural ecology.

HIGH-RISK BEHAVIORS High-risk behaviors include use of tobacco, alcohol, or recreational drugs; lack of physical activity; increased calorie consumption; unsafe driving practices; failure to use seat belts and helmets; failure to take precautions against HIV and STIs; and high-risk recreational activities. Johnson’s research (2000) found that barriers to exercise among South Asians included unsafe neighborhoods and lack of gender-speciﬁc facilities. High-risk behaviors occur in all ethnocultural groups; the degree and types of highrisk behaviors vary. The steady decline in smoking prevalence has beenobserved nationally, but in some segments of the

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population, smoking prevalence remains high, highlighting the need for expanded interventions that can better reach persons of low socioeconomic status and populations living in poverty. In 2004, 44.5 million adults in the United States were current smokers—23.4 percent of men and 18.5 percent of women. Among racial and ethnic groups, smoking prevalence was highest among American Indians/Alaska Natives (33.4 percent) and lowest among Hispanics (15 percent) and Asians (11.3 percent). Among income groups, smoking prevalence was higher among adults living below the poverty level (29.1 percent) than among those at or above the poverty level (20.6 percent). Smoking prevalence was highest among those aged 18 to 24 years (23.6 percent) and 25 to 44 years (23.8 percent) and lowest among those aged 65 years and older (8.8 percent). Whereas from 1993 to 2004 the proportion of heavy smokers and the overall number of cigarettes smoked among daily smokers declined, the percentage of daily smokers who smoked 1 to 4 cigarettes and 5 to 14 cigarettes per day increased. Middle school and high school student smoking rates have remained steady at 15 and 21 percent (CDC, 2005). Alcohol consumption crosses all cultural and socioeconomic groups. Enormous differences exist among ethnic and cultural groups around use of and response to alcohol. Even in cultures in which alcohol consumption is taboo, it is not ignored. However, alcohol problems are not simply a result of how much people drink. When drinking is culturally approved, it is typically done more by men than women and is more often a social, rather than a solitary, act. The group in which drinking is most frequently practiced is usually composed of same-age social peers (Peele & Brodsky, 2001). Studies on increasing controls on the availability of alcohol to decreasing alcohol consumption, with the premise that alcohol-related

problems occur in proportion to per capita consumption, has not been supported. Furthermore, countries with temperance movements have greater alcohol-related behavior problems than do countries without temperance movements (Purnell & Foster, 2003a, 2003b). Countries in which drinking alcoholic beverages is integrated into rites and social customs, and in which one is expected to have self-control and sociability have lower rates of alcohol-related problems than those of countries and cultures in which ambivalent attitudes toward drinking prevail (Purnell & Foster, 2003a; 2003b). In addition, Hilton’s (1987) study demonstrated a clear and distinct difference in alcohol abuse rate by socioeconomic status. Higher–socioeconomic status Americans were more likely to drink but also more likely to drink without problems. The conclusion of many studies suggests that alcohol-related violence is a learned behavior, not an inevitable result of alcohol consumption (Purnell & Foster, 2003a; 2003b). Other studies have correlated per capita alcohol consumption rates with the number of Alcoholics Anonymous (AA) groups per million population. Countries with the lowest per capita consumption rate of alcohol had higher numbers of AA groups. Countries with the highest per capita consumption rate of alcohol had lower numbers of AA groups; for example, Iceland, with a low per capita alcohol consumption rate of 3.9 L, had 784 AA groups, whereas France, with a per capital alcohol consumption rate of 13.2 L, had 7 AA groups (Table 2–1). THE PURNELL MODEL FOR CULTURAL COMPETENCE •39

BOX 2.5

Biocultural Ecology Skin Color and Biological Variations 1. Identify the skin color and physical variations for this group. 2. Explore any special problems or concerns skin color may pose for health-care practitioners. 3. Identify biological variations in body habitus or structure. Diseases and Health Conditions 4. Identify speciﬁc risk factors for individuals related to the topography or climate. 5. Identify hereditary or genetic diseases or conditions that are common within this group. 6. Identify endemic diseases speciﬁc to this cultural or ethnic group. 7. Identify any diseases or health conditions for which this group has increased susceptibility. Variations in Drug Metabolism 8. Identify speciﬁc variations in drug metabolism, drug interactions, dosages, and related side effects.

TABLE 2.1 Alcohol Consumption by Country

Number of Alcoholics Alcohol Anonymous Groups Consumption (per million Country (L/capita) population)

Iceland 3.9 784 Norway 4.0 28 Sweden 5.5 33 Canada 7.1 177 Ireland 7.2 210 United States 7.2 164 United Kingdom 7.6 51 Finland 7.8 110 New Zealand 7.8 102 Australia 8.3 56 Netherlands 8.4 12 Italy 8.6 6 Denmark 9.8 22 Belgium 9.9 53 Portugal 9.9 1 Spain 10.4 8 Switzerland 10.8 22 Austria 11.5 92 Germany 12.6 26 France 13.2 7 Luxembourg 13.6 0

Source: The Stanton Peale Addiction Center. Http://www.stantonpeele.net

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No information was found about the number of people in each group. Of world drinking patterns, Luxembourg has the highest yearly consumption of alcohol per individual at 11.9 L, followed by Hungary at 11.1 L, and the Czech Republic and Ireland at 10.8 L each. The United States did not rank in the top 20 (Pocket World in Figures, p. 98). When assessing clients’ alcohol and recreational drug use, the health-care provider must place these high-risk behaviors within the context of their cultural group. Healthcare providers can have a signiﬁcant impact on behaviorrelated health problems of alcohol by encouraging moderate drinking, providing educational and counseling materialsin their preferred language, working with the regulators of alcohol manufacturing as well as the beverage industry, and working with elementary and secondary school teachers to promote responsible drinking.

Health-Care Practices In 2003 to 2004, 17.1 percent of children and adolescents 2 to 19 years of age were overweight, and 32.2% of adults were obese. Signiﬁcant differences in obesity among racial and ethnic groups remain. The prevalence of overweight in Mexican American and non-Hispanic black girls was higher than among non-Hispanic white girls. Among boys, the prevalence of overweight was signiﬁcantly higher among Mexican Americans than among either non-Hispanic black or white boys. Among adults, similar differences existed. Approximately 30 percent of nonHispanic white adults were obese, and 45 percent of nonHispanic black adults and 36.8 percent of Mexican American adults were obese (National Center for Health Statistics, 2004). Signiﬁcant differences existed by age. Adolescents were more likely to be overweight than younger children, and older adults were more likely to be obese than younger adults. The only exception was among adults 80 years and over who were no different than adults 20 to 39 years of age. Between 1999 and 2004, there was a signiﬁcant increase in the prevalence of overweight among girls—3.8 percent in 1999 to 16.0 percent in 2004. Similarly, among boys, the prevalence increased signiﬁcantly from 14.0 percent in 1999 to 18.2 percent in 2004. The prevalence of obesity among men also increased signiﬁcantly from 27.5 percent to 31.1 percent. There was no change in obesity among women—33.4 percent in 1999 to 33.2 percent in 2004 (National Center for Health Statistics, 2004). Obesity and overweight are a result of an imbalance between food consumed and physical activity. National data have shown an increase in the calorie consumption of adults and no change in physical activity patterns. But obesity is a complex issue related to lifestyle, environment, and genes. Many underlying factors have been linked to the increase in obesity, such as increased portion sizes; eating out more often; increased consumption of sugar-sweetened drinks; increased television, computer, electronic gaming time; changing labor markets; and fear of crime, which prevents outdoor exercise. Obese adults are at increased risk of type 2 diabetes, hypertension, stroke, certain cancers, and other conditions. Overweight

adolescents often become obese adults. Although the United States has the highest prevalence of obesity among the more developed nations, it is not alone in terms of trends. Increases in the prevalence of overweight and obesity among children and adults have been observed throughout the world (National Center for Health Statistics, 2004). Health-care providers can assist overweight clients in reducing calorie consumption by identifying healthy choices among culturally preferred foods, altering preparation practices, and reducing portion size. The ethnocultural practice of self-care using folk and magicoreligious practices before seeking professional care may also have a negative impact on the health status of some individuals. Overreliance on these practices may mean that the health problem is in a more advanced stage when a consultation is sought. Such delays make treatment more difﬁcult and prolonged. Selected complementary and alternative health-care practices are addressed in this chapter under the domain healthcare practices and in each culture-speciﬁc chapter. The cultural domain of high-risk behaviorsis one area in which health-care providers can make a signiﬁcant impact on clients’ health status. High-risk health behaviors can be controlled through ethnic-speciﬁc interventions aimed at health promotion and health-risk prevention through educational programs in schools, business organizations, churches, and recreational and community centers, as well as through one-on-one and family counseling techniques. Taking advantage of public communication technology can enhance participation in these programs if they are geared to the unique needs of the individual, family, or community.

