Transcultural nursing : health care providers and ethnically diverse clients.

TRANSCULTURAL NURSING:
HEALTH CARE PROVIDERS AND ETHNICALLY DIVERSE CLIENTS

A Dissertation Presented

by

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Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May 1991

School of Education

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ACKNOWLEDGEMENTS

My sincerest thanks and gratitude to the members of my dissertation committee; namely, Dr. Emma Cappelluzzo, Dr. Ted Chen, and Dr. Robert Wellman for their time, their energy and their expertise have guided me through this process.

Two other people I wish to thank are Henrietta Bernal and Robin Froman of the University of Connecticut for allowing me to adapt and use their questionnaire on confidence levels of community health nurses in caring for ethnically diverse populations.

On a more personal note, a very special acknowledgement to my "second" mother, Despena Zervas, without whose constant support and editorial skills I would never have completed this dissertation.

ABSTRACT

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MAY 1991

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This study was designed to explore through two surveys and interviews the question of confidence levels of practicing professional nurses in giving quality care to ethnically diverse client populations. One questionnaire to nursing faculty in 170 colleges and universities across the United States was concerned with the transcultural educational preparation of students, and the second questionnaire to 40 community health agency and inpatient (hospital) facility nurses pertained to their present level of confidence. The comments on situations encountered by practicing professional nurses and how they handled the situation were sought. These nurses also discussed how transcultural education would have helped them to either prevent or solve the problems.

Faculty were surveyed regarding the inclusion of transcultural nursing concepts in their nursing curricula, their transcultural education background, and the ethnic background of their student and client populations. The practicing professional nurses were surveyed as to their personal and professional backgrounds and their knowledge of and perceived confidence levels in giving holistic nursing care to three different ethnic groups - Asians, Blacks, Southeast Asians and Spanish-speaking people. Three variables were assessed; namely, family organization, health care beliefs and lifestyles.

Results indicated that in the surveys of the colleges and universities 96.3% of the nursing programs included some general transcultual nursing concepts in their courses and 31,5% offered them in theory, seminar and clinical components of the program

Only 26% of those who responded offered specific courses or certification classes. In order to assist students in developing cultural awareness 74.1% of the colleges and universities offer clinical experiences with ethnically diverse populations.

The second part of the survey (Self-efficacy) illustrated a definite lack of confidence in giving holistic nursing care to Asian/Southeast Asian clients. Although there appears to be no significant relationship between the three major ethnic minorities and the inclusion of transcultural nursing concepts or the number of years since graduation, there are definite levels of significance between the variables of family organization, health care beliefs, and lifestyles and background information as to the type of nursing program, length and place of employment, and past clinical experiences with ethnic minorities.

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CHAPTER I

INTRODUCTION

The dissertation here proposed will explore through two surveys and interviews the question of confidence levels of practicing professional nurses in giving quality care to ethnically diverse client populations. One questionnaire to nursing faculty is concerned with the educational preparation of students and the second questionnaire to community health and inpatient (hospital) facility nurses will pertain to their present level of confidence. The two communities to be studied will be Lawrence and Lynn, Massachusetts.

Leininger (1976) defines transcultural nursing as:

> the subfield of nursing which focuses upon a comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior; nursing care; and health-illnesss values, beliefs, and patterns of behavior with the goal of developing a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care practices.(p. 8)

Transcultural nursing care is the synthesis of concepts from nursing and other disciplines such as anthropology, sociology and biology.

The concern is to provide care that is sensitive to the needs of individuals, families and groups who represent diverse cultural populations within a society. A thorough assessment of the cultural aspects of a client's lifestyle, health beliefs and health practices will enhance the nurse's decision making and

judgment skills when providing care. Unfortunately, many nursing educational programs allocate one to two hours for the discussion of cultural influences on health care practices, while many others completely omit the topic. Nursing intervention that is culturally sensitive and relevant to the needs of the client will decrease the possibility of stress and conflict arising from cultural misunderstandings and will probably increase compliance withthe medical regimen.

Today's world situation and concern for the welfare of mankind is challenging nurses to know and understand the concept of culture and its effects on health care practices. Because of modern methods of communication, transportation, education and job opportunities nurses, most of whom are of the dominant white culture, frequently come in contact with clients from different cultural backgrounds; and the nurses have a limited knowledge of the client's beliefs, values and health care practices. It is a professional responsibility to learn about the beliefs and lifestyles of other cultures and use this knowledge in giving comprehensive, holistic nursing care.

Nurses work in all geographical locations around the world and even in space exploration; and if they are not prepared to cope with people from different cultures/planets, peace and good health may never be realized!

As early as 1955, Dr.Madeline Leininger(1978), a nurse anthropologist, began her pioneering efforts to help the nursing profession become aware of the need to consider caring within a cultural context. Since that time a group of nurse

anthropologists, educated and guided by Dr. Leininger, has increased in number, and an international force of 250 nurses are the core group of the Transcultural Nursing Society. The organization is not restricted to nurse anthropologists but is open to any professional person interested in the cultural nursing needs of ethnically diverse population. Leininger (1990) even quoted Margaret Mead(1935):

> If we are to achieve a richer culture, rich in contrasting values, we must recognize the whole gamut of human potentialities, and so weave a less arbitrary social fabric, one in which each diverse human gift will find a fitting place.(p. 52)

From my literature search there is a paucity of systematic studies revealing the impact of modern health care programs upon cultural groups. Most of the studies indicate that our profssional western health care programs have not been too successful, especially with non-western clients. This has been demonstrated by the high incidence of non-compliance with medical regimens or returning to native healers. Could it possibly be due to our lack of knowledge of the client's cultural beliefs, values and health care practices and our own ethnocentrism?

For all of the above reasons and my belief that everyone, regardless of race, creed, color and lifestyle deserves comprehensive, holistic nursing care. I feel that all nurses must be at least knowledgeable about their own culture, the culture of Nursing, and the culture of their clients or else comprehensive, holistic nursing care can not be carried out. Too many nursing programs give just a brief introduction or even omit the topic of transcultural nursing concepts. If this knowledge is not offered

in their educational preparation for nursing, how can they, in their clinical practice be confident in caring for an ethnically diverse population?

Anthropologists have long studied cultures and sociologists concentrate on family-kinship patterns and child-bearing/rearing practices but the health care field has been very lax in incorporating such concepts. In less sophisticated times, nursing did consider the above needs. Since the Korean War and the advances of technology, the health care professional has been forced to re-evaluate his/her health care practices. It has been a very slow and tedious job to integrate cultural aspects of care into professional healkth care curricula, It began with nursing schools requiring courses in anthropology and sociology electives but left the integration of these concepts to the students or interested faculty. This frequently resulted in incorrect, incomplete and definately hapharzardous utilization. As long as cultural aspects of patient care other than those required in transcultural nursing courses are not seen as "need to know" but "nice to know", the nurse and the client will be the losers! Mattson (1987) summarizes the dire need for these concepts in nursing:

> The U.S. today is experiencing the largest influx of immigrants since the 19th Century, with a resultant increase in the numbers of ethnic, immigrant, and refugee clients found among the patient population. This diversity presents, without a doubt, considerable challenges for us in the health care field..... Clients are making their identity, problems, and needs known, and professional groups can no longer remain indifferent to the view points and needs of cultural groups. (p. 206)

HOW CAN WE PROVIDE HOLISTIC NURSING CARE WHEN WE DO NOT UNDERSTAND OUR CLIENTS/PATIENTS?

A. Purpose of the Study

The purposes of this study are threefold:

1. to survey colleges and universities in the United States to identify the number of transculturally prepared faculty and the inclusion of transcultural nuring concepts/ courses in their programs.
2. to survey/interview practicing professional nurses to determine to what degree they feel confident in caring for an ethnically diverse client population.
3. to determine what educational preparation would increase their confidence in the clinical area.

It is recognized by the writer that there are many other factors affecting clinical practice but for the purpose of this research, the significance of the inclusion of transcultural nursing concepts is the only one to be surveyed. The primary concern of the writer is not merely relegated to the clinical practice area but focuses upon the influence of transcultural nursing educational preparation on the nurse's confidence level in caring for ethnicaly diverse clients and providing quality holistic nursing care. It is the author's contention that nurses who receive a nursing education which includes transcultural nursing concepts will feel more confident when they encounter

clients from different cultures and who may have different health care values.

H. Bernal and R. Froman (1987)reported that community health nurses did not feel confident in caring for three distinct ethnically diverse populations: blacks, Puerto Ricans and Southeast Asians.

> During the past 20 years changes in the education and practice of community health nurses have influenced the ability of community health nurses to serve the culturally different client. These changes range from increased emphasis on home care of the sick client to the increased use of the integrated curriculum models. At the saem time, urban centers have seen major increases in ethnic groups such as Hispanics, blacks, and Southeast Asians. Unlike the aging white population, these groups are in greater need of traditional public health nursing services and maternal and child health programs. Many of the nurses being asked to take care of these clients in the community have not been adequately prepared in cross-cultural concepts and have had a limited educational experience in public health nursing. (p. 201)

Dr. Madeline Leininger (1990) in her article on the significance of cultural concepts in nursing describes transcultural nursing as a new phase in health care where we examine the impact of cultural factors upon health and illness behaviors.

> During the FIRST era of health services, considerable emphasis was given to the physical and protective needs of people, The SECOND era gave emphasis to the psychological aspects of the patient's sick behavior, but combined the physical aspects with the psychological so that a psychophysiological approach to patient treatment and care was evident. Only very recently is the THIRD or NEW ERA becoming manifest with an emerging interest in and emphasis upon cultural and societal factors relating to the patient's illness.....
> In the THIRD ERA, progress will be dependent upon nursing and medical staff to have substantive

knowledge about sociocultural factors influencing patient behaviorand care.(p. 53)

Considering all the factors, it is the belief of the writer that something will have to be done to help practicing professional nurses as well as nursing students to increase their level of confidence in caring for ethnically diverse populations.

In an effort to enhance this confidence level of professional nurses, the research in this study is designed to investigate and report on what transcultural nursing concepts are presently being taught, the preparation of faculty in transcultural nursing, and the transcultural educational needs perceived by professional nurses both in the educational and clinical practice settings.

Faculty members will respond to a questionnaire relating to transcultural nursing concepts presently being taught and the number of transculturally academically prepared faculty. Respondents will answer items focusing on the following points:

1. The number of transculturally prepared faculty in your college or university.
2. The presence or absence of transcultural nursing concepts/courses in your nursing education program.
3. The ethnic background of your student and client population.

The second part of the study will focus on questions pertaining to confidence levels of practicing professional nurses in caring for an ethnically diverse population. With permission of the authors, a modified version of Henrietta Bernal and Robin Froman's "Cultural Self-efficacy Scale" will be used for the confidence level questions. In analyzing the responses, it is

the intent of the writer to identify specific transcultural nursing concepts which could be included in the educational preparation of professional nurses. This part of the research is designed to answer the following questions.

1. What is the major ethnic composition of the professional nurse's practice?
2. What is the degree of confidence of the practicing professional nurse in caring for ethnically diverse clients?
3. What is the present transcultural nursing knowledge level of practicing professional nurses?
4. What is the transcultural educational preparation of practicing professional nurses?
5. What educational preparation would have been beneficial for practicing professional nurses to give holistic care to ethnically diverse client populations?

It is the intent of the writer to survey both the transcultural educational preparation of present baccalaureate nursing students and the confidence level of practicing professional nurses in an effort to support the position that there is a direct relationship between holistic nursing care and compliance with the health care regimen of ethnically diverse clients. The suggestions follow, therefore, that in order for practicing professional nurses to give holistic nursing care, colleges and universities in their nursing education programs must make a concerted effort to provide these transcultural concepts.

B. Significance of the Study

This research study is to be of significance to nursing educational faculty and practicing professional nursing staff devcelopment departments in planning and implementing courses and programs to help practicing professional nurses meet the cultural needs of their ethnically diverse clients. All persons have a right to holistic nursing/health care.

As the reader can visualize, the ethnic population changes between 1900 and 1980 due to the refugee influx have made nurses, a majority of whom are of the white dominant culture, look at their own ethnocentrism, the culture of nursing,and their lack of knowledge of the ethnic/cultural needs of their clients. (see Table 1)

Table 1

Population Characteristics - Percentages

Ethnicity	Lawrence 1980	Lynn 1980
White	80.89	93.18
Black	2.16	3.88
Native American ,Eskimo & Aleut	.21	.13
Asian & Pacific Islanders	.44	.26
Hispanics	16.30	2.55

If nurses are allowed to administer holistic nursing care, the number of non-compliant cases would decrease. Imagine both a native healer and a Western medical health care professional working together for the benefit of the client! For example, age is a very important aspect in the life of the Oriental and Greek families. In the Greek culture, it is the duty of the eldest daughter to care for aging family members; and if there is no daughter, it is the duty of the daughter-in-law. The "old ones" are revered and their advice or wisdom is often sought by other family members. On the other hand, the old Eskimo who is unable to care for himself/herself is given a small supply of food and left to die - alone.