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In which high-risk health behaviors do you engage? What do you do to control or reduce your risk? Which high-risk health behaviors do you see most frequently in your family? In your community? What might you do to help decrease these high-risk behaviors?

Box 2–6 identiﬁes guidelines for assessing the cultural domain high-risk behaviors.

NUTRITION The cultural domain of nutrition includes more than having adequate food for satisfying hunger. This domain also comprises the meaning of food to the culture; common foods and rituals; nutritional deﬁciencies and food limitations; and the use of food for health promotion and wellness, illness and disease prevention, and health maintenance and restoration. Understanding a client’s food patterns is essential for providing culturally competent dietary counseling. Health-care practitioners may be considered professionally negligent when prescribing, for example, an American diet to a Hispanic or an Asian client whose food choices and mealtimes may be different from American food patterns.

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Common Foods and Food Rituals American food and preparation practices reﬂect traditional food habits of early settlers who brought their unique cuisines with them. Accordingly, the “typical American diet” has been brought from elsewhere. Americans vary their mealtimes and food choices according to the region of the country, urban versus rural residence, and weekdays versus weekends. In addition, food choices vary by marital status, economic status, climate changes, religion, ancestry, availability, and personal preferences. Overall, the typical American diet is high in fats and cholesterol and low in ﬁber, according to the U.S.

Department of Agriculture (USDA). The USDA recommends the Food Pyramid for Americans, originally adapted in 1950, and revised in 1992, and again in 2005. This food pyramid is commonly taught in elementary and secondary education and is used as a guide for teaching healthy eating to the public. Daily recommendations include 6 to 11 servings of bread, cereal, rice, or pasta; 3 to 5 servings of vegetables; 2 to 4 servings of fruit, 2 to 3 servings of milk, yogurt, or cheese; 2 to 3 servings of meat, poultry, ﬁsh, dry beans, eggs, and nuts; and limited use of fats, oils, and sweets. However, it has been recognized that speciﬁc foods in this pyramid must be adapted for nonAmerican food preferences. Speciﬁc food pyramids have been developed by several organizations and are available for Vietnamese, African American, Chinese, Puerto Rican, Navajo, Jewish, and Asian Indians. They are included in culture-speciﬁc chapters and can also be found on the Web by going to a search engine and typing in “multicultural food pyramid.” Many older people and people living alone do not eat balanced meals, stating they do not take the time to prepare a meal, even though most American homes have labor-saving devices such as stoves, microwave ovens, refrigerators, and dishwashers. For those who are unable to prepare their own meals because of disability or illness, most communities have a Meals on Wheels program through which community and church organizations deliver, usually once a day, a hot meal along with a cold meal for later and food for the following morning’s breakfast. Other community and church agencies prepare meals for the homeless or collect food, which is delivered to those who have none. When people are ill, they generally prefer toast, tea, juice, and other easily digested foods. Socioeconomic status may dictate food selections: for example, hamburger instead of steak, canned or frozen vegetables and fruit rather than fresh, and ﬁsh instead of shrimp or lobster. Given the size of the United States and its varied terrain, food choices differ by region: beef in the Midwest, ﬁsh in coastal areas, poultry in the South and along the Eastern seaboard. Vegetables vary by season, climate, and altitude, although larger grocery stores have a wide variety of all types of American and international meats, fruits, and vegetables. Many television stations and major newspapers have large sections devoted to foods and preparation practices, a testament to the value that Americans place on food and diversity in food preparation. Special occasions and holidays are frequently associated with ethnic-speciﬁc foods. For example, in the United States, hot dogs are consumed at sports events, and turkey is served at Thanksgiving. Many religious groups are required to fast during speciﬁc holiday seasons, such as Ramadan for Muslims and Lent for Catholics. However, health-care providers may need to remind clients that fasting is not required during times of illness or pregnancy. Given the intraethnic variations of diet, it is important for health professionals to inquire about the speciﬁc diets of their clients. Expecting the client to eat according to an American mealtime schedule and to select American foods from an exchange list may be unrealistic for clients of different cultural backgrounds. Counseling about food-group THE PURNELL MODEL FOR CULTURAL COMPETENCE •41

BOX 2.6

High-Risk Behaviors High-Risk Behaviors 1. Identify speciﬁc high-risk behaviors common among this group. 2. Explore behaviors related to the use of alcohol, tobacco, and recreational drugs and other substances among this group. 3. Explore beliefs and practices related to safe sex. Health-Care Practices 4. Identify the typical health-seeking behaviors of this group. 5. Assess the level of physical activity in their lifestyle. 6. Assess the use of safety measures such as seat belts and helmets.

Meaning of Food Food and the absence of food—hunger—have diverse meanings among cultures and individuals. Cultural beliefs, values, and types of foods available inﬂuence what people eat, avoid, or alter to make food congruent with cultural lifeways; and food offers cultural security and acceptance. Food plays a signiﬁcant role in socialization; has symbolic meaning for peaceful coexistence; denotes caring or lack of caring, closeness, kinship, and solidarity; and may be used as an expression of love or anger (Leininger, 1988). When Americans invite a guest to dinner for the ﬁrst time, the guest frequently brings a gift, although this is not required, and one of the choices is often food. There are no speciﬁc rules as to what type of food to bring, but wine, cheese baskets, and candy are usually appropriate. Bread (unless it is a very special bread) and soft drinks are not usually appropriate unless speciﬁcally requested.

What are your personal beliefs about weight and health? Do you agree with the dominant American belief that thinness correlates with desirability and beauty? What does food mean in your culture besides satisfying hunger?

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requirements, intake restrictions, and exercise must respect cultural behaviors and individual lifeways. Culturally congruent dietary counseling, such as changing amounts and preparation practices while including preferred ethnic food choices, can reduce the risk for obesity, cardiovascular disease, and cancer. Whenever possible, determining a client’s dietary practices should be started during the intake interview.

comparable nutritional ingredients. Consequently, they do not know which foods to select for balancing their diet. Widespread nutritional deﬁciencies of many types have occurred with recent immigrants from Southeast Asia, in part because of the time spent in refugee camps, but also because of changes in food habits when immigrating to America. Among the Hindu, the consumption of a single grain such as rice may result in a poor intake of lysine and other essential amino acids. Enzyme deﬁciencies exist among some ethnic and racial groups. For example, many Vietnamese Americans are lactose-intolerant and are unable to drink milk or eat dairy products to maintain their calcium needs. By consuming soups and stews made with pureed bones and cooked to an edible consistency, this deﬁciency can be overcome. In general, the wide availability of foods in this country reduces the risks of these disorders as long as people have the means to obtain culturally nutritious foods. Recent emphasis on cultural foods has resulted in larger grocery stores having sections designated for ethnic goods and in small businesses selling ethnic foods and spices to the general public. The health-care provider’s task is to determine how to assist the client and identify alternative foods to supplement the diet when these stores are not ﬁnancially or geographically accessible.