As Peter Morley (Henderson and Primeaux, 1981) succinctly describes the relationship between Western and non-western medicine:

> Throughout the history of western medicine with a few exceptions, there has been a tendency to view traditional medical systems and beliefs from the vantage point of contemporary Western medical science, regarding them as not only 'primitive', but archaic and largely irrelevant to both scientific medicine and the health of human populations. The emphasis has been on the quaint, but queer, customs and lore of the 'savage'.
> Imbued with the idea of progress, physicians, medical historians, and early anthropologists viewed 'primitive' medicine as an early stage in evolutionary development. Traditional medicine, even as currently practiced in many non-Western societies, was therefore seen as a simple predecessor of complex modern scientific medicine.(p. xvii)

On close scrutiny, traditional and modern medical beliefs and practices are more interrelated than many scientists will admit. For example, a Native American with a heart problem would chew the plant called Foxglove. Today, the Cardiac specialists recommend

the drug Digitalis, a product of the Foxglove plant. It is the writer's belief that modern societies must bend and make room for traditional medical systems. How many more similarities are there?

The results of this research will assist faculty and staff development departments in planning course/continuing education programs in transcultural nursing in order to increase the confidence level of practicing professional nurses caring for ethnically diverse clients and increase compliance with the health care regimen.

C. Design and Methodology

1. Design. The study is designed according to the procedure listed in the following statements:

    1. A list of professional nursing educational programs, based upon a review of the National League for Nursing's list of approved Schools of Nursing and a thorough search of the literature, will be formulated.
    2. Construct 2 questionnaires and interview questions (details are given in the section of the study entitled Instrumentation).
    3. Mail the survey questionnaire to a random sampling of colleges and universities in the United States. Approximately 40% of the population will be included in the sample.
    4. A survey questionnaire will be distributed to practicing professional nurses in two inpatient

practicing professional nurses in two inpatient hospital facilities and two community health agencies. The two communities to be researched will be Lawrence and Lynn, Massachusetts.

5. An interview will be conducted in Lawrence and Lynn with the same practicing professional nurses to acquire examples of cultural conflicts and resolutions, if any.

2. Methodology: In planning this study, the researcher investigated several research methods before concluding that the descriptive survey would be the most appropriate for this study.

As Daniel Fox (1969) stated:

> In educational research there are two conditions which justify the descriptive survey. First, there is an absence of information about a problem of educational significance, and second, that the situation which could generate that information do exist and are accessible to the researcher. (p. 424)

Dorothy Brockopp and Marie Hastings-Tolsma (1989) agree with Fox and state:

> Descriptive research is present-oriented, that is, it describes what exists at the present time..... Data are generally collected through the use of a questionnare interview, observation, literature review, or critical incident technique..... Areas of interest that have not been investigated in any depth can frequently be best understood through designing a descriptive study. (p. 194)

Because of the increased emphasis on high technology nursing skills and monitoring of life-supporting machines, there has been less emphasis on the humanistic needs of the client especially those of a different ethnic culture. For example, patients are

frequently referred to as "the vent case in 312" not Mrs. Rodriquez who has a respiratory crises.

Borg and Gall (1971) state that descriptive research involves collecting data in order to test hypotheses or answer research questions concerning the current status of the subject of the study.

It is the intent of the writer to answer the research question "Are nurses educationally prepared sufficiently to have confidence in caring for ethnically diverse clients?". The descriptive survey is an attempt by the writer to collect data from the members of nursing faculty population of baccalaureate nursing programs in the United States in order to determine the present day status of transcultural nursing and to collect data from practicing professional nurses in order to determine their level of confidence in caring for ethnically diverse clients who are either hospitalized or receiving home care. In addition, the writer will try to identify what transcultural educational preparation would have helped professional practicing nurses.

The correlational research method was also considered by the writer. According to Kovacs (1985):

> Correlational surveys are statistical studies used for the purpose of predicting possible outcomes or results. They require the collection of data on more than one variable from any one group of respondents and aim to show the relationship between the variables. It is to be emphasized, though, that correlational studies do not show cause and effect unless they are experimental in design (p. 52).

Polit and Hungler (1978) describe retrospective correlational studies as:

> Investigations in which the manifestation of the same phenomena existing in the present is linked to other phenomena occuring in the past. That is, the investigator is interested in some 'effect' and attempts to shed light upon the factors that have caused it.....
> In nursing research as well as medical research, retrospective studies are quite prevalent. To illustrate the concept of retrospection more concretely, let us take as an example the case of a nursing school which is trying to understand the factors that cause certain students to drop out of its baccalaureate nursing program while other students continue until graduation, The researcher's problem is to try to identify and disentangle the independent variables (such as motivation, academic ability, financial problems, personality traits, and so on) which have caused some students to leave the program before completion.....Findings from a single retrospective study are rarely convincing and, thus, often require confirmatory research efforts. (p. 185)

Since it is the writer's intent to determine whether transcultural nursing concepts taught during the professional nurse's educational preparation will assist these nurses in becoming more confident in caring for ethnically diverse clients, the descriptive survey method was deemed most appropriate for this study.

D. Instrumentation

The instruments utilized for this study will be two questionnaires and an interview. In deciding on the method of instrumentation, it is noted by the writer that descriptive data are typically collected through the use of interviews, questionnaires or observations.

In considering the interview, Borg and Gall (1971, p. 189) believed that the principal advantage of the interview as a

research technique is in its adaptability, The well-trained researcher can make full use of the responses of the subjects to alter the interview situation.
It permits the researcher to follow-up leads and then obtain more data and greater clarity.

Jackson and Rothney (1961, p. 569) concluded that under favoravble conditions, the interview tends to yield more complete and also more data concerning negative aspects of self. They found that respondents were fairly consistent when the interview and questionnaire responses to fact or yes or no items were compared.

Borg and Gall (1971) discussed some of the disadvantages of the personal interview approach. They stated that:

> Although it has a number of important advantages over the other data collection tools, the interview has definite limitations. Most importantly, the very adaptability gained by the interpersonal situation leads to subjectivity and possible bias. (p. 211)

Factors such as eagerness to please the interviewer, personality conflicts, and tendency of the interviewer to seek out answers which support his/her preconceived notions definitely must be considered. Therefore, the writer proposes to use a combination of a questionnaire and interview when soliciting information about the level of confidence in caring for ethnicaly diverse populations from the practicing professional nurses in the inpatient/hospital and community health settings. Polit and Hungler (1978) state that questionnaires do not provide immediate feedbck and the total number sent are not returned. It does save a great deal of time in scheduling appointments and traveling. It

is the belief of the writer that a questionnaire is the most efficient method, takes less time, is less expensive, and permits collection of data from a much larger sample. For this reason, the questionnaire was the only tool used to survey nursing faculty across the United States.

Recognizing the problem of non-respondents, the writer realizes the importance of developing a creative cover letter in an effort to motivate faculty to respond to the initial mailing.

Questionnaire: There will be two questionnaires and one interview. Questionnaire #1 will deal with the inclusion of transcultural nursing concepts in present baccalaureate nursing education programs and will include two major sections:

1. The first section will survey the colleges and universities in the United States regarding the inclusion of transcultural nursing concepts in their nursing education programs. Included will be questions concerning courses such as sociology, anthropology and transcultural nursing as well as the opportunity for learning experiences with ethnically diverse clients.
2. The second section will include questions on the transcultural preparation of the faculty, educational and professional background, and the ethnic composition of the student population and the communities in which they practice.

The second questionnaire and the interview will survey practicing professonal nurses as to their level of confidence in caring for ethnically diverse clients.

1. The first section will be demographic data (personal, educational, and professional).
2. The second is a cultural self-efficacy questionnaire, using a Likert scale, to determine confidence levels (knowledge and skills).

The interview will be a followup to elicit from the practicing professional nurses specific examples of cultural conflict and frustrations when working with ethnically diverse clients.

Details on the design and implementation of the instrument and the study will appear in Chapter III of the dissertation.

E. Sample Selection

1. Identification of the Population: The population for the study will be composed of faculty members from colleges and universities in the United States. In addition, nurses from two inpatient/hospital and two community health agencies will be surveyed.

2. Determination of the Sample Size: Gay (1976) states that for descriptive research, a sample size of 10% is a minimum. Kovacs (1985) states:

> It is evident that the researcher might expect a loss or attrition of study subjects snd thus, a loss of data when the selected sample and data producing sample are not the same size. Researchers can not overlook the posibility that individuals

> who elect not to participate or who for some reason can not/ do not participate would have responded differently from those who do participate.
> .....
> A loss of 30% of the selected sample is unfortunate but not uncommon. However, conclusions may be drawn from 60% returns of usable data. Indeed, a 60% return to a questionnaire survey is considered a high return rate.....
> Sample size may be arbitrarily determined by selecting a portion of the population; for example, 10-20% However, the sample should be large enough to be representative, and, in addition, be randomly selected. (p. 105)

Considering these points, it is the decision of the writer to survey approximately 40% of the colleges and universities in the United States and 40 practicing professional nurses. Since there are approximately 400 college and university nursing education programs in the United States, the survey questionnaire will be sent to 160 faculty. Due to the inconsistency of the numbers and work schedule of practicing professional nurses both in inpatient and community health settings, volunteers will be sought.

3. Selection of the Sample: It is the writer's intention that every college/university have the same probability of being selected as a part of the sample. For this reason, a random sampling of colleges and universities will be used.
Gay (1976) states that random sampling is the best single way to obtain a representative sample. He mentions that although no technique guarantees a representative sample, the probability is higher for this procedure than any other.

In order to assure a valid random sample, a non-nurse will select 160 numbers out of the possible 400 (40%).

F. Observational Technique

Rating: Attitude scales attempt to determine what an individual believes, perceives, or feels. For this reason the writer has chosen to use a 5 point Likert scale for use in rating a selection of responses on the confidence level items and the entire part of the study dealing with confidence levels in caring for ethnicaly diverse clients.

According to Gay (1976) a Likert scale asks an individual to respond to a series of statements indicating whether he/she:

Strongly Agree (SA)	= 5 points
Agree (A)	= 4 points
Undecided (U)	= 3 points
Disagree (D)	= 2 points
Strongly Disagree (SD)	= 1 point (p. 69)

In the writer's scale the statements range from Quite Confident (QC - 5 points) to Very Little Confidence (VLC - 1 point).

Tabulation of the other data will be group frequency distribution. According to Polit and Hungler (1978):

> A frequency distribution is a systematic arrangement of numerical values from the lowest to the highest, together with a count of the number of times each value was obtained. ..... It should be apparent that the organized arrangement make it convenient to see at a glimpse how nurses performed. (p. 508)

G. Data Collection, Processing and Analysis

A cover letter and questionnaire #1 will be mailed to nursing faculty members of the colleges and universities who are selected

as part of a random sample. A stamped, self-addressed envelope will be included in each mailing for convenience in replying. It is well-known that a survey with an enclosed stamped, self-addressed envelope is more frequently returned than one without the envelope. It is estimated that the first mailing will be sent out at the end of February 1991 with a followup request to be mailed if necessary. The plan will be to encourage faculty to return the questionnaire to the writer by May, the close of the academic year.

The second questionnaire will also have a cover letter to be given to the volunteer participants- practicing professional nurses. This questionnaire will be distributed in March 1991 and will be picked up by the author a week later. At that time an appointment for the interview will be made.

Once the repondents have returned the questionnaires, the responses will be coded, and the analysis used will be a frequency distribution for questionnaire #1 and inferential statistics - Analysis of Variance (ANOVA) for questionnaire #2. The returns are to be tabulated and will be presented in different forms. Tabular results of ANOVA will be reported as degree of freedom (df), F value, and probability level.

Responses from the study will be organized to provide base line data for analysis and for future studies on the influence of transcultutal nursing education on confidence levels of professional nurses when caring for ethnically diverse client populations.

H. Limitations of the Study

The writer notes the following limitations of the study:

1. The survey of the nursing education institutions must be mailed early in the semester as not all colleges/universities have the same academic year.
2. Because it is a mailed questionnaire (31) requesting anonymous responses, the percentage of returns is difficult to predict.
3. The anonymous nature of the questionnaire (#1) will make followup difficult.
4. The research on confidence levels is limited to two communities in Massachusetts.
5. Only two inpatient/hospital and two community health agencies will be included in the study.
6. Although a random sample can be used for questionnaire #1, volunteers will be sought for questionnaire #2 and the interviews.

I. Definition of Terms

The following is a list of the terms which will be used in this study:

1. Caring - The direct or indirect nurturance and skilled activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and otherwise dependent upon the needs, problems, values and goals of the individual or group being assisted.

2. Client/Population - persons who are in an inpatient/hospital setting and people who are cared for in their homes or community health agencies.