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In what food rituals does your family engage? Do you have speciﬁc foods and rituals for holidays? What would happen if you changed these rituals? Do food patterns change for you by the season? During the week versus the weekend?

Dietary Practices for Health Promotion The nutritional balance of a diet is recognized by most cultures throughout the world. Most cultures have their own distinct theories of nutritional practices for health promotion and wellness, illness and disease prevention, and health maintenance and restoration. Common folk practices and selected diets are recommended during periods of illness and for prevention of illness or disease. For example, many societies such as Iranian, Mexican, Puerto Rican, Chinese, and Vietnamese subscribe to the hot-andcold theory of food selection to prevent illness and maintain health. Although each of these ethnic groups has its own speciﬁc name for the hot-and-cold theory of foods, the overall belief is that the body needs a balance of opposing foods. These practices are covered in culturespeciﬁc chapters. A thorough history and assessment of dietary practices can be an important diagnostic tool to guide health promotion. Although school lunch programs, Meals on Wheels, and church meal plans, to name a few, are programs through which the health-care provider can encourage and support families in attaining better nutrition, these may not provide optimal nutritional selections.

What do you eat to maintain your health? What does a healthy diet mean to you? Do you agree with the U.S. Department of Agriculture Food Pyramid? Why? Why not? What do you eat when you are ill?

Nutritional Deﬁciencies and Food Limitations Because of limited socioeconomic resources or limited availability of their native foods, immigrants may eat foods that were not available in their home country. These dietary changes may result in health problems when they arrive in a new environment. This is more likely to occur when individuals immigrate to a country where they do not have native foods readily available and do not know which new foods contain the necessary and

What enzyme deﬁciencies run in your family? Do you have any difﬁculty getting your preferred foods? What other food limitations do you have?

Box 2–7 identiﬁes guidelines for assessing the cultural domain nutrition.

BOX 2.7

Nutrition Meaning of Food 1. Explore the meaning of food to this group. Common Foods and Food Rituals 2. Identify foods, preparation practices, and major ingredients commonly used by this group. 3. Identify speciﬁc food rituals. Dietary Practices for Health Promotion 4. Identify dietary practices used to promote health or to treat illness in this cultural group. Nutritional Deﬁciencies and Food Limitations 5. Identify enzyme deﬁciencies or food intolerances commonly experienced by this group. 6. Identify large-scale or signiﬁcant nutritional deﬁciencies experienced by this group. 7. Identify native food limitations in their new country that may cause special health difﬁculties.

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PREGNANCY AND CHILDBEARING PRACTICES The cultural domain pregnancy and childbearing practices includes culturally sanctioned and unsanctioned fertility practices; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and the postpartum period. Many traditional, folk, and magicoreligious beliefs surround fertility control, pregnancy, childbearing, and postpartum practices. The reason may be the mystique that surrounds the processes of conception, pregnancy, and birthing. Ideas about conception, pregnancy, and childbearing practices are handed down from generation to generation and are accepted without validation or being completely understood. For some, the success of modern technology in inducing pregnancy in postmenopausal women and others who desire children through in vitro fertilization and the ability to select a child’s gender raises serious ethical questions about parenting.

Fertility Practices and Views Toward Pregnancy Commonly used methods of fertility control in the United States include natural ovulation methods, birth control pills, foams, Norplant, the morning-after pill, intrauterine devices, sterilization, vasectomy, prophylactics, and abortion. Although not all of these methods are acceptable to all people, many women use a combination of fertility control methods. The most extreme examples of fertility control are sterilization and abortion. Sterilization in the United States is now strictly voluntary; however, some countries still perform involuntary sterilization to control birth rates and to control conception in people with mental retardation or deformities. Abortion remains a controversial issue in the United States and in other countries. For example, in some countries, women are encouraged to have as many children as possible, and abortion is illegal. However, in China, abortion is commonly used as a means of limiting family size because of China’s one-couple, onechild law. Many women in China have 5 or 6 abortions in their lifetime because they lack other birth control methods (personal communications with Chinese women in Beijing and Xian, China, 1998). The “morning-after pill” also continues to be controversial to some. Anyone, male or female, over the age of 18 years can purchase the drug without a prescription. Those under the age of 18, whether male or female, must have a prescription. A current literature search did not reveal any recent and dependable data on fertility control used by select cultural or ethnic groups. One notable study by Herold, Westhoff, Warren, and Seltzer (1989) studied the use of fertility control methods among Catholic Puerto Rican women and found that the incidence of pregnancy is higher for Catholic Puerto Ricans than for non-Catholic Puerto Ricans. However, contraceptive use is widespread among the Puerto Rican population regardless of social contexts such as socioeconomic levels, rural versus urban residence, and educational level. Other studies report fertility control from decades past and are deemed too dated to be accurate. Although some men have vasectomies, the literature is also scarce on the number of families who use vasectomy as a method of birth control.

Fertility practices and sexual activity, sensitive topics for many, is one area in which “outside” health-care practitioners may be more effective than health-care providers known to the client because of the concern about providing intimate information to someone they know. Some of the ways health-care providers can promote a better understanding of practices related to family planning include using videos in the native language and videos and pictures of native ethnic people, using material written at the individual’s level of education, and providing written instructions in both English and the native language. Health-care providers should avoid family planning discussions on the ﬁrst encounter; such information may be better received on subsequent visits when some trust has developed. Approaching the subject of family planning obliquely may make it possible to discuss these topics more successfully. THE PURNELL MODEL FOR CULTURAL COMPETENCE •43

Does pregnancy have a special meaning in your culture? Is fertility control acceptable in your culture? Do most people adhere to fertility control practices in your culture? What types of fertility control are acceptable? Unacceptable?

Prescriptive, Restrictive, and Taboo Practices in the Childbearing Family Most societies have prescriptive, restrictive, and taboo beliefs for maternal behaviors and the delivery of a healthy baby. Such beliefs affect sexual and lifestyle behaviors during pregnancy, birthing, and the immediate postpartum period. Prescriptive practices are things that the mother should do to have a good outcome (healthy baby and pregnancy). Restrictive belief practices are those things that the mother should not do to have a positive outcome (healthy baby and delivery). Taboo practices are those things that, if done, are likely to harm the baby or mother. A prescriptive belief among Americans is that women are expected to seek preventive care, eat a well-balanced diet, and get adequate rest to have a healthy pregnancy and baby. The American health-care system encourages women to breastfeed, and many places of employment have made arrangements for women to breastfeed while working. A restrictive belief among Americans is that pregnant women should refrain from being around loud noises for prolonged periods of time. Taboo behaviors during pregnancy among Americans are smoking, drinking alcohol, drinking large amounts of caffeine, and taking recreational drugs—practices that are sure to cause harm to the mother or baby. A taboo belief common among many cultures is that a pregnant woman should not reach over her head because the baby may be born with the umbilical cord around its neck. A restrictive belief among Indians in Belize and Panama is that permitting the father to be present in the delivery room and seeing the mother or baby before they have been cleaned can cause harm to the baby or mother. Because the father is absent from the delivery room or does not want to see the mother or baby immediately

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after birth does not mean that he does not care about them. However, in the American culture, in which the father is often encouraged to take prenatal classes with the expectant mother and provide a supportive role in the delivery process, fathers with opposing beliefs may feel guilty if they do not comply. The woman’s female relatives provide assistance to the new mother until she is able to care for herself and baby. Additional cultural beliefs carried over from cultural migration and American diversity include If you wear an opal ring during pregnancy, it will harm the baby. Birth marks are caused by eating strawberries or seeing a snake and being frightened. Congenital anomalies can occur if the mother sees or experiences a tragedy during her pregnancy. Nursing mothers should eat a bland diet to avoid upsetting the baby. The infant should wear a band around the abdomen to prevent the umbilicus from protruding and becoming herniated. A coin, key, or other metal object should be put on the umbilicus to ﬂatten it. Cutting a baby’s hair before baptism can cause blindness. Raising your hands over your head while pregnant may cause the cord to wrap around the baby’s neck. Moving heavy items can cause your “insides” to fall out. If the baby is physically or mentally abnormal, God is punishing the parents. In some other cultures, the postpartum woman is prescribed a prolonged period of recuperation in the hospital or at home, something that may not be feasible in the United States because of the shortened length of conﬁnement in the hospital after delivery. Among the Vietnamese, the head is considered sacred, and it is taboo to touch the head of the mother or the infant. Even removal of vernix from the infant’s head can cause distress. The health-care provider must respect cultural beliefs associated with pregnancy and the birthing process when making decisions related to the health care of pregnant women, especially those practices that do not cause harm to the mother or baby. Most cultural practices can be integrated into preventive teaching in a manner that promotes compliance.