3. Culturally prepared faculty - Registered professional nurses who have graduated from an established Transcultural Nursing program or who has been certified through an examination aadministered by The Transcultural Nursing Society.

4. Culture - Learned and transmitted knowledge about a particular group of people with their values, beliefs, rules of behavior, and lifestyle practices that guide that group in their thinking and actions in patterened ways.
5. Ethnically diverse - people of various racial, religious and cultural backgrounds.
6. Ethnocentrism - The tendency of an individual or group by feelings and beliefs that one's own lifeways are the most desirable, acceptable, or best, and to act in a superior manner to another culture's lifeways.
7. Holistic/Humanistic nursing care - The integration and balance of the physical, emotional, spiritual, and cultural aspects of the individual to achieve total well-being.
8. Noncompliance - nonadherence to the prescribed medical and nursing regimen.
9. Self-efficacy - A person's sense of confidence that a particular behavior can be carried out.

10. Transcultural Nursing - A subfield of nursing which focuses upon the comparative study and analysis of different cultures and subcultures with respect to nursing and health-illness caring practices, beliefs, and values with the goal of generating scientific knowledge and of using this knowledge to provide appropriate nursing care practices.

CHAPTER II

REVIEW OF LITERATURE

To serve as the background for this research, the review of literature was focused on studies pertaining to transcultural nursing and self-efficacy. Theories of Transcultural Nursing and Social Learning in relationship to the confidence levels of practicing professional nurses in caring for ethnically diverse client populations are discussed.

Although the United States has always had a variety of different types of people and cultures, the nature of this mixture has changed drastically in the last two decades. This is due, in part, to the change in the United States immigration policies and the establishment of special refugee catagories. From 1921 to 1968 quotas were based upon nationality and Europeans were favored. The Immigration Act of 1965 changed the old quota system and to allow the entrance of at least 170,000 immigrants from Eastern countries. In 1966, special refugee status was given to Cubans and in 1977, to the Vietnamese. Since 1970 there has been the admission of over two million refugees from Asian countries and nearly 1 milllion more under special refugee status. (Bullough & Bullough, 1990)

Transcultural nursing and self-efficacy will be defined throughout the literature, the factors influencing the confidence levels will be reviewed, and the research on selected transcultural nursing practices will be included.

A. Transcultural Nursing

Transcultural Nursing is " the learned subfield of nursing which focuses upon the comparative study and analysis of different cultures and subcultures with respect to nursing and health-illness caring practices, beliefs, and values with the goal of generating scientific and humanistic knowledge and of using this knowledge to provide culture-specific and culture-universal nursing care practices". (Leininger, 1978, p.493) It is concerned with the provision of quality nursing care that is sensitive to the needs of individuals, families and groups who represent ethnically diverse client populations. Nursing intervention that is culturally sensitive and relevant to the needs of the clients will decrease the possibility of stress or conflicts arising from cultural misunderstandings and will increase the probability of compliance with the health regimen planned for them.

Bullough and Bullough (1990) contend that one measure of society's level of civilization could be the way it treats its temporarily or permanently disadvantaged members such as infants, aged, sick and minority group members. Today with DRG's (Diagnosis Related Guidelines) the length of hospital stays and the number of home visits by health care professionals is limited, and this restriction diminishes the health care treatment to such groups. Public Law 98-21 of the Social Security Amendments was signed into law and stipulates that Medicare reimbursement for hospital inpatient services be on a prospective payment system (DRG). This payment system has caused a national health care revolution. The DRGs (467 in number) reimbursement approach is based upon payment

of a predetermined amount for the care of persons who have a medically related diagnosis and treatment and a similar length of stay. At the end of this predetermined time the client is either discharged or the physician must certify the need to keep the patient. Unless it is a dire emergency, there is no medical coverage. One example of the potentially disasterous effects of DRGs can be illustrated by the following actual situation: the scheduled discharge of a 90 year-old post-operative woman to her home five days after surgery because she had a daughter in the home who was classified as a caretaker. If the nurse had not followed up on the case, the discovery would never have been made that the patient's daughter was 70 years old and was severely mentally handicapped. A similar situation may be used with an ethnically diverse client whose family does not understand the health care needs of the patient and instead of following the medical regimen uses home/cultural remedies.

Nursing as a profession constantly strives to improve the delivery of nursing care to clients of all races, creeds, nationalities, and socioeconomic status. Yet research shows many nurses do not feel confident caring for blacks, Asians, and Spanish-speaking clients. Therefore, it is mandatory that nurses build a more comprehensive knowledge base regarding the transcultural aspects of nursing care.

Today's world situation and concern for the welfare of humanity is challenging the nursing profession to understand the concept of culture and its effects on health care practices. Because of the modern methods of communication, transportation,

and education, nurses frequently encounter people from a variety of cultures and often have a limited knowledge of lifestyles, beliefs and health care practices for these people. Very often observed in the health care profession is Ethnocentrism " the tendency of an individual to hold by feelings and beliefs that one's own lifeways are the most desireable, acceptable, or best, and to act in a superior manner to another's cultural lifeways" (Leininger, 1978, p. 492) . These professionals have grown up in one culture and have been educated in another culture (western health care practices - highly technical). For the above reasons, the writer feels that it is a professional responsibility to learn about the values and beliefs of other cultural groups and use this knowledge in providing quality holistic nursing care. The following example demonstrates such a problem and a possible solution.

> For a long time, administrators at a hospital in a Texas community near the Mexico border were unable to understand why their obstetrical unit had many more empty beds than the obstetrical unit at the other local hospital. Although it had been known for some time that many more women of Mexican or Mexican-American ancestry had their babies at the competing hospital, administrators could not identify the reason. One day, a nurse who often talked with one of the orderlies (a Mexican-American) heard from him that his wife was in the other hospital after having delivered their third child. She commented that it would have been more convenient for him if his wife had been hospitalized where he was employed. The orderly revealed that his wife and her friends looked forward to the special burrito dinner prepared by the Mexican cooks at the other hospital. Providing tasty Mexican food was proof of the other hospital's personal interest in its clients. (Kneisel, 1986, p. 54)

It would appear that the problem of ethnocentrism has not been resolved since Leininger's research on transcultural needs of clients more than 35 years ago.

A thorough assessment of the cultural aspects of a client's lifestyle, health beliefs, and health practices will enhance the nurse's decision making and judgment skills when providing quality care. Tripp-Reimer (1984, p. 78) points out that " cultural assessments elicit shared beliefs, values, and customs that have relevance to health behaviors; they are performed to identify patterns that may assist or interfere with a nursing intervention or planned treatment regimen". Assessment is the cornerstone of the nursing process. It is the process of compiling a data base about the client's health care needs.

> For many clients, a thorough cultural assessment is not necessary; most clients do not need complete assessments in all areas. Complete asessments of all systems (biological, psychological, environmental and sociocultural) are not routinely performed on all clients because they would be too time consuming and costly for both the practitioner and the client. The point is that cultural data are embedded in many good nursing assessment tools. Basic cultural data include: ethnic affiliation, religious preference, family patterns, food patterns, and ethnic health care practices.... If the client is not adhering to a prescribed or recommended treatment plan, cultural factors may be important..... Cultural assessment involves a shared negotiation or contract between client and professional in which each is treated as an equal bringing important and relevant materials to the interview (Tripp-Reimer, 1984, p. 85).

Anderson (1990, p. 136) agrees that if not recognized and taken into account, the different cultural perspectives on health and illnes held by recent immigrants could become obstacles to

effective care. "Health professionals are often unaware of the complex factors that influence patients' responses to professional care. Consequently, patients may not comply with treatments so as not to conflict with their priorities".

The point here is that the benefits of western biomedical science can not be realized unless health care practitioners are able to provide care in such a way that it is socially and culturally acceptable to their clients.

Lipson and Meleis (1985) reviewed many assesment tools and found many to be too time consuming. They felt that, in regard to immigrants, the following information was important.

1. length of time client has been here and where client was raised;
2. language or languages spoken and skill in the language of the host country;
3. nonverbal communication style;
4. usual religious practices;
5. ethnic affiliation and ethnic identity;
6. family roles especially decision-making; and
7. social support in the new country (p. 50).

Mattson (1987, p. 206) discusses the need for cultural concepts in nursing curricula.

> The United States today is experiencing the largest influx of immigrants since the 19th century, with a resultant increase in the numbers of ethnic, immigrant, and refugee clients found among patient populations. This diversity presents, without a doubt, considerable challenges for the health care field. For example, in the language area alone.

> Theiderman (1986) estimated that there are currently 104 languages spoken in the state of California itself! She further indicated that the barriers to effective health care facing the nurse are obvious. "Variations in values, etiquette, religion and pain responses all affect the ability to perceive these people accurately and to deliver health care with the efficiency and compassion every patient deserves" (p.6). According to Leininger (1976), "These people are making their identity, problems, and needs known, and professional groups can no longer remain indifferent to the viewpoints and needs of cultural groups" (p. 97).

Mattson (1987) states that in order to meet this challenge, nurses must be exposed to the concepts of transcultural nursing and must be provided with a framework by which to approach any ethnic or cultural group.

Theiderman (1986, p. 52) states in her article on ethnocentrism as a barrier to health care that:

> The effective delivery of health care to growing ethnic populations within the United States is a challenge for nurse practitioners. A breakdown in cross-cultural communication and understanding, which stems from the tendency of health care professionals to project their own culturally specific values and behaviors onto the foreign-born patient, has contributed significantly to non-compliance in this patient population. In order to remedy this situation, it is important for nurse practitioners to separate the values of their own cultural background from the cultural background and values of the patients for whom they provide care.

Fong, (1985, p. 3) agrees with the other authors and says:

> When discussing cultural diversities, it is tempting to stereotype people according to ethnic and cultural group characteristics. However, since members of a group are individuals, it is essential that intracultural diversity be considered. Nurses must demonstrate an appreciation of the patient's response to his/her culture..... The nurse must use the

> nursing process to assess patient needs and to deliver high-quality, individualized care to each person regardless of heritage.

Louie (1985,p. 78) continues to discuss the fact that since the 1970's, governmental regulations, programs and strategies have been formulated in an effort to remove various barriers to quality care for ethnically diverse populations. However, the apathy of the health care professionals toward some ethnic clients has seen more serious morbidity cases and a higher mortality rate.

> Infant mortality rates and cardiovascular and carcinoma diseases are higher for non-Caucasian groups; in addition, black, male adults experience the highest mortality rates in the total population. One explanation offered for this trend is that ethnic clients and other disadvantaged groups suffer from poverty, lower standards of living, discrimination, and lack access to health care. Nurses need to look further into why ethnic clients are experiencing greater health problems than Caucasian clients.

Leininger (1989) contends that there is a major crises in nursing (even greater than the nursing shortage) in that most nurses are unprepared to function effectively with migrants and cultural strangers. As a consequence, stress and burnout of nurses occurs and makes them feel inadequate and helpless in their roles. This will increase if nurses are expected to work with even more cultural groups about whom they know little or nothing.

The United States Bureau of Census (1989) indicates that in the first half of the 1980's (1980-1985) over a million immigrants have entered the United States. Asian and Spanish-speaking immigrants were by far the largest groups to enter the United States.

> According to the United Census Bureau (1989), two of the largest minorities include Spanish-speaking Americans, numbering eighteen million officially (with many more entering illegally), representing approximately 7 percent of the population, and Asian-Americans, numbering roughly five million, or approximately 2 percent of the population. (According to informal predictions, half of all Americans will be Spanish-speaking by the year 2000. The largest minority group in the United States continues to be blacks, numbering close to 30 million, or about 12% of the population.

Airhihenbuwa and Pineiro (1988) discuss the need to include cross-cultural concepts in health education in school curricula. Their conclusion was that:

> Multicultural education is a necessary ingredient for promoting cultural diversity in the United States educational system. School health care curricula should incorporate instruction about health problems among ethnic minorities. If we are to educate youth for what we want the future of society to be, educators must encourage and promote diversity. In school health curricula, diversity is critical to adequately promote health for all.

To summarize the literature review on transcultural nursing concepts and their need for inclusion in a nursing education program, let me cite two examples.

Bernal, Pardue, and Kramer (1987) did a study on the rewards and frustrations of working with an Hispanic minority population. The home care nurses cited their sources of frustration as:

1. Not home, not found visits
2. Nurse's limited fluency in Spanish
3. Client's inability to make lasting lifestyle changes
4. Client's high level of poverty without hope of relief
5. Too burdensome demands on the nurse as client advocate

6. Socioeconomic problems of unempowered single women as heads of households
7. Rigid sex roles within client families
8. Overreliance on nurse to solve all problems
9. Client's non-compliance with instructions and
10. Other health care workers negative attitudes.