DEATH RITUALS The cultural domain death rituals includes how the individual and the society view death and euthanasia, rituals to prepare for death, burial practices, and bereavement. Death rituals of ethnic and cultural groups are the least likely to change over time and may cause concerns among health-care personnel. Some staff may not understand the value of customs with which they are not familiar, such as the ritual washing of the body. Death practices, beliefs, and rituals vary signiﬁcantly among cultural and religious groups. To avoid cultural taboos, health-care professionals must become knowledgeable about unique practices related to death, dying, and bereavement.

Death Rituals and Expectations For many American health-care providers educated in a culture of mastery over the environment, death is seen as one more disease to conquer, and when this does not happen, death becomes a personal failure. Thus, for many, death does not take a natural course because it is “managed” or “prolonged,” making it difﬁcult for some to die with dignity. Moreover, death and responses to death are not easy topics for many Americans to verbalize. Instead, many euphemisms are used rather than verbalizing that the person died: for example, “He passed on or passed away,” “She is no longer with us,” and “He went to visit the Grim Reaper.” The American cultural belief in self-determination and autonomy extends to people making their own decisions about end-of-life care. Mentally competent adults have the right to refuse or decide what medical treatment and interventions they wish to extend life, such as artiﬁcial life support and artiﬁcial feeding and hydration.

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What are some prescriptive practices for pregnant women in your culture? What are some restrictive practices for pregnant women in your culture? What are some taboo practices for pregnant women in your culture? What special foods should a woman eat to have a healthy baby in your culture? What foods should be avoided? What foods should a nursing mother eat postpartum? What foods should she avoid?

What terms do you use when referring to death? Why do you use these terms? What speciﬁc burial practices do you have in your family/culture?Box 2–8 identiﬁes guidelines for assessing the cultural domain pregnancy and childbearing practices.

BOX 2.8 Pregnancy and Childbearing Practices Fertility Practices and Views Toward Pregnancy 1. Explore cultural views and practices related to fertility control. 2. Identify cultural practices and views toward pregnancy. Prescriptive, Restrictive, and Taboo Practices in the Childbearing Family 3. Identify prescriptive, restrictive, and taboo practices related to pregnancy, such as foods, exercise, intercourse, and avoidance of weather-related conditions. 4. Identify prescriptive, restrictive, and taboo practices related to the birthing process, such as reactions during labor, presence of men, position for delivery, preferred types of health practitioners, or place of delivery. 5. Identify prescriptive, restrictive, and taboo practices related to the postpartum period, such as bathing, cord care, exercise, foods, and roles of men.

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Among most Americans, the belief is that a dying person should not be left alone, and accommodations are usually made for a family member to be with the dying person at all times. Health-care personnel are expected to care for the family as much as for the patient during this time. Most people are buried or cremated within 3 days of the death, but extenuating circumstances may lengthen this period to accommodate family and friends who must travel a long distance to attend a funeral or memorial service. The family can decide whether the deceased will have an open casket, for viewing the deceased by family or friends, or whether the casket will remain closed. Signiﬁcant variations in burial practices occur with other ethnocultural groups in the United States. The tradition among Orthodox Jews is to bury their deceased before sundown the next day and have postdeath rituals that last for several days. Other groups have elaborate ceremonies in commemoration of the dead, such as a velorio among Mexican Americans, which may last for days. To some people, these rituals look like a celebration; in reality, it is a celebration of the person’s life. In Greek Orthodox culture, successive stages of mourning include memorial services 40 days after burial and then at 3 months and 6 months, with yearly rituals thereafter. When Muslims approach death, they may wish to face Mecca and recite passages from the Qur’an; the healthcare provider needs to determine the direction of Mecca and position the bed accordingly. Whether in the hospital, in an extended-care facility, or at home in the community, the furniture may need to be rearranged to accomplish this important ritual.

Responses to Death and Grief American society has been launching major initiatives to help patients die as comfortably as possible without pain. As a result, more people are choosing to remain at home or to enter a hospice for end-of-life care where their comfort needs are better met. One of the requirements for entering a hospice in the United States is that the patient must sign documents indicating that he or she does not want extensive life-saving measures performed. When death does occur, most Americans conservatively control their grief, although women are usually more expressive than men. For many, especially men, they are expected to be stoic in their reactions to death, at least in public. Generally, tears are shed, but loud wailing and uncontrollable sobbing rarely occur. The belief is that the person has progressed to a better existence and does not have to undergo the pressures of life on Earth. Bereavement time for Chinese people may be a week or longer, depending on the relationship of the family member to the deceased and the degree of acculturation. The family of a deceased Chinese American may need extra leave time to fulﬁll their cultural obligations. These variations in the grieving process may cause confusion for health-care providers, who may perceive some clients as overreacting and others as not caring. The behaviors associated with the grieving process must be placed in the context of the speciﬁc ethnocultural belief system in order to provide culturally competent care. Caregivers should accept and encourage ethnically speciﬁc bereave

ment practices when providing support to family and friends. Bereavement support strategies include being physically present, encouraging a reality orientation, openly acknowledging the family’s right to grieve, accepting varied behavioral responses to grief, acknowledging the patient’s pain, assisting them to express their feelings, encouraging interpersonal relationships, promoting interest in a new life, and making referrals to other resources such as a priest, minister, rabbi, or pastoral care. THE PURNELL MODEL FOR CULTURAL COMPETENCE •45

How do men grieve in your culture? How do women grieve in your culture? Do you have a living will or advance directive? Why? Why not? Are you an organ donor?Why? Why not? Is there a speciﬁc time frame for bereavement?

Box 2–9 identiﬁes guidelines for assessing the cultural domain death rituals.

SPIRITUALITY The domain spirituality involves more than formal religious beliefs related to faith and afﬁliation and the use of prayer. For some people, religion has a strong inﬂuence over and shapes nutrition practices, health-care practices, and other cultural domains. Spirituality includes all behaviors that give meaning to life and provide strength to the individual. Furthermore, it is difﬁcult to distinguish religious beliefs from cultural beliefs because for some, especially the very devout, religion guides the dominant beliefs, values, and practices even more than their culture. Spirituality, a component of health related to the essence of life, is a vital human experience that is shared by all humans. Spirituality helps provide balance among the mind, body, and spirit. Trained and traditional religious leaders provide comfort to both the patient and the family. Spirituality does not have to be scientiﬁcally proven andis patterned unconsciously from a person’s worldview. Accordingly, people may deviate somewhat from the majority view or position of their formally recognized religion.

Dominant Religion and Use of Prayer Of the major religions in the world, 33 percent of people are Christians; 21 percent are Islamic; 16 percent are atheist,

BOX 2.9

Death Rituals Death Rituals and Expectations 1. Identify culturally speciﬁc death rituals and expectations. 2. Explain death rituals and mourning practices. 3. What are speciﬁc burial practices, such as cremation? Responses to Death and Grief 4. Identify cultural responses to death and grief. 5. Explore the meaning of death, dying, and the afterlife.