Their rewards cited were:

1. Client's appreciation of the nurse's services
2. Hospitality of the clients
3. Client's attitude of respect for the nurse
4. Expressiveness and warmth of the clients
5. A sense of family ... caring for each other
6. Acceptance of the nurse
7. Ability to communicate in a second language
8. Success in advocacy role and
9. Admiration of the client's spirit in the face of adversity.

Wilson (1990) uses the example of a Kiowa Indian during a one half hour interview for admission to an alcohol treatment unit.

> The Kiowa man folded his arms across his chest as he sat in the chair in front of the Anglo nurse. .....he never made eye contact with the nurse as she asked him the routine questions. In her assessment the nurse documented, 'This 52-year-old man avoided eye contact during the initial intake interview. He appeared withdrawn and avoided talking about himself. This patient may be depressed and have difficulty accepting treatment. This is not an uncommon deduction from the data, but quite an erroneous one because this native American gentleman was merely being polite in a new situation. It has been pointed out

> that 'native Americans show respect by not making eye contact, but a nurse from another culture may misinterpret this as advoidance. Folded arms by native Americans reflects an unhurried attitude and comfort with a situation, not standoffishness or indifference' . (p. 41)

The surveillance within nursing education, service, and administration, is a responsibility and concern of professional nurses in their multifaceted roles. To assure greater acceptance of populations as culturally diverse as clients, students, and nursing practitioners, cultural and ethnic attitudes and stereotypes must be reexamined. Continuing efforts and activities such as teaching transcultural nursing concepts in nursing education programs also need to be implemented and evaluated to transcend cultural bias.

B. Self-efficacy

The concept of self-efficacy is becoming increasingly important as a means of predicting human behavior. It is a useful way to look at the connection between how people think about a particular task and the way they ultimately behave or accomplish that task. Self-efficacy has been described by Bandura (1977) as a person's sense of confidence that a particular behavior can be carried out.

According to Bandura (1977, 1981), individuals use four sources of information in forming perceptions of self-efficacy or confidence about particular tasks: (1) performance of the task itself, (2) vicarious experiences or information derived from observing others, (3) verbal persuasion or praise, and (4) emotional or psychological factors such as arousal, comfort or pain. An

example is the factors influencing the confidence level of community health nurses in caring for ethnically diverse clients, and including the opportunity to work with such clients, having appropriate role models from whom they can observe positive behaviors, receiving praise and encouragement, and being in a receptive physical and emotional state to care for these clients.

The theory from which self-efficacy is derived is the Social Learning Theory developed by Bandura. This theory emphasizes the prominent roles played by vicarious, symbolic, and self-regulatory processes in psychological functioning.

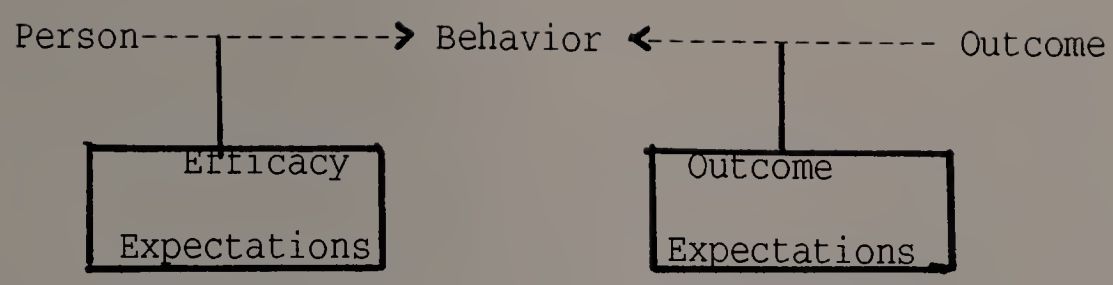
> Social learning theory approaches the explanation of human behavior in terms of a continuous reciprocal interaction between cognitive, behavioral, and environmental determinents. Within the process of reciprocal determinism lies the opportunity for people to influence their destiny as well as the limits of self-directon. This conception of human functioning then neither casts people into the role of powerless objects controlled by environmental forces or free agents who can become whatever they choose. Both people and their environment are reciprocal determinents of each other. (Bandura, 1977, p. vii)

Current developments in the field of behavioral change reflect two major divergent trends. The difference is especially evident in the treatment of dysfunctional inhibitions and defensive behavior. On the one hand, the mechanisms by which human behavior is acquired and regulated are increasingly formulated in terms of cognitive processes. On the other hand, it is performance-based procedures that are proving to be the most powerful for effecting psychological changes. Bandura (197, p. 191) states,

> The apparent divergence of theory and practice can be reconciled by postulating that cognitive processes mediate change but that cognitive events are induced and altered most readily by experience of mastery arising from effective performance..... It has now been amply documented that cognitive processes play a prominent role in the acquisition and retention of new behavior patterns..... The initial approximation of response patterns learned observationally are further refined through self-corrective adjustments based on informative feedback from performance.

Motivation which is primarily concerned with activation and persistence of behavior is part of the cognitive activities. Through cognitive representation of future outcomes individuals can generate current motivators of behavior. Seen from this perspective, reinforcement operations affect behavior largely by creating expectancies that behaving in a certain way will produce anticipated benefits or avert further difficulties. An example might be a visiting nurse who doesn't understand the culture/language of a client and who gets very upset with the client who says "yes" but really means "no". In many cultures, if the person (nurse in this case) is an authority figure, the client has been educated to agree - a sign of politeness only.

Bandura's present theory is based on the principal assumption that psychological procedures, whatever their form, serve as means of creating and strengthening expectations of personal efficacy. Figure 2 illustrates the differences between efficacy expectatons and outcome expectations.



Differences Between Efficacy and Outcome Expectations

FIGURE 2.1

He defines an outcome expectancy as a person's estimate that a given behavior will lead to certain outcomes and efficacy expectations as the conviction that one can successfully execute the behavior required to produce the outcome (p. 193). In this conceptual system, expectatons of personal mastery affect both initiation and persistence of coping behaviors. The reader must remember that people fear and tend to avoid threatening situations they believe exceed

their coping skills, whereas they get involved in activities and behave assuredly when they judge themselves capable of handling situations that would otherwise be imtimidating. The writer believes that if transcultural concepts are taught in basic nursing education programs and possibly include a multicultural clinical experience, practicing professional nurses will have more confidence in caring for ethnically diverse clients.

In 1982 Bandura presented a paper which addressed the centrality of the self-efficacy mechanism in the human agency. The issues addressed were concerned with how people judge their capabilities and how, through their self-precepts of efficacy, they affect their motivation and behavior.

> Efficacy in dealing with one's environment is not a fixed act or simply a matter of knowing what to do. Rather, it involves a generative capability in which component cognitive, social, and behavior skills must be organized into integrated courses of action to serve innumerable purposes. A capability is only as good as its execution. Operative competence requires orchestration and continuous improvisation of multiple subskills to manage ever-changing circumstances. Initiation and regulation of transactions with the environment are therefore partly governed by judgments of operative capabilities. Perceived self-efficacy is concerned with judgments of how well one can execute courses of action required to deal with prospective situations. (p.122)

He continues by saying that persons who have a strong sense of efficacy deploy their attention and effort to the demands of the situation and are spurred to greater effort by obstacles. Nurse who are comfortable and confident in caring for ethnically diverse clients are usually the ones who request to be a student preceptor.

Bandura and Schunk (1981) did a study testing the hypothesis that self-motivation through a proximal goal setting serves as an effective mechanisms for cultivating competencies, self-percerpts of efficacy, and intrinsic interest. The subjects studied were children who exhibited gross deficits and disinterest in mathematical tasks. They pursued a program of self-directed learning under conditions involving either proximal subgoals, distal goals, or no goals.

> Under the proximal goals the children progressed rapidly in self-directed learning, achieved substanntial mastery of mathematical operations, and developed a sense of personal efficacy and intrinsic interest in arithematic activities that initially held little attention for them. Distal

> goals had no demostrable effects. In addition to its other benefits, goal proximity fostered veridical self-knowledge of capabilities a reflected in high congruence between judgments of mathematical self-efficacy and subsequent mathematical performance. Perceived self-efficacy was positively related to accuracy of mathematical performance and to intrinsic interest in arithmetic activities. (p. 586)

Lawrence and McLeroy (1986) wrote an article which applied Bandura's theory of self-efficacy to health education. " This paper interprets Bandura's ideas about self-efficacy for nonpsychologists, describes research in health education which has documented the importance of self-efficacy in behavior change programs, and suggests ways self-efficacy can be used in designing, implementing and evaluating health education programs".(p. 317)

Starting with Bandura's studies of snake phobics, numerous applications of self-efficacy have been made to preventative and rehabilitative health behaviors. Outside of health education, self-efficacy has been used to explain educational achievement, racial behavior in children, career choices, writing performances of college students, and sales performance in business. Specific health education applications have been used in the areas of addictive behaviors such as smoking, alcohol and heroin, pain control, eating disorders, cardiac rehabilitation, and adherence to regimens. O'Leary's (1985) article on self-efficacy and health reviewed the findings of different lines of research applying self-efficacy theory to various facets of health behavior. Her results point to the importance of perceived self-efficacy as a cognitive factor affecting health.

" Self-efficacy theory suggests that while specific procedures may differ for different domains, the general strategy of assessing and enhancing self-percepts of efficacy to affect health, especially by means of providing performance mastery experiences, has substantial general utility." (p. 449)

Lamarine (1987) conducted a study on self-esteem, health locus of control, and health attitudes among Native American children. The results demonstrated a statistically significant relationship between self-esteem and positive attitudes toward health. Self-esteem was a modest predictor of health attitudes and health behavioral intentions among Navajo and Pueblo children. His last sentence really issues a statement. " The major finding of this study that self-esteem may be a determinènt of health attitude in Native American children holds little practical value until a successful methodology can be demonstrated enhancing self-esteem in Native American children".The same is true for nurses working with ethnically diverse client populations.

Gonzalez (1990) conducted a descriptive study of low-income Mexican American women which examined the central role of self-efficacy or perceived capacity to perform a given activity as it related to the frequency of breast self-examination. The findings of the study imply that even if a woman is not fluent in English, she will feel efficacious in the practice of breast self-examination with proper guidance and training in a seting that is sensitive to her cultural needs. Furthermore, utilization arriers to health care can be reduced by the presence of self-efficacy.

It is the contention of the writer that if cultural concepts are taught in nursing educational programs, practicing professional nurses will have confidence in caring for ethnically diverse clients.

CHAPTER III

DESIGN AND METHODOLOGY

A. Introduction

The purpose of this chapter is to review the specifics regarding the design and implementation of the study. Attention is focused upon the identification of the research population, comments on the population size, the choice of design used for the questionnaires and the interviews., details on the design of the study, and a look at the methods of analysis to be detailed in Chapter IV.

B. Research Population Identification

Several authors have defined the target population. L. Gay (1976, p. 67) describes the population as " the group of interest to the researcher, the group to which he or she would like the results of the study to be generalized". The author goes on and says that populations may be virtually any size and cover almost any geographic area.

Kovacs (1985, p. 100) defines population as " a portion of the universe with characteristics defined as crucial to the investigation; total membership of a defined set of subjects (people, plants, animals,books, test scores) from whom the study subjects will be selected and to whom the findings will be generalized".

Brockopp and Hastings-Tolsma (1989, p. 376) define population as "the entire group of persons or objects that is of interest to

the investigator. The population is designated by specific criteria such as age, sex, and illness state".

Polit and Hungler (1978) state that the population refers to the aggregate or totality of all the objects, subjects or members which conform to a designated set of specifications.

> For example, we may specify nurses (RNs) and living in the United States as the attributes of interest, our population then consists of all licensed registered nurses who reside in the United States.....
> The requirement of defining a population for a research project arises from the need to specify the group to which the results of a study can be applied. It is seldom possible to study an entire population, unless it is quite small.....
> It is precisely because of the desire to extrapolate beyond a specific situation that it is essential to be clear about the population of interest (often referred to as the TARGET POPULATION). (P. 46)

It is the belief of the writer that the lack of transcultural concepts in professional nursing education programs is the cause of the lack of confidence of practicing professional nurses who care for ethnically diverse populations and that the conflict is similar throughout the United States. Because the writer is a full-time faculty member and a part-time practicing community health nurse, the witer chose to survey faculty as to cultural content in their nursing education programs and to survey/interview practicing professional nurses as to their confidence level in caring for ethnically diverse client populations. In addition, the writer feels that these cultural conflicts can be observed in inpatient settings. One of the primary consideration for the research in making this choice is

the availability of accurate college and university listings and the close proximity of the health care facilities that are used by our nursing program for clinical nursing experiences.

Although it is beyond the scope of this research project to identify all members of a defined population, the researcher will be able to compile a current, accurate listing of the names and addresses of colleges and universities who offer baccalaureate nursing programs to determine what transcultural nursing concepts are presently being taught. She will be able to use Lawrence General Hospital and the Lawrence Visiting Nurses Association in Lawrence, Massachusetts and the Atlanticare Medical Centerand the Greater Lynn Visiting Nurses Association in Lynn, Massachusetts to determine confidence levels of practicing professional nurses.

C. Population Size

Once the determination to survey colleges and universities who offer baccalaureate nursing programs and the two communities of Lawrence and Lynn Massachusetts for practicing professional nurses was made, the next decision of the writer was the size of the sample for the study.

Borg and Gall (1971, p. 115) have stated that if sampling is done properly, the researcher can reach valid conclusions about the entire population by studying only a small sample drawn from that population.

When the master lists of colleges and universities and the number of practicing professional nurses were compiled, they

contained the names of approximately 400 colleges/universities and approximately 400 practicing professional nurses.

It is the intent of the writer to survey the largest sample possible considering the issues of time, expense and scope of the study. For the above reasons the decision of the writer was to survey 40% of the college/university population (questionnaire #1) and to survey/interview 10% (Questionaire #2 and interview) of the practicing professional nurses. Since questionnaire #1 is to be mailed to faculty asking for anonymous responses, it was recognized by the writer that it would be best to plan for a large sample. In the nursing field, responses to questionnaires are usually good.

In the second part of the study the writer plans to distribute questionnaire #2 to 40 practicing professional nurses and will return one week later to collect them. At that time an appointment for the interview will be made.

Kovacs (1985) states that a sample should be representative and unbiased or randomly selected.

> It should be selected so that it is representative in terms of characteristics crucial to the population. Representativeness is important because if the sample is not representative, the researcher is limited to the extent to which the findings can be generalized. Likewise the reader can not accept the findings of this if there is no evidence that the sample is representative. (p. 103)

In part one of the study, it is the writer's intention that each college/university should have an equal chance of being included in the sample. For this reason, a random sampling will be used.

Borg and Gall (1971) noted that simple random sampling is a powerful technique for selecting a sample that is representative for larger populations, and it is probably the sampling technique most frequently used by educational researchers.

Brockopp and Hastings-Tolsma (1989) state:

> The process of random sampling is based on probability theory, that is, the possibility that events occur by chance..... The advantage of using probability sampling are that (1) statistical techniques can be applied that will show to what degree the sample actually represents the population, (2) an unconscious bias toward selecting a particular segment of the population can be avoided, and (3) an appropriate sample size can be statistically derived. (p. 176)

They further explain that there are a variety of techniques that can be used to derive a simple random sample. One suggestion, the use of a table of random numbers, was selected by the writer as the means of selecting the individuals to be included in the questionnaire #1 sample population.

Since there was a diligent effort by the writer to compile an accurate, up-to-date list of colleges and universities that offer nursing education programs, it was decided that the use of a random sample table would assure a representative sample. The table of random numbers used in the process was developed by Denise F. Polit and Bernadette Hungler (1989).

Following the procedures for random sampling outlined, the researcher will begin the sampling process. From the master list of colleges and universities offering nursing education programs a random listing will be developed. Each name on the master list will be given a number from 1-400. Once the names are numbered,

the table of random sampling wil be used to select the colleges/universities to be included in the study. A non-nurse will arbitrarily select a starting point on the table and following the selection process will begin to compile the sample population list.

The second part of the study, questionnaire #2 and the interview, will be conducted by using a non-probability sampling method entitled accidental sampling. Brockopp and Hastings-Tolsma (1985, p. 179) defines accidental or convenience sampling as one in which the sample is obtained by selecting those subjects who are readily available. The example they cited was asking individuals at a shopping center to respond to a health care questionnaire.

Kovacs (1985) define a non-probability sample as one purposely chosen because the subjects possess the characteristics under study.

> Frequently it is not possible to randomly select subjects as there may not be enough of them.... Non-probability samples include volunteers, sometimes motivated by financial reward or special interest in the topic under study. When using volunteers it is essential to consider the kinds of persons who volunteered and ponder whether the results could be influenced by the nature of the subject. (p. 103)

Following the acquisition of the list of volunteers from the four clinical agencies, Atlanticare, Lawrence General Hospital, Greater Lynn Visiting Nurses Association and Lawrence Visiting Nurses Association, the writer will arbitrarily select 10 participants from each agency to answer a self-efficacy questionnaire and participate in one interview. As J. Stone (1988, p. 139) states:

> The objectives of nursing education are to prepare professional nurse who is clinically competent, a critical decision maker,a patient advocate, and an autonomous practitioner. These goals will be unattainable if students are constantly faced with the consequences of stereotypes. (p. 139)

D. Design of the Instruments

It has been stated by Borg and Gall (1971) that probably no instrument of research has been used or abused in educational research as much as the questionnaire. They believe the questionnaire dates back to Horace Mann, who used it as a research tool in 1847.

As previously discussed in the study when considering both the advantages and disadvantages of using the questionnaire as a survey instrument, the writer believes that in order to obtain responses from the largest possible sample, the questionnaire was deemed to be the most appropriate instrument for the first part of the study. The purpose of the questionnaire is to gain information as to the inclusion or omission of transcultural nursing concepts as well as the number of transculturally academically prepared nursing faculty. In addition the writer will

discover the ethnic composition of the nursing student population and the communities in which they do their clinical practice.

From the author's experience in clinical nursing and being a member of the Transcultural Nursing Society, a questionnaire (#1) was developed and included the following items:

1. Type of nursing program
2. Provision of transcultural nursing concepts in courses
3. Percentage of transculturaly academically prepared faculty
4. Ethnic composition of student population
5. Ethnic composition of clinical facilities

The second part of the study includes both a questionnaire and an interview. With the permission of the authors, questionnaire (#2), a cultural self-efficacy scale, was adapted. The questionnaire was divided into two areas of confidence levels - knowledge and skills. The three largest ethnic minorities were included: blacks, Spanish-speaking and Southeast Asians. The list includes the following items:

1. Confidence in knowledge of cultural concepts
2. Discrimination between intercultural and intracultural diversity.
3. Discrimination between ethnocentrism and prejudice
4. Discrimination between ethnicity and culture
5. Confidence in transcultural nursing skills

6. Confidence in the use of an interpreter
7. Confidence in developing an ethnically appropriate nursing care plan

The third instrument will be a 30 minute interview with practicing professional nurses during which the researcher will validate the questionnaire by the discussion of actual experiences encountered by the nurses and how transcultural education would have helped them to give culturally appropriate care.

It was stated by Gay (1971, p. 98) that " attitude scales attempt to measure what an individual believes, perceives or feels."

Polit and Hungler (1989) have stated:

> The most ubiquitous form of attitudinal measurement is the Likert Scale..... A Likert Scale consists of several declarative statements expressing a viewpoint on a topic. Respondents are asked to indicate to what degree they agree or disagree with the opinion expressed in the statement. (p. 261)

Since it is the function of the second questionnaire to measure nurses' opinions, the writer chose to use a Likert scale for this section of the study. There are five general catagories from which the respondents can choose. They are:

Strongly Agree (SA)	= 5 points
Agree (A)	=4 points
Undecided (U)	=3 points
Disagree (D)	=2 points
Strongly Disagree (SD)	=1 point

The writer plans to adapt it by having the catagories range from Very Confident (VC) for 5 points to Very Little Confidence (VLC) for 1 point.

In addition to the college/university survey and the self-efficacy scale for practicing professional nurses, a questionnaire will be developed tp provide demographic data on the respondents. Questions were developed providing information on the following:

1. Age
2. Sex
3. Ethnic/racial background
4. Nursing educational preparation
5. Courses or continuing education program pertaining to transcultural concepts
6. Year of graduation from nursing education program
7. Number of years professionally employed
8. Birth and residency out of the United States
9. Marital status and ethnicity of spouse
10. Language(s) spoken
11. Employment outside of the United States
12. Work experience with culturally diverse populations.

Four major components will provide the research informaton for the study:

1) transcultural nursing concepts in the educational preparation of baccalaureate degree nurses,
2) Self-efficacy scale on confidence levels of

practicing professional nurses caring for ethnically diverse clients,

3) an interview with practicing professional nurses as to their experiences with culturally diverse clients, and
4) demographic data.

E. Design and Implementation of the Study

Once decisions were made concerning the population size, sample selection, questionnaires and interview contents, the writer began with the design and implementation of the study.

After the questionnaires were adapted, the writer developed three cover letters; namely, a research permission clearance letter from the four agencies,and informational letters to the participants of the study.

Both the questionnaires and cover letters will be professionally printed on a high-grade of stock to give the most professional appearance possible. They will be typeset using a large, clear, readable print on a sheet of paper measuring 8 1/2 inches and 11 inches. It is the belief of the writer that a concise questionnaire would encourage the largest possible returns from the participants.

The three cover letters to be sent will explain the nature of the study and encourage the respondents to have their information and opinions included in the study. For the first questionnaire and the agency permission letter, a self-addressed, stamped envelope will be included. The letters to the agencies will be

sent out by March 1, 1991 as well as the questionnaires to the colleges and universities. After agency permission is granted, the questionnaire for the practicing professional nurses will be distributed and interview will be conducted. The mailing for questionnaire #1 to the colleges and universities was planned for that date or earlier so as to avoid faculty receiving the questionnaire too near the end of the academic year. Also not all colleges and universities have the same academic calendar.

Three weeks after the initial mailing of questionnaire #1, a postcard will be sent to all 160 colleges and universities in the sample. It is also recognized by the writer that other means of followup could be used, but the choice of a postcard appears to be the least bothersome and threatening to those being surveyed. Questionnaire #2 followup will be direct contact with the participants one week after the questionnaire is distributed. At that time the interview appointment will be made.

F. Method of Analysis

The methods of analysis varies in the different sections of the study.

In an effort to determine the inclusion of transcultural nursing concepts in present baccalaureate nursing programs, the transcultural academic preparation of the faculty, and the ethnic composition of the student body and client populations, the writer plans to show the data by individual items in terms of group frequency distribution.

For the second questionnaire, the Self-efficacy Scale, it is the intent of the writer to use Analysis of Variance (ANOVA) in terms of degree of freedom, F-ratio value and probability levels. According to Polit and Hungler (1989):

> Analysis of Variance (ANOVA) is another parametric procedure to test the significance of differences between means. ANOVA, unlike the t-test, is not restricted to two group situations: the means of three or more groups can be compared. The statistic computed in the ANOVA test is the F-ratio statistic..... Analysis of Variance decomposes the total variability of a set of data into two components: (1) the variability attributable to the independent variable and (2) all other variability, such as individual differences and measurement error. Variation between the groups being compared is contrasted with variation within groups to yield an F-ratio. (p. 280)

It is anticipated that this information will be beneficial to future researchers who are interested in the influence of transcultural nursing concepts on the confidence level of practicing professional nurses working with ethnically diverse client populations.

CHAPTER IV

ANALYSIS OF THE DATA

This chapter details the procedures followed in the collection of data, the analysis of the data, and the interpretation of the data. Tables and figures are used to present findings in summary form in an effort to add clarity to the presentation of the results of the study.

A. Collection of the Data

The survey of faculty instrument (Questionnaire #1) was mailed out on Saturday morning, February 16, 1991 to a random sample of 400 colleges and universities. From the 170 which were mailed, one was returned with a note indicating that the program was no longer in existence. This left the writer to assume that the other 169 were received. Responses began to arrive almost immediately. One week following the mailing, a total of 60 questionnaires was received. The remaining respondents returned their questionnaires within the following three-week period. In total, 114 of the 170 questionnaires were returned. This amounted to 68.2 percent of the sample. Since the high return within the first three weeks after mailing, the writer did not send out a reminder. Of these, three declined to participate in the study. Although it was the hope of the writer to receive a larger percentage of returns, it was recognized that many factors could account for the response rate. Nursing departments in colleges and universities are

bombarded with questionnaires during the academic year, and many limit the number that they can comfortably answer. Another factor which may have contributed to the rate of return is the assignment of the questionnaire to a faculty member who is not interested in the topic and refuses to answer. A third factor to be considered is the anonymity of the questionnaire. Borg and Gall (1971, p. 202) state:

> The use of an anonymous questionnaire poses many research problems. Follow-ups are difficult and ineffective because non-responding individuals cannot be identified.

It was the belief of the writer that it was essential to use an anonymous questionnaire in anticipation of accurate replies.

The survey of practicing professional nurses (Questionnaires #2 and #3) was conducted by the writer at the clinical agencies. The writer spoke to the nurses during staff meetings explaining the purpose of the survey and requested volunteers to seek the writer out after the meeting. Out of the four agencies canvassed a total of forty volunteers answered the anonymous survey. A major problem of time constraints was the reason many declined to participate. The writer did not have the nurses take the questionnaires home because of the anonymity of the questionnaire and the fact that many papers taken away from the research area are usually either lost or discarded.