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agnostic, or nonreligious; and 14 percent are Hindu (Major Religions, 2006). In the United States, the three major religious groups are Christians, 76.5 percent; nonreligious/secular, 13.2 percent; Judaism, 2.3 percent. Hindu, Islam, Agnostic, and Buddhist are each 0.5 percent and are increasing more rapidly than other groups (Top Twenty Religions, 2001). Obviously, the United States does not mirror the world in terms of religious afﬁliation. Immigration to the United States is increasing the nation’s religious diversity. Many groups settled in America for religious freedom. Furthermore, speciﬁc religious groups are concentrated regionally in the United States, with Baptists in the South, Lutherans in the North and Midwest, and Catholics in the Northeast, East, and Southwest. Within this context, there is a separation of church and state, and the U.S. government cannot support any particular religion or prevent people from practicing their chosen religion. However, this does not include cults or extremist groups, which usually devote themselves to esoteric ideals and fads. Even though there is a separation of church and state in the United States, many public events and ceremonies open with a prayer, and phrases such as “one nation under God” are often heard. American money still has the phrase “in God we trust.” Most people see these religious symbols as harmless rituals. Instead of speaking to “religious values,” politicians speak to “family values” as a way of getting around religious principles. However, these issues are subject to debate from time to time. Unlike in many countries that support a speciﬁc church or religion and in which people discuss their religion frequently and openly, religion is not an everyday topic of conversation for most Americans. The health-care practitioner who is aware of the client’s religious practices and spiritual needs is in a better position to promote culturally competent health care. The practitioner must demonstrate an appreciation of and respect for the dignity and spiritual beliefs of clients by avoiding negative comments about religious beliefs and practices. Clients may ﬁnd considerable comfort in speaking with religious leaders in times of crisis and serious illness. Prayer takes different forms and different meanings. Some people pray daily and may have altars in their homes. Others may consider themselves devoutly religious and say prayers only on special occasions or in times of crisis or illness. Among the Amish, faith-related behavior includes corporate (group) worship, prayer, and singing, which help build conformity and maintain harmony within the group. Prayer is a signiﬁcant source of strength for many including devout Muslims, who pray ﬁve times a day. Health-care providers may need to make special arrangements for individuals to say prayers in accordance with their belief systems.

Meaning of Life and Individual Sources of Strength What gives meaning to life varies among and within cultural groups. To some people, their formal religion may be the most important facet of fulﬁlling their spirituality needs, whereas for others, religion may be replaced as a driving force by other life forces and worldviews. Among other people, family is the most important social entity and is extremely important in helping meet their spiritual needs. For others, what gives meaning to life is good health and well-being. For a few, spirituality may include work or money. A person’s inner strength comes from different sources. Among the Navajo, the inner self is dependent on being in harmony with one’s surroundings. For Christians, a belief in God may give personal strength. For most people, spirituality includes a combination of these factors. Knowing these beliefs allows health-care providers to assist individuals and families in their quest for strength and self-fulﬁllment.

Spiritual Beliefs and Health-Care Practices Spiritual wellness brings fulﬁllment from a lifestyle of purposeful and pleasurable living that embraces free choices, meaning in life, satisfaction in life, and selfesteem. For example, when Navajo Indians are not in harmony with their surroundings and experience insomnia from anxieties, the Blessing Way Ceremony, ritual dancing, and herbal treatments, combined with prayers and songs, are performed for total body healing and the return of spirits to the body. Practices that interfere with a person’s spiritual life can hinder physical recovery and promote physical illness. Health-care providers should inquire whether the person wants to see a member of the clergy even if she or he has not been active in church. Religious emblems should not be removed as they provide solace to the person and removing them may increase or cause anxiety. A thorough assessment of spiritual life is essential for the identiﬁcation of solutions and resources that can support other treatments. Box 2–10 identiﬁes guidelines for assessing the cultural domain spirituality.

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With what religion do you identify? Do you consider yourself devout? Do you need anything special to pray? When do you pray? Do you pray for good health? How do religiosity and spirituality differ for you? What gives meaning to your life? How are spirituality, religiosity, and health connected for you?

BOX 2.10

Spirituality Religious Practices and Use of Prayer 1. Identify the inﬂuence of the dominant religion of this group on health-care practices. 2. Explore the use of prayer, meditation, and other activities or symbols that help individuals reach fulﬁllment. Meaning of Life and Individual Sources of Strength 3. Explore what gives meaning to life for individuals. 4. Identify the people’s sources of strength. Spiritual Beliefs and Health-Care Practices 5. Explore the relationship between spiritual beliefs and health practices.

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HEALTH-CARE PRACTICES Another domain of culture is health-care practices. The focus of health care includes traditional, magicoreligious, and biomedical beliefs; individual responsibility for health; self-medicating practices; and views toward mental illness, chronicity, rehabilitation, and organ donation and transplantation. In addition, responses to pain and the sick role are shaped by speciﬁc ethnocultural beliefs. Signiﬁcant barriers to health care may be shared among cultural and ethnic groups.

Health-Seeking Beliefs and Behaviors For centuries, people’s health has been maintained by a wide variety of healing and medical practices. Currently, the United States is undergoing a paradigm shift: from one that places high value on curative and restorative medical practices with sophisticated technological care to one of health promotion and wellness; illness, disease, and injury prevention; health maintenance and restoration; and increased personal responsibility. Most believe that the individual, the family, and the community have the ability to inﬂuence their health. However, among other populations, good health may be seen as a divine gift from God, with individuals having little control over health and illness. The primacy of patient autonomy is generally accepted as an enlightened perspective in American society. To this end, advance directives such as “durable power of attorney” or a “living will” are an important part of medical care. Accordingly, patients can specify their wishes concerning life and death decisions before entering an inpatient facility. The durable power of attorney for health care allows the patient to name a family member or signiﬁcant other to speak for the patient and make decisions when or if the patient is unable to do so. The patient can also have a living will that outlines the person’s wishes in terms of life-sustaining procedures in the event of a terminal illness. Each inpatient facility has these forms available and will ask the patient what his or her wishes are. Patients may sign these forms at the hospital or elect to bring their own forms, many of which are on the Internet. The acceptance of advanced directives and living wills is not uniform across ethnocultural groups. A study in New Jersey found that non-Hispanic whites were more than six times more likely to have advance directives than either Hispanics or Asians, and nearly three times more likely than African Americans (Advance Care Planning, 2004). People born in the United States were more than three times more likely than people who wore not born in the United States to have advanced directives. People who speak English at home were 10 times more likely to have advanced directives than people who do not speak English at home (Advance Care Planning, 2004). What is not known is what inﬂuence religion has on advance directives. Most countries and cultural groups engage in preventive immunization for children. Guidelines for immunizations were developed largely as a result of the inﬂuence of WHO. Speciﬁc immunization schedules and the

ages at which they are prescribed vary widely among countries and can be obtained from the Web site of WHO (http://www.who.int.gov). Campaigns since the early 1970s in the United States have resulted in an increase in immunization rates for children. In 1999, 78 percent of children age 19 to 35 months had completed the combined series of vaccinations for diphtheria-pertussis-tetanus (DPT), polio, measles, and Haemophilus inﬂuenza type b (Hib), up from 69 percent in 1994. Some still consider this unsatisfactory because other countries have higher immunization rates (Federal Interagency Forum, 2006). However, some religious groups, such as Christian Scientists, do not believe in immunizations. Beliefs like this, which restrict optimal child health, have resulted in court battles with various outcomes. Some societies do not have the sophisticated technology and resources needed to facilitate health promotion. For example, Pap smears are relatively new in Egypt, and mammograms are either not offered or unavailabe. Thus, the health-care provider’s ﬁrst step may be to assess a person’s previous knowledge and experience related to preventive and acute-care practices.