The third part of the dissertation research was more difficult - the interview. Many participants were willing to answer a questionnaire which could be done in a few minutes but were reluctant to give up thirty minutes or more to be

interviewed. The writer compromised with many by allowing them to cite on the questionnaire a particular situation which they encountered, how they handled the problem, and what educational preparation would have helped them. They were also willing to let the writer contact them for clarification. The clinical agencies were very reluctant to allow nurses an extra half hour to be interviewed. The interview was conducted whenever possible.

As the questionnaires (3) were received, they were numbered consecutively beginning with 001. This provided an identification number for each of the respondents. Coding each questionnaire by number allowed for easy handling when processing the data for computer analysis. Once they were numbered, responses to the questionnaire items were coded with their numerical values and recorded on computer sheets. The writer was assisted throughout this process with a computer and a statistical consultant. After the data were prepared for the computer, the Statistical Package for the Social Sciences (SPSS) program was used to process the results of the study.

As each questionnaire was designed to provide information regarding different research questions, the analysis of the data differed from questionnaire to questionnaire. Again, throughout this process, the services of a statistical consultant were used to establish the procedures for the analysis. The pages which follow report the results of the study from various statistical perspectives.

B. Analysis of the Data

The survey was divided into parts: Part I, Survey of Colleges and Universities, and Part II, Survey of Practicing Professional Nurses.

1. Survey of Colleges and Universities. The first section of the questionnaire was developed to solicit information about the type of nursing program offered, the inclusion of transcultural nursing concepts, the transcultural nursing education preparation of the faculty, and the ethnic minorities among the student body and the clinical experience communities.

a. Types of Programs. Questionnaires were sent to all levels of colleges ans universities soliciting this information. The writer was very surprised that there were no returns from Associate Degree programs because this is a large number of professional nursing programs offered today. Table 2 shows the types of programs surveyed.

b. Inclusion of Transcultural Nursing Concepts. The writer noted that all types of professional nursing programs were surveyed. Thirty-eight percent offered integrated courses, 42.9% offered block courses, and 19.0% had some of both. This is important in planning the incorporation of transcultural nursing concepts as it could affect the program financially. In the integrated programs the transcultural nursing concepts can be spread throughout the various courses; whereas, block course programs would necessitate the inclusion of another course.

TABLE 2

Type of Nursing Program

(N=110)

Type of Program	Number	Percent
Associate	0	0.0
Diploma	0	0.0
Bachelor	49	44.5
Master/Doctoral	0	0.0
Associate/Bachelor	6	5.5
Bachelor/Advanced	52	47.3
Associate/Bachelor/Advance	3	2.7
Totals	110	100.0

faculty teaching loads regulated by unions and faculty associations this could indicate the need to hire an additional faculty member.

For years nursing has followed the "Medical Model" from which physicians and nurses developed their profession. It was based upon body systems such as Circulatory, Respiratory, Reproductive, Gastrointestinal, etc. This has worked well for physicians but not for nurses. In the past few decades a concerted effort has been made to develop a body of knowledge unique to nursing which would serve as the theoretical basis for the profession of nursing. Such a theoretical basis, when more fully developed, will consist of scientifically derived general principles that will serve to describe, explain, and predict the practice of nursing. Nursing theories will provide a guide for viewing nursing holistically and for determining the probable results of nursing actions in advance of their implementation. However, only as theories of nursing evolve and mature and as they are tested and retested will a general theory of nursing develop. The writer is of the opinion that transcultural nursing concepts with the caring theory is the basis for the profession of nursing. Since nursing is a practice-oriented discipline nursing theories are constantly evolving.

Ninety-six percent of the programs include some transcultural nursing concepts and 17% offer specific courses. Table 3 indicates the number of classes in transcultural nursing offered.

TABLE 3

Transcultural Concepts Integration

(N=108)

Class	Number	Percent
None	4	3.7
Yes, Unspecified	34	31.5
One Class	14	13.0
Two Classes	22	20.4
All Classes	34	31.5
Total	108	100.0

These concepts are taught in all areas of the nursing programs. Classes taught in the clinical component are usually student presented post conferences and last about one hour. Since these conferences are taught during the clinical rotation not all students hear the same content. Unless students are assigned specific clinical topics you do not hear a presentation on cultural needs of the client. What has occurred in many clinical presentations is that a list of topics is presented to the student body (usually 10 students), and they select the topic to be discussed. If students are not interested in transcultural concepts, the topic may never be covered.

In the theory component of nursing education programs, transcultural nursing concepts need to be included in the very first nursing courses where the content is about the healthy clients and his/her holistic needs. Table 4 indicates where these classes are taught.

TABLE 4

Transcultural Nursing Concepts Placement

(N=101)

Placement	Number	Percent
Theory	17	16.8
Seminar	1	1.0
Clinical	1	1.0
Theory/Seminar	5	5.0
Theory/Clinical	24	23.8
Seminar/Clinical	0	0.0
All Three Areas	53	52.4
Total	101	100.0

The general concepts of cultural needs of clients may be included in required courses such as Psychology and Sociology or electives such as Cultural Anthropology. For example, of the 110 colleges

and universities who replied only 27.3% required an Anthropology course. Some highly recommended it, and only 15.5 required a second language. With the increased number of ethnically diverse populations entering the health field as clients, nurses need to be bilingual, For example, an Anglo nurse who works in the Spanish section of a community and doesn't speak the language is of no value. A situation cited by a Visiting Nurse was one in which she had an interpreter with her on her visits to a Spanish-speaking mother and newborn. Every visit the nurse was turned away. One day the nurse was ill and another, Spanish-speaking nurse, made the visit without the interpreter. The interpreter was telling the client that she would come back to help the client and didn't need the nurse. As a result the interpreter was fired and the Anglo nurse learned Spanish.

c. Transculturally Prepared Faculty. Forty four percent of the colleges and universities surveyed stated they had faculty prepared in tanscultural nursing and of these 73.1% were academically prepared. Table 5 lists the methods of transcultural nursing preparation for faculty.

Even though colleges and universities may not have transculturally prepared faculty, 74.1% do offer specific learning experiences to help students develop cultural awareness. Some colleges and universities offer /require a semester in a foreign country as part of their required nursing curriculum. Two such schools are Atlantic Union in Lancaster, Massachusetts and Goshen in Goshen, Indiana. Some of these programs include a semester overseas for its faculty as well.

Table 5

Transculturally Prepared Faculty

(N=26)

Method	Number	Percent
Educational Courses	19	73.1
Certification	5	19.2
Both	2	7.7
Total	26	100.0

d. Ethnic Composition of Student Bodies and Clinical Communities. In addition to the inclusion of transcultural nursing concepts in nursing educational programs and the number of transculturally prepared nursing faculty, the writer solicited information regarding the ethnic composition of both the students enrolled in nursing educational programs as well as information regarding the ethnic composition of the clinical experience facilities and the ethnic population which it serves. It is the opinion of the writer that transcultural nursing education should be appropriate for the communities where their graduates will be employed. Table 6 shows the minority population within a nursing program. (See Table 6).

The breakdown by specific minority groups indicated the fact that 86.9% had Black students; 54.8% had Spanish-speaking students; 40.5% had Southeast Asian students and 39.9 had Asian students. For purposes of clarification Asian and Southeast Asian are defined as Asian (China and Japan) and Southeast Asian as Thailand, Cambodia, Vietnam, Indonesia and the Islands. The writer questions the lack of response to the presence of Native Americans as minority students. A possible conclusion might be the method of sampling. A future study should include this ethnic minority to determine whether there is a greater need to recruit these people. Native Americans live and work throughout the United States and have a distinct health belief culture with which the nursing profession must cope.

TABLE 6

Minority Nursing Student Population

(N=105)

Minority Percentage Range	Number	Percent
0-10	44	44.8
11-20	29	27.6
21-30	8	7.6
31-40	2	1.9
41-50	8	7.6
51-60	2	1.9
61-70	1	1.0
71-80	1	1.0
81-90	1	1.0
91-100	6	5.7
Total	105	100.0

It is gratifying to note that 74.3% of the colleges and universities surveyed are actively recruiting minorities. It would be interesting to study their methodologies of recruitment.

The selection of clinical experiences for students is an important component in selecting the transcultural nursing concepts to be taught. The concepts must coincide with the ethnic minority being served. It makes no sense to teach the Southeast Asian culture in depth when the client population is Spanish-speaking. Due to the large number of clinical experiences available to student nurses today, the writer, for the purposes of analysis, categorized the responses into three groupings - Inpatient, Community Agencies, and Community Centers. The Inpatient group included hospitals, Outpatient Departments and Nursing Homes. The Community Agencies included off site clinics, Health Maintenance Organizations, Visiting Nurses and Home Care Agencies, and Public Health Agencies. The third group, Community Centers, included cultural centers, community centers such as Council on Aging, and shelters. There are many more but that could possibly be another study in itself. Table 7 indicates the utilization frequency of clinical experience agencies. (See Table 7)

An obvious conclusion of this table is the increase need for transcultural concepts in nursing education providing these agencies treat diverse ethnic populations.

TABLE 7

Clinical Experience Agency Utilization

(N=109)

Agency category	Number	Percent
Inpatient	0	0.0
Community Agency	0	0.0
Community Center	0	0.0
Inpatient/Community Agency	9	8.3
Inpatient/Community Center	0	0.0
Community Agency/Center	0	0.0
All three categories	100	91.7
Total	109	100.0

Based upon this assumption the writer sought information regarding the languages spoken in the clinical agencies and the ethnic composition of the various communities. Table 8 indicates the number of language spoken within the clinical facilities regardless of their category.

TABLE 8

Number of Languages Spoken in Clinical Agencies

(N=109)

Languages	Number	Percent
1	43	39.4
2	21	19.3
3	15	13.8
4	15	13.8
5	6	5.5
6	3	2.8
7-8	2	1.8
9-10	0	0.0
11	1	0.9
12	2	1.8
More than 12	1	0.9
Total	109	100.0

The survey indicated that the languages spoken were English, Black American, Spanish, Asian (Chinese & Japanese) and Southeast Asian (Cambodian and Vietnamese).

Clinical facilities from some areas are too small to accommodate the number of nursing students. Students in West

Virginia have to cross the border into Kentucky, and many students from Boston go into other communities such as Malden. An excellent example is the college at which the writer works. It is in a small community on the northshore of Massachusetts and students are receiving clinical experiences in Salem, Lynn, Beverly, Melrose, Stoneham, Lawrence and Lowell, Massachusetts. Even students from Boston come to hospitals in Salem for clinical experience.

The factors above led the writer to survey the ethnic composition of the local communities. Within a multiethnic community there is a reservoir of resource persons to assist with the development of cultural awareness possibly in the multidisciplinary committee of a nursing program and who could possibly serve as a pool for recruiting minority nursing students. Table 8, using the same ethnic categories of Caucasians, Blacks, Spanish-speaking, Asian and Southeast Asians, will indicate the percentages of major ethnic groups within the community. (See Table 9)

Once colleges and universities have surveyed their communities, they can best determine what transcultural nursing concepts are appropriate for their nursing programs as have colleges and universities in Florida, California and Michigan. Figure 1 is a comparison of the types of programs offered (integrated, block or mixed), with transcultural nursing variables such as courses offered, classes offered, prepared faculty, and clinical experiences.

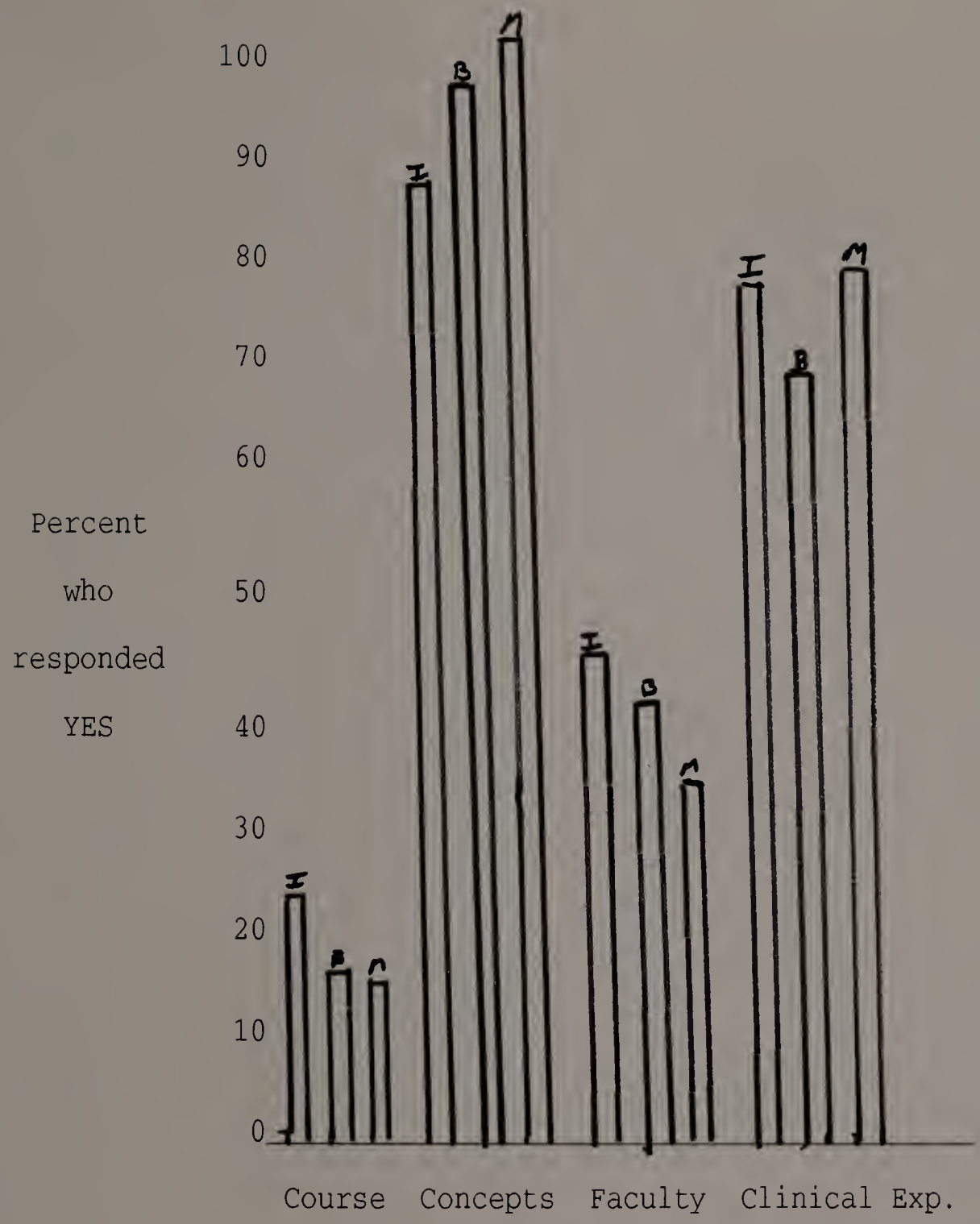
TABLE 9

Major Ethnic Minorities

(N=109)

Ethnic Groups	Number	Percent
1	23	21.1
2	26	23.9
3	18	16.5
4	21	19.3
5	11	10.1
6	7	6.4
7	3	2.8
Total	109	100.0

Upon examining the results of this questionnaire it appears that transcultural nursing concepts are being taught in at least 87.5% of the colleges and universities surveyed and at least 68.9% have some multicultural clinical experiences. The number of transculturally prepared faculty, below 47.5%, and the lack of transcultural nursing programs, below 20%. indicate a need for more transcultural nursing programs especially on the east coast of the United States.



CODE: I= integrated, B= block, M= mix

Comparison of Types of Program with Transcultural Variables

Figure 4.1

This concludes the data from the first major part of the study, Survey of colleges and universities.

2. Survey of Practicing Professional Nurses. The background information and self-efficacy questionnaire sought information concerning the level of confidence of practicing professional nurses in giving quality holistic nursing care to ethnically diverse populations. The major ethnic minorities included Asians, Blacks, Southeast Asians and Spanish-speaking clients. Background information included age, sex, nursing education preparation, transcultural nursing concepts knowledge, number of years since graduation from nursing education program, number of years professionally employed, place of employment, and multicultural nursing experiences.

The 38 female and 2 male ranged in age from 22 years to 59 years which is the average range of employment for nurses. The majority of the older nurses were employed in Inpatient settings such as hospitals, outpatient departments, and nursing homes.

Educational preparation was mainly at the diploma or baccalaureate level with some advanced degrees. Of the forty participants 5 graduated from an associate degree program, 13 from a diploma program, 15 from a baccalaureate program and 9 from advance degree programs. The survey indicated the fact that those nurses with the most education were Caucasians, and those with advanced degrees either taught in nursing education programs or worked in cultural centers. A possible correlation could be the level of self-esteem, age and work experience. The nurses who were from minority cultures were graduates of a diploma program. From the personal experience of the writer, colleges recruit minority students, but many students do not have the secondary

school preparation to complete the program. Many cultures still feel that if there is a male in the family, he should have a college education, Females will marry and stay at home caring for their family. Another possibility so few minorities are in nursing is the practice of restricted admissions by colleges and universities. They frequently admit the minimum required number of minorities to meet the criteria for federal or other source funding.

Again the male student is frequently accepted over a female. Table 10 indicates the ethnic composition of the participants of the study.

The writer noted that although 5 respondents cited their ethnicity as Native American on the survey of practicing professional nurses, none of the schools surveyed indicated any Native Americans in either their student or community populations. The discrepancy could be due to the fact that the survey of schools was a random sample and may not have included such schools. As the writer anticipated the majority of respondents were from either diploma or baccalaureate programs. What did interest the writer was the fact that only 12.5% were graduates of an associate degree program. Both of the inpatient agencies surveyed had associate degree program students at their agency for clinical experiences.

TABLE 10

Ethnic Composition of Participants

(N=40)

Participant	Number	Percent
Caucasian	31	77.5
Black	0	0.0
Spanish-speaking	3	7.5
Asian/Southeast Asian	1	2.5
Native American	5	12.5
Total	40	100.0

Although only 44.4% of the practicing professional nurses had some transcultural nursing concepts in their basic nursing program, there was not enough variability in the number of courses taken to relate significantly to age or work experience with ethnic minorities in the United States. Table 11 illustrates the variability of transcultural nursing concepts taught in basic nursing education preparation, age and work experience with ethnic minorities in the United States.

TABLE 11

Transcultural Concepts Age and Experience

Item	Mean	Standard Deviation
Age	40.8	9.21
Transcultural concepts	0.475	0.75
Experience	4.575	2.95

The lack of significance may be due to the small number of participants and the similarity in their background. Of the 40 respondents only ten had lived outside of the United States, and 12.5% listed themselves as dependents of military personnel. Some did work at base hospitals.

In addition, of the 40 respondents 37.5% spoke a second language, and of these Spanish and French were the most common.

Again due to the small number of respondents and the need for statistical numbers, the categories Asian and Southeast Asian was combined. Therefore, the ethnic minorities being surveyed will be Asians, Blacks and Spanish-speaking. Table 12 lists the ethnic minority groups and the percentage of nurses who have worked with them.

TABLE 12

Ethnic Minorities and Nursing Experience

Minority	Percentage
Asian	75
Black	72.5
Spanish-speaking	82.5

The author is concerned with the lack of a second language with so many nurses working with the major ethnic minorities. Not all health care facilities provide translators. How can nurses give holistic nursing care with such a communication problem? Communication skills are essential for compliance to the health care plan.

The questions pertaining to confidence levels were divided into knowledge of and skills in caring for an ethnically diverse population. The knowledge component was further divided into specific categories of family organization, health care belief systems and lifestyle for the three major minority groups of Asian, Blacks and Spanish-speaking. In order to get statistically significant numbers the three categories included more than one question. Family organization was concerned with role differentiations, child care practices, support system, nutritional patterns, beliefs about privacy and beliefs about death and dying. The second category, health care belief systems, included utilization of health care facilities, utilization of

indigenous health care practices, patterns of health and illness, and knowledge beliefs about health and illness. The third category, lifestyles included economics, style of living, class structure, employment patterns, beliefs about respect/authority and religious beliefs. The questionnaire asked nurses to respond by means of a Likert Scale coded with values ranging from 5 (Strongly Agree) to 1 (Strongly Disagree). The general questions were analyzed by frequency and the more specific by analysis of variance (ANOVA). Table 13 illustrates the level of confidence of practicing professional nurses in their ability to distinguish between inter and intracultural diversity, ethnocentrism and discrimination, and ethnicity and culture.

TABLE 13

Confidence in Knowledge of Cultural Concepts

(N=40)

Variable	Mean	Standard Deviation
Inter vs. intracultural diversity	2.55	1.131144
Ethnocentrism vs. discrimination	2.775	1.025008
Ethnicity vs. culture	2.875	1.113726

The second section of the general questions, confidence in skills, included nine categories. Table 14 indicates this level of confidence.

The second section of the general questions, confidence in skills, included nine categories. Table 14 indicates this level of confidence.

TABLE 14

Transcultural Skill Confidence

(N=40)

Variable	Mean	Standard Deviation
Use of interpreter	3.653846	1.230927
Ethnic community	3.287500	1.165132
Advocacy	3.337500	1.033959
Participant observer	3.525641	1.175119
Develop genogram	2.486842	1.406965
Nursing history	3.782051	1.140146
Nutrition history	3.371795	1.375146
Medications	3.525641	1.175119
Compliance	3.448718	1.260717

Nurses tended to rate themselves higher on specific skills than on general concepts. One exception was the ability to develop a genogram. Sixty three percent had very little or no confidence in this skill and 15.8% felt very confident. A possible problem encountered here could be the terminology. If the writer had said a health family tree, the results may have been more accurate. The group that felt more confident were younger nurses who worked in community agencies.

The section of the questionnaire pertaining to specific knowledge about cultural concepts of the three major ethnic groups were analyzed by mean, standard deviation and ANOVA.
Analysis of variance (ANOVA) is a parametric procedure to test the significance between means. ANOVA breaks down the total variability of a set of data into two components: (1) the variability resulting from the independent variable and (2) all other variables such as individual differences, measurement unreliability and so on. The most important number is the F-ratio because it is the value that permits the writer to reach a decision about accepting or rejecting a null hypothesis. (See Table 15.) The results show that the lowest levels of confidence were when working with the Asian population. Table 16 compares the level of confidence of practicing professional nurses from the standpoint of background of the practicing professional nurse and the three major ethnic minority groups. The variables of the educational background, cultural experiences, years and places of professional employment, and employment with ethnic minorities in the United States The length of time since graduation from a nursing program (probabilities >0.5) and the number of transcultural classes (probability >0.5) were not significant, therefore, they were not included in the study. The latter is probably due to the fact that only 44.4% of the respondents cited classes in transcultural nursing courses included in their nursing educational preparation,

TABLE 15

Confidence Levels of Nurses with Three Major Minority Groups

(N=40)

Variable	Mean	Standard Deviation
Family organization		
Asian	2.478022	1.036026
Black	2.812500	0.901288
Spanish-speaking	2.987180	0.926382
Health Care Beliefs		
Asian	2.217105	1.067282
Black	2.487180	0.937081
Spanish-speaking	2.660256	1.058312
Lifestyle		
Asian	2.307692	0.957075
Black	2.603604	0.849247
Spanish-speaking	2.747863	0.928647

Tables 16 - 19 are sources of variance among the significant categories of the background of the practicing professional nurse and the ethnic minority categories of family organization (1), health care beliefs (2) and lifestyle (3).

TABLE 16

Educational Preparation of Nurses and Ethnic Minorities

Source of variance		SS	df	MS	F	P
Asian	(1)	6.49361	2	3.24680	3.40	0.0517!
	(2)	4.45665	2	2.22832	1.96	0.1580
	(3)	8.92130	2	4.46065	6.15	0.0054*
Black	(1)	5.17475	2	2.58737	3.33	0.0477*
	(2)	5.55972	2	2.77986	3.31	0.0488*
	(3)	3.83724	2	1.91862	2.77	0.0780
Spanish-speaking	(1)	5.17693	2	2.58846	3.14	0.0566 !
	(2)	7.94271	2	3.97135	3.89	0.0303*
	(3)	4.50417	2	2.25208	2.64	0.0862

Code: * - a probability <0.05 is the criterion for a level of significance.

! - marginal probability

The areas of significance between the educational preparation of the nurse and the ethnic minority are (1) Asian lifestyle, (2) Black family organization and health care beliefs, and (3) Spanish-speaking health care beliefs.

Table 17 illustrates the significance between the number of years of employment of the practicing professional nurse and the ethnic minorities.

TABLE 17

Length of Professional Employment and Ethnic Minorities

Source of variance		SS	df	MS	F	P
Asian	(1)	1.4849	4	0.3712	0.32	0.8618
	(2)	2.8689	4	0.7172	0.60	0.6634
	(3)	0.9159	4	0.2289	0.23	0.9198
Black	(1)	5.3592	4	1.3398	1.78	0.1546
	(2)	7.8138	4	1.9534	2.60	0.0534!
	(3)	4.5677	4	1.1419	1.71	0.1726
Spanish-speaking	(1)	5.4800	4	1.3700	1.72	0.1690
	(2)	11.0377	4	2.7594	2.98	0.0329*
	(3)	7.8166	4	1.9542	2.66	0.0492*

Code: * - a probability <0.05 is the criterion for a level of significance.

! - marginal probability.