Responsibility for Health Care The United States is moving to a paradigm in which people take increased responsibility for their health. In a society in which individualism is valued, people are expected to be self-reliant. In fact, people are expected to exercise some control over disease, including controlling the amount of stress in their lives. If someone does not maintain a healthy lifestyle and then gets sick, some believe it is the person’s own fault. Unless someone is very ill, she or he should not neglect social and work obligations. The health-care delivery system of the country of origin may shape the client’s and employee’s beliefs regarding personal responsibility for health care. In the United States, everyone, regardless of socioeconomic or immigration status, can receive acute-care services. However, they will be charged a fee for the service, and they may not be able to get nonacute follow-up care unless they can prove they are able to pay for the service. Even if they are covered by health insurance, an insurance company representative may need to approve the visit and then have a list of procedures, medicines, and treatments for which it will pay. Individuals who did not need health insurance in their native country may not realize the importance of having health insurance in the United States. A large number of the working poor cannot afford to purchase basic economic essentials for the family and, thus, cannot even consider the purchase of health insurance. As of 2004, 46 million people living in the United States were not covered by health insurance and were unevenly distributed. Almost 30 percent of Hispanics and Native Americans/Alaskan Natives and 20 percent of African Americans are not covered by health insurance, compared with 11 percent of whites (U.S. Bureau of the Census, 2004). Considering that a family insurance plan averaged $10,800 a year in 2006, which is higher than the salary of a person making minimum wage, it is understandable why so many are uninsured. In most countries

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in the more developed world as well as in the less developed world, citizens have free access to care at the point of entry. Of the more developed nations, only the United States and South Africa do not have free access to care at the point of entry (Dagmara & Hopkins, 2003). Healthcare providers should not assume that clients who do not have health insurance or practice health prevention do not care about their health. The health-care provider must assess clients individually and provide culturally congruent education regarding health promotion and wellness and illness, disease, and injury prevention activities.

Folk and Traditional Practices Some societies favor traditional, folk, or magicoreligious health-care practices over biomedical practices, and use some or all of them simultaneously. For many, what are considered alternative or complementary health-care practices in one country may be mainstream medicine in another society or culture. In the United States, interest has increased in alternative and complementary health practices. The U.S. government has an Ofﬁce of Alternative Medicine at the National Institutes of Health that has awarded millions of dollars in grants to bridge the gap between traditional and nontraditional therapies.

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What do you do to take responsibility for your health? Do you take vaccines yearly to prevent the ﬂu or other illnesses? Do you have adequate health insurance? Do you have regular checkups with your health-care practitioner?

A potential high-risk behavior in the self-care context includes self-medicating practices. Self-medicating behavior in itself may not be harmful, but when combined with or used to the exclusion of prescription medications, it may be detrimental to the person’s health. A common practice with prescription medications is for people to take medicine until the symptoms disappear and then discontinue the medicine prematurely. This practice commonly occurs with antihypertensive medications and antibiotics. No culture is immune to self-medicating practices; almost everyone engages in it to some extent. Each country has some type of control over the purchase and use of medications. The United States is more restrictive than many countries and provides warning labels and directions for the use of over-the-counter medications. In many countries, pharmacists may be consulted before physicians for fever-reducing and painreducing medicines. In parts of Central America, a person can purchase antibiotics, intravenous ﬂuids, and a variety of medications over the counter; most stores sell medications, and vendors sell drugs in street corner shops and on public transportation systems. People who are accustomed to purchasing medications over the counter in their native country frequently see no problem in sharing their medications with family and friends. To help prevent contradictory or exacerbated effects of prescription medication and treatment regimens, health-care providers should ask about clients’ self-medicating practices. One cannot ignore the ample supply of over-the-counter medications in American pharmacies, the numerous television advertisements for self-medication, and media campaigns for new medications, encouraging viewers to ask their doctor or health-care provider about a particular medication such as the “purple pill.”

In what self-medicating practices do you engage? What makes you decide when to see your healthcare practitioner when you have an illness?

In the context of Western medicine, in what complementary and alternative practice have you practiced? For what conditions have you used them? Were they helpful? How willingly do you accept other people’s traditional practices?

As an adjunct to biomedical treatments, many people use acupuncture, acupressure, acumassage, herbal therapies, and other traditional treatments. Some cultural groups, for example, Hispanics, commonly visit traditional healers because modern medicine is viewed as inadequate. Examples of folk medicines include covering a boil with axle grease, wearing copper bracelets for arthritis pain, mixing wild turnip root and honey for sore throat, and drinking herbal teas. Native American traditions include ceremonial dances and songs. The Chinese subscribe to the yin-and-yang theory of treating illnesses, and Hispanic groups believe in the hot-and-cold theory of foods for treating illnesses and disease. Traditional schools of pharmacy in Brazil grow, sell, and teach courses on folk remedies. Most Americans practice folk medicine in some form; they may use family remedies passed down from previous generations. An awareness of combined practices when treating or providing health education to individuals and families helps ensure that therapies do not contradict each other, intensify the treatment regimen, or cause an overdose. At other times, they may be harmful, conﬂict with, or potentiate the effects of prescription medications. Many times, these traditional, folk, and magicoreligious practices are and should be incorporated into the plans of care for clients. Inquiring about the full range of therapies being used, such as food items, teas, herbal remedies, nonfood substances, over-the-counter medications, and medications prescribed or loaned by others, is essential so that conﬂicting treatment modalities are not used. If clients perceive that the health-care provider does not accept their beliefs, they may be less compliant with prescriptive treatment and less likely to reveal their use of these practices.

Barriers to Health Care In order for people to receive adequate health care, a number of considerations need to be addressed. Several studies have identiﬁed that a lack of ﬂuency in language

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is the primary barrier to receiving adequate health care in the United States (U.S. Department of Health and Human Services, 2004). One can only deduce that this is true for other countries as well. Availability: Is the service available and at a time when needed? For example, no services exist after 6 p.m. for someone who needs suturing of a minor laceration. Clinic hours coincide with clients’ work hours, making it difﬁcult to schedule appointments for fear of work reprisals. Accessibility: Transportation services may not be available, or rivers and mountains may make it difﬁcult for people to obtain needed health-care services when no health-care provider is available in their immediate region. It can be difﬁcult for a single parent with four children to make three bus transfers to get one child immunized. Affordability: The service is available, but the client does not have ﬁnancial resources. Appropriateness: Maternal and child services are available, but what might be needed are geriatric and psychiatric services. Accountability: Are health-care providers accountable for their own education and do they learn about the cultures of the people they serve? Are they culturally aware, sensitive, and competent? Adaptability: A mother brings her child to the clinic for an immunization. Can she get a mammogram at the same time or must she make another appointment? Acceptability: Are services and client education offered in a language preferred by the client? Awareness: Is the client aware that needed services exist in the community? The service may be available, but if clients are not aware of it, the service will not be used. Attitudes: Adverse subjective beliefs and attitudes from caregivers means that the client will not return for needed services until the condition is more compromised. Do health-care providers have negative attitudes about patients’ homebased traditional practices? Approachability:Do clients feel welcomed? Do healthcare providers and receptionists greet patients in the manner in which they prefer? This includes greeting patients with their preferred names. Alternative practices and practitioners: Do biomedical providers incorporate clients’ alternative or complementary practices into treatment plans? Additional services: Are child- and adult-care services available if a parent must bring children or an aging parent to the appointment with them? Health-care providers can help reduce some of these barriers by calling an area ethnic agency or church for assistance, establishing an advocacy role, involving professionals and laypeople from the same ethnic group as the client, using cultural brokers, and organizationally providing culturally congruent and linguistically appropriate services. If all of these elements are in place and used appropriately, they have the potential of generating culturally responsive care.

Cultural Responses to Health and Illness Signiﬁcant research has been conducted on patients’ responses to pain, which has been called the “ﬁfth vital sign.” Most Americans believe that patients should be made comfortable and not have to tolerate high levels of pain. Accrediting bodies, such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), survey organizations to assure that patients’ pain levels are assessed and that appropriate interventions are instituted. Beliefs regarding pain are one of the oldest culturally related research areas in health care. A 1969 study revealed that Irish Americans are stoic in their responses to pain, whereas Jewish Americans and Italian Americans are more vocal (Zborowski, 1969). A number of studies related to pain and the ethnicity/culture of the patient have been completed. Most of the studies have come from end-of-life care. Some of the salient research ﬁndings follow: • Sixty-ﬁve percent of “minority” patients have inadequate pain control versus 30 percent of “nonminority” patients (Anderson, Richman, Hurley, et al., 2000; Cleeland et al., 1994; Cleeland, Gonin, Baez, Loeher, & Pandya, 1997; Foley, 2000). • A patient’s ethnicity has a greater inﬂuence on the amount of opioid prescribed by the clinician than on the amount of opioid self-administered by the patient (Ng, Dimsdale, Rollnik, & Shapiro, 1996). • Communication between patient and health-care provider inﬂuences pain diagnosis and treatment (American Academy of Pain Medicine, 2004; Purnell & Paulanka, 2005). • The brain’s pain-processing and pain-killing systems vary by race and ethnicity (American Academy of Pain Medicne, 2004). • Few minority patients are told in advance about possible side effects of pain medicine and how to manage them (Anderson et al., 2002). • African American and Hispanic patients with severe pain are less likely than white patients to be able to obtain needed pain medicine because pharmacies do not carry the medicines (Morrison, Wallenstein, Natale, Senzel, & Huang, 2001). • African Americans are less likely to have their pain recorded (Bernabei et al., 1998). • Inadequate education of pain and analgesia expectations may contribute to poor pain relief in the Asian populations (Kuhn, Cooke, Collins, Jones, & Mucklow, 1990). • Disparities in pain management and quality care at end of life exist among African American

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Looking at the list of barriers to health care, which apply to you? How can you decrease these barriers? What are the barriers to health care in your community?

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women in general and speciﬁcally with breast cancer (Payne, Medina, & Hampton, 2003). • Hispanic patients are more likely to describe pain as “suffering,” the emotional component. African Americans are more likely to describe pain as “hurts,” the sensory component (Anderson et al., 2002). • Socioeconomic factors negatively inﬂuence prescribing pain medicine. • Pain does not have the same debilitating effect for patients from Eastern cultures as it does for patients from Western cultures (Kodiath & Kodiath, 1992). • Stoicism, fatalism, family, and spirituality have a positive impact on Hispanics and pain control (Duggleby, 2003; Purnell & Paulanka, 2005; Zoucha & Purnell, 2003). • Chinese, Korean, and Vietnamese patients do not favor taking pain medicine over a long period of time. • Vietnamese Canadians prefer herbal therapies over prescription pain medicine (Voyer, Rail, Laberge, & Purnell, 2005). • Haitians, Haitian Americans, and Haitian Canadians combine herbal therapies with prescription medicine without telling the health-care provider (Voyer et al., 2005). • Black, Hispanic, and Asian women receive less epidural analgesia than do white women (Rust et al., 2004). • Cultural background, worldview, and primary and secondary characteristics of culture profoundly inﬂuence the pain experience. • The greater the language differences, the poorer the pain control. • For Asians, tolerating pain may be a way of atoning for past sins.

Astute observations and careful assessments must be completed to determine the level of pain a person can and is willing to tolerate. Some recommendations: (1) Always ask about preferred treatment and integrate complementary alternative medicine (CAM) into pain/symptom control and management; (2) review the literature of the ethnicity of the patients for whom you provide care; (3) discover your own ethnocentrism and stereotyping of various ethnocultural groups (Mann, 2006); (4) observe for verbal and nonverbal responses to pain; and (5) have pain scales in different languages and with ethnic faces appropriate to the language and ethnicity of the patient (Pain Source Book, 2005). Additional resources for pain are the American Pain Foundation, The American Pain Society, the Boston Cancer Pain Education Center (in 11 languages), and the OUCHER Pain scale for children, all of which are available on the Internet. Health-care practitioners must investigate the meaning of pain to each person within a cultural explanatory framework to interpret diverse behavioral responses and provide culturally competent care. The health-care provider may need to offer and encourage pain

medication and explain that it will help the healing progress. Research needs to be conducted in the areas of ethnic pain experiences and management of pain.

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What is your ﬁrst line of intervention when you are having pain? When do you decide to see a health-care practitioner when you are in pain? What differences do you see between yourself and others when they are in pain? Where did you learn your response to pain? Do you see any difference in the clinical setting in response to pain among ethnic and cultural groups? Between men and women?

The manner in which mental illness is perceived and expressed by a cultural group has a direct effect on how individuals present themselves and, consequently, on how health-care providers interact with them. In some societies, such as American and Asian, mental illness may be seen by many as not being as important as physical illness. Mental illness is culture-bound; what may be perceived as a mental illness in one society may not be considered a mental illness in another. For some, mental illness and severe physical handicaps are considered a disgrace and taboo. As a result, the family is likely to keep the mentally ill or handicapped person at home as long as they can. This practice may be reinforced by the belief that all individuals are expected to contribute to the household for the common good of the family, and when a person is unable to contribute, further disgrace occurs. In Korea, mentally disturbed children are stigmatized, and the lack of supportive services may cause families to abandon their loved ones because of the cost of long-term care and the family’s desire and desperate need for support. Such children are kept from the public eye in hope of saving the family from stigmatization. Koreans in the United States may hold these same values.

What are your perceptions about mental illness? Does mental illness have the same value as physical illness and disease? When you are having emotional difﬁculties, what is your ﬁrst line of defense? Have you observed different attitudes/ responses from providers regarding physical and mental illnesses?

The physically and mentally handicapped may be treated differently in diverse cultures. In previous decades, physically handicapped individuals in the United States were seen as less desirable than those who did not have a handicap. If the handicap was severe, the person was sometimes hidden from the public’s view. In 1992, the Americans with Disabilities Act went into effect, protecting handicapped individuals from discrimination. In the United States, rehabilitation and occupational health services focus on returning individuals with handicaps to productive lifestyles in society as soon as possible.

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The goal of the American health-care system is to rehabilitate everyone: convicted criminals, people with alcohol and drug problems, as well as those with physical conditions. Rehabilitation seems to now be well established in the United States. To establish rapport, health-care practitioners working with clients suffering from chronic disease must avoid assumptions regarding health beliefs and provide rehabilitative health interventions within the scope of cultural customs and beliefs. Failure to respect and accept clients’ values and beliefs can lead to misdiagnosis, lack of cooperation, and alienation of clients from the health-care system.

Some people will not sign donor cards because the concept of organ donation and transplantation is not customary in their homelands. Health-care professionals should provide information regarding organ donation on an individual basis, be sensitive to individual and family concerns, explain procedures involved with organ donation and procurement, answer questions factually, and explain involved risks. A key to successful marketing approaches for organ donation is cultural awareness. THE PURNELL MODEL FOR CULTURAL COMPETENCE •51

Do you see physically challenged individuals as important as nonphysically challenged individuals in terms of their worth to society? What are your beliefs about rehabilitation? Should everyone have the opportunity for rehabilitation?

Are you averse to receiving blood or blood products? Why? Why not? Are you an organ donor? Why? Why not?

What do you normally do when you have a minor illness? Do you go to work (class) anyway? What would make you decide to not go to work or class? Does the sick role have a speciﬁc meaning in your culture?

Sick role behaviors are culturally prescribed and vary among ethnic societies. Traditional American practice calls for fully disclosing the health condition to the client. However, traditional Filipino families prefer to be informed of the bad news ﬁrst, and then slowly break the news to the sick family member. The sick role may not be readily accepted by Italian Americans and Polish Americans; some individuals may keep an illness hidden from the family until it reaches a more advanced stage. Given the ethnocultural acceptance of the sick role, health-care providers must assess each client and family individually and incorporate culturally congruent therapeutic interventions to return the client to an optimal level of functioning.

Blood Transfusions and Organ Donation Most Americans and most, but not all, religions favor organ donation and transplantation and transfusion of blood or blood products. Jehovah’s Witnesses do not believe in blood transfusions. Christian Scientists, Orthodox Jews, Greeks, and some Spanish-speaking societies choose not to participate in organ donation or autopsy because of their belief that they will suffer in the afterlife or that the body will not be whole on resurrection. Because organ and tissue donation rates are lower among African Americans and Hispanics, some donor organizations have started to target speciﬁc campaigns to these communities. Information about kidney transplants and ethnicity can be found at the National Kidney Foundation’s Website, http://www.kidney.org, and in indiviual chapters in this book. Health-care providers may need to assist clients in obtaining a religious leader to support them in making decisions regarding organ donation or transplantation.

Box 2–11 identiﬁes guidelines for assessing the cultural domain health-care practices.

BOX 2.11

Health-Care Practices Health-Seeking Beliefs and Behaviors 1. Identify predominant beliefs that inﬂuence healthcare practices. 2. Describe health promotion and prevention practices. Responsibility for Health Care 3. Describe the focus of acute-care practice (curative or fatalistic). 4. Explore who assumes responsibility for health care in this culture. 5. Describe the role of health insurance in this culture. 6. Explore practices associated with the use of over-thecounter medications. Folklore Practices 7. Explore combinations of magicoreligious, folk, and traditional beliefs that inﬂuence health-care behaviors. Barriers to Health Care 8. Identify barriers to health care such as language, economics, accessibility and geography for this group. Cultural Responses to Health and Illness 9. Explore cultural beliefs and responses to pain that inﬂuence interventions. Does pain have a special meaning? 10. Describe beliefs and views about mental illness in this culture. 11. Differentiate between the perceptions of mentally and physically handicapped in this culture. 12. Describe cultural beliefs and practices related to chronicity and rehabilitation. 13. Identify cultural perceptions of the sick role in this group. Blood Transfusion and Organ Donation 14. Describe the acceptance of blood and blood products, organ donation, and organ transplantation among this group.

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HEALTH-CARE PRACTITIONERS The domain health-care practitioners includes the status, use, and perceptions of traditional, magicoreligious, and biomedical health-care providers. It is interconnected with communications, family roles and organization, and spirituality. In addition, the gender of the health-care provider may be signiﬁcant for some people.

Traditional Versus Biomedical Practitioners Most people combine the use of biomedical health-care practitioners with traditional practices, folk healers, and magicoreligious healers. The health-care system abounds with individual and family folk practices for curing ortreating speciﬁc illnesses. A signiﬁcant percentage of allcare is delivered outside the perimeter of the formal health-care arena. Many times herbalist-prescribed therapies are handed down from family members and may have their roots in religious beliefs. Traditional and folk practices often contain elements of historically rooted beliefs.

Status of Health-Care Providers Health-care practitioners are perceived differently among ethnocultural groups. Individual perceptions of selected practitioners may be closely associated with previous contact and experiences with health-care providers. In many Western societies, health-care providers, especially physicians, are viewed with great respect, although recent studies show that this is declining among some groups. Although many nurses in the United States do not believe they have respect, public opinion polls usually place clients’ respect of nurses higher than that of physicians. The advanced practice role of registered nurses is gaining respect as more of them have successful careers and the public sees them as equal or preferable to physicians and physician assistants in many cases.

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What alternative practitioners do you see for your health-care needs besides traditional allopathiccare practitioners? For what conditions do you use nonallopathic practitioners? Do you think traditional practitioners are as valuable as allopathic practitioners?

Do you prefer a same-gender practitioner for your general health care? Do you mind having an opposite gender practitioner for intimate care? Why? Why not? Do you prefer Western-trained healthcare providers or does it not make any difference?

Does one type of health-care practitioner have increased status over another type? Should all health-care practitioners receive equal respect, regardless of educational requirements? Does the ethnicity or race of a provider make any difference to you? Why? Why not?

The American practice is to assign staff to patients regardless of gender differences, although often an attempt is made to provide a same-gender health-care provider when intimate care is involved, especially when the patient and caregiver are of the same age. However, health-care providers should recognize and respect differences in gender relationships when providing culturally competent care, because not all ethnocultural groups accept care from someone of the opposite gender. For example, many Hispanics are traditionally quite modest, even with health-care providers and, as a result, may feel uncomfortable and refuse care provided by someone of the opposite gender unless it is an emergency. Healthcare providers need to respect clients’ modesty by providing adequate privacy and assigning a same-gender caregiver whenever possible. In providing care to a Hasidic male client, a female caregiver should touch him only when providing care, and then preferably with gloves. Therapeutic touch is inappropriate with these clients.

Within Arab cultures, the physician may rely more on physiological cues than technology for a diagnosis. When physicians order many tests or ask clients what they think the problem is, the client may view them as incompetent (Lipson & Meleis, 1985). Immigrant physicians from Iran may misunderstand the assertive behavior of American nurses, and immigrant Iranian nurses may be considered not as assertive as they should be in the American culture. Many people from the Middle East perceive older male physicians as being of higher rank and more trustworthy than younger health professionals. Chinese Americans, as well as many other people from collectivest societies especially, are taught from a very early age to respect elders and to show deference to nurses and physicians, regardless of gender or age. Evidence suggests that respect for professionals is correlated with their educational level. In Australia, rather than equal respect, paramedics and police ofﬁcers are often held in higher regard than nurses. In most cultures, the nurse is expected to defer to physicians. In many countries, the nurse is viewed more as a domestic than as a professional person, and only the physician commands respect. Nurses in the United States, however, are held in high regard. This may be related to factors such as the completion of high school or an equivalency examination before entering a nursing program; the rigorous licensing examination required before practicing the profession; baccalaureate-, master’s-, and doctoral-level programs of study; and the impact of nursing interventions on healthcare outcomes. Some countries do not have programs leading to a master’s or doctorate in nursing but they are in the initial stages of starting them. In some cultures, folk and magicoreligious health-care providers may be deemed superior to biomedically educated

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physicians and nurses. It may be that folk, traditional, and magicoreligious health-care providers are well known to the family and provide more individualized care. In such cultures, practitioners take time to get to know clients as individuals and engage in small talk totally unrelated to the health-care problem to accomplish their objectives. Establishing satisfactory interpersonal relationships is essential for improving health care and education in these ethnic groups. Throughout the world, except for Francophone Africa where the number of men and women in nursing are equal, a gender disparity exists between men and women in nursing. In Spain and Portugal, 20 to 23 percent of nurses are men because during communist times, if a man agreed to go to nursing school, he did not have to serve in the military. Twenty percent of nurses in Italy are men, 16.5 percent of nurses in Israel are men, and 10 percent of nurses in the Scandanavian countries and Great Britain are men. In the United States approximately 10 percent of nurses are men, with very active campaigns in some areas of the country to recruit men and other underrepresented groups into nursing (Purnell, 2007). Iceland did an effective major recruitment effort to enroll men. In 1999, 30 percent of the student nurses were men. However, because they lacked a program to support men who faced bias and stigma from faculty and other students, only one man completed the program 3 years later. Currently, less than 1 percent of nurses in Iceland are men (Kristinsson, 2001). Box 2–12 identiﬁes the guidelines for assessing the cultural domain health-care practitioners.