The levels of significance between the length of employment of the practicing professional nurse and ethnic minorities were in the areas of Spanish-speaking health care beliefs and lifestyles. There is a marginal significance in the category of Black health care beliefs.

Table 18 illustrates the levels of significance between the place of professional employment of the nurse and ethnic minorities.

TABLE 18

Site of Employment of Nurse and Ethnic Minorities

Source of variance		SS	df	MS	F	P
Asian	(1)	0.4598	2	0.2299	0.21	0.8098
	(2)	0.7013	2	0.3507	0.31	0.7341
	(3)	6.8238	2	3.4108	0.04	0.9649
Black	(1)	5.8497	3	1.9499	2.72	0.0589!
	(2)	2.4125	2	1.2063	1.74	0.1915
	(3)	4.5530	2	2. 2765	4.79	0.0154*
Spanish-speaking	(1)	5.5592	1	5.5592	7.83	0.0083*
	(2)	9.6462	2	4.8231	5.93	0.0063*
	(3)	7.3929	2	3.6964	0.750	0.0134*

Code: * - a probability <0.05 is the criterion for a level of significance.

! - marginal probability.

There is a definite level of significance between place of professional employment and Black lifestyles and Spanish-speaking family organization health care beliefs, and lifestyle.

Table 19 illustrates the level of significance between minority clinical experience of the nurse and the major ethnic minorities.

TABLE 19

Minority Clinical Experience and Ethnic Minorities

Source of variance		SS	df	MS	F	P
Asian	(1)	0.1942	1	0.1942	0.18	0.6764
	(2)	1.1495	1	1.1495	1.32	0.2575
	(3)	0.5801	1	0.5801	0.63	0.4335
Black	(1)	3.6106	1	3.6106	4.89	0.0331*
	(2)	3.1919	1	3.1919	3.91	0.0554!
	(3)	3.1056	1	3.1056	4.76	0.0360*
Spanish-speaking	(1)	3.7300	1	3.7300	4.78	0.0352*
	(2)	6.0029	1	6.0029	6.08	0.0185*
	(3)	3.9036	1	3.9036	5.00	0.0314*

Code: * - a probability <0.05 is the criterion for a level of significance.

! - marginal probability.

There is a definite level of significance between nurses who have had ethnic minority nursing experience and the ethnic minorities.

Although there appears to be no significant relationship between the three major ethnic minorities surveyed and the inclusion of transcultural nursing classes in the educational

preparation of nurses or the number of years since graduation, there are definite levels of significance between the transcultural variables of family, health care beliefs and lifestyles and background information of type of educational preparation program, length and place of employment, and past clinical experiences with ethnic minorities. A noteworthy point is that lack of confidence levels of nurses caring for the Asian population. This could be due to fact that the Asian and Southeast Asian population live in concentrated communities where indigenous healers are consulted before contacting the western medical system. They are also the latest influx of refugees, and this population was very small during the educational preparation of nurses.

In summary, and in the writer's opinion, the fact that the mean age of the 40 respondents was over 40, the number of years since graduation was over 15, and fewer than 44% had transcultural nursing classes, the levels of confidence in giving quality holistic nursing care to ethnically diverse populations are directly affected by their clinical experience with ethnic minorities.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Tripp-Reimer, Brink and Saunders (1984) are in agreement that in a pluralistic society nurses need to be prepared to work with all patients regardless of cultural background and to provide culturally appropriate nursing care for each patient. To provide culturally appropriate nursing care, nurses must understand specific factors that influence individual health and illness behaviors. Culturally diverse nursing care refers to the variability in nursing aproaches needed to provide culturally appropriate nursing care. Culturally diverse nursing care must take into account six cultural phenomena that vary with application and use, yet are evidenced among all cultural groups: (1) communication, (2) space, (3) social organization, (4) time, (5) environmental control, and (6) biological variations.

The results of this study suggest a real concern for the inclusion of transcultural nursing concepts in the basic educational preparation of professional nursing students. Professional nurses can not provide holistic nursing care unless they have some knowledge and understanding of their clients'/patients' backgrounds. Without this educational background the level of confidence in caring for ethnically diverse populations will be poor at best.

With the focus of this study addressing the need for the inclusion of transcultural nursing concepts in nursing education curricula, it is the hope of the writer to provide insight into areas which can enhance the confidence levels of practicing professional nurses. The comments which follow summarize the findings of the writer.

A. Conclusions

The purpose of this study was to provide possible answers to several research questions regarding the transcutural nursing educational preparation of today's professional nursing students and the confidence levels of practicing professional nurses who care for ethnically diverse clients in a variety of clinical settings.

1. Survey of Colleges and Universities. This part of the study was developed to solicit information concerning the type of nursing education offered, the inclusion of transcultural nursing concepts within the program, the number of transculturally prepared faculty and the ethnic composition of both the student body and the local communities in which the students do their clinical experiences.

One hundred percent of the respondents had as their basic nursing education program at the baccalaureate or higher level. Some advanced degree programs offer a nursing program to those candidates having a degree in another field.

Of the 108 respondents to the question of the inclusion of transcultural nursing concepts in their program there was a range of answers from "hit or miss" to inclusion in all classes. Only 52.4% offered these concepts in the three areas of nursing education - theory, seminar and clinical conferences. One percent offered these concepts only in clinical conferences. As many of these clinical conferences are student presented some may never receive any transcultural nursing education. In many programs the faculty offer the students a list of topics from which to choose their presentation. Frequently there are more topics than students or time; consequently if there is no interest in the topic it is not presented. In addition the student body is divided into specialty groups and no two groups hear the same presentations. For example, a group of ten students are doing their Maternity rotation in a period of seven weeks. The first week is orientation and the last termination so there are only five conferences left with a choice from 12 topics.

The response to the question of transculturally prepared faculty was as expected. Only 26 respondents have transculturally prepared faculty, but 74.1% offer specific learning experiences to help develop cultural awareness of the student. As mentioned before some schools such as Atlantic Union and Goshen require a semester in another culture. The writer is also in the process of developing this type of experience for her students in Community Health Nursing. Experiences contemplated are Appalachia, Ireland, Haiti, Dominican Republic, and Puerto Rico. One of the respondents suggested Puerto Rico as an excellent experience

because the Puerto Rican culture on the mainland is different from the culture on the island. A transculturally prepared professor emeritus from California has inaugurated an exchange program with nurses from the China mainland. These experiences can also be offered to registered nurses to increase their cultural awareness and provide them with the required Continuing Education credits for renewal of their nursing licenses.

The ethnic minority composition of both the student body and the community was enlightening, Over 86% of the colleges and universities had Black, 54.8% Spanish-speaking. 40.5 % Southeast Asian and 39.9% Asian students. There were no statistics for the Native American. Possibly the method of sampling of 170 out of 400 colleges and universities did not go to places where they were enrolled. Within the communities surveyed over 60% were multilingual - between 2 and 8 languages or dialects and there were more than two ethnic minorities and 2.8% listed seven. The author knows that in one of the communities used as a clinical experience, there are over 100 languages or dialects spoken in the public high school. Just think of the ethnic/minority resources available locally and the pool for minority recruitment!

2. Survey of Practicing Professional Nurses. This part of the survey was developed to solicit information on the confidence levels of 40 practicing professional nurses in giving holistic nursing care to ethnically diverse populations. Background information included age, sex, ethnicity, basic nursing education preparation, inclusion of transcultural nursing concepts in nursing program, number of years since graduation, number of years

professionally employed, site of employment, language proficiency, experiences outside of the United States and clinical experience with ethnic minorities in the United States.

The ages of the 38 female and 2 males ranged from 22-59 and the majority had graduated from either a diploma or baccalaureate nursing program. Those with the advanced degrees were Caucasian and either educators or worked in cultural centers. There may be a correlation among self-esteem, age and work experience. Minority nurses tended to have a diploma school education. From the college and university survey it was noted that 74.3% are actively recruiting minority students and programs to help decrease the attrition rate.

Forty four percent of the respondents stated that they had some transcultural nursing concepts included in their nursing education program, but the sample was too small to have significance with the age of the practicing professional nurse or clinical experiences with ethnic minorities. This study was conducted in two suburban (75,000 population) general hospitals and home care agencies in the same cities. A possible replication of the study at inner city health care facilities and a larger sample may demonstrate significance.

In order to do some statistical analysis the number of places of employment was decreased to three: (1) Inpatient (hospitals, outpatient departments, and nursing homes), (2) Community Agencies (clinics, health maintenance organizations, public health, and home care), and (3) Community Centers (cultural centers, senior citizen, schools and shelters). Forty percent were employed in

inpatient settings, 27.5% in community agencies, 25% in cultural centers and 7.5% as educators. The latter group worked additional hours at an inpatient setting to supplement their salaries.

Although a large number of the respondents stated they worked with ethnic minorities (Asian - 75%, Black - 72.5%, and Spanish-speaking - 82.5%), only 37.5% spoke a second language and were not fluent. The two most common languages were Spanish and French. The writer noted that in one of the cities surveyed, Lawrence, Ma., there are over 100 languages or dialects spoken in the public high school. Again for the purposes of analysis the ethnic minorites were reduced to three in number - Asian (Chinese, Japanese,Cambodian, Thai and Vietnamese), Black, and Spanish-speaking (Puerto Ricans, Filipinos, Mexican, Caribbean Islands, and Spaniards).

The final section of the questionnaire solicited information about the knowledge of specific transcultural concepts, their level of transcultural skills, and their level of confidence in giving quality care to ethnically diverse populations. Nurses tended to rate themselves on a higher scale in the area of skills rather than on knowledge. One question of developing a genogram indicated a lack of knowledge of confidence but may also indicate a lack of knowledge of the term. After speaking with several nurses the suggestion was made to identify a genogram as a health care family tree.

Two areas that showed no significant relatonship between the inclusion of transcultural nursing concepts in the educational program of the nurse or the number of years since graduation with

any of the three major ethnic groups studied. In fact there showed a definite lack of confidence in all areas concerning the ability to give holistic nursing care to the Asian population.

There is no level of significance between the Asian variables of family organization, health care beliefs and lifestyle with the years of experience, place of employment.

A marginal relationship was found between the variable of Asian family organization and the basic educational preparation of the nurse(0.0577) and a definite relationship in the variable of Asian lifestyle(0.0054). Any probability <0.05 is the criterion for a level of significance.

There were several areas in the level of significance in the Black minority. Significant relationships were found between the basic educational preparation of the nurse and the variables of family organization(0.0477), and health care beliefs(0.0488).

Other levels of significance with the Black minority were:

1. Years of employment and health care beliefs which was marginal (0.0534).
2. Place of employment and lifestyle which was significant(0.0154).
3. Work experience with minorities and family organization which was significant(0.0331).
4. Work experience with minorities and health care beliefs was marginal(0.0554).

5. Work experience with minorities and lifestyle was significant(0.0360).

There were nine levels of significance found among the Spanish-speaking minority which included:

1. Basic educational preparation of the nurse and family organization(0.0566) was marginal.
2. Basic educational preparation of the nurse and health care beliefs(0.0303)
3. Years of professional employment and health care beliefs(0.0329).
4. Years of professional employment and lifestyle (0.0492).
5. Place of employment and family organization(0.0083).
6. Place of employment and health care beliefs(0.0063).
7. Place of employment and lifestyle(0.0134).
8. Work experience with minorities and family organization(0.0352)
9. Work experience with minorities and health care beliefs(0.0185).
10. Work experience with minorities and lifestyle (0.0314).

This concludes the summary of findings provided by the research.

B. Recommendations

With the increasing number of immigrants and refugees entering the United States who have a language barrier, many indigenous health care beliefs, and different lifestyles, it is the opinion

of the writer that nurses need to include more transcultural nursing concepts in the basic preparation of nurses. Many nurses have learned these concepts by "trial and error" which is not beneficial to either the nurse or the client. Colleges and universities need to survey their communities for the ethnic/minority populations and develop classes/courses based upon these findings. The colleges and universities can serve the rest of the nursing population in their community with either specific transcultural courses or through Continuning Education seminars. The latter could be offered in the college setting or in the clinical facilities.

Using this as the basic premise of the writer, the following recommendations are made:

1. Replication of the study with a larger population sample in the inner city health care facilities.
2. Survey colleges and universities concerning specific transcultural concepts taught in their basic nursing education program.
3. Development and implementation of culture specific clinical experiences for nursing students. These experiences might be national or international.

4. Assessment of the need for advanced degree programs in transcultural nursing to prepare certified faculty.
5. Survey colleges and universities pertaining to recruitment and retention policies for minority students.
6. Evaluation of the inclusion of cultural health care belief systems in the prerequisites to nursing courses.

APPENDIX A

LETTER OF PERMISSION FROM CLINICAL FACILITIES

32 Woodland Avenue
Salem, New Hampshire 03079
December 1, 1990

Dear

I am in the process of completing a research proposal and I am currently seeking appropriate clinical facilities where the research can be implemented. The research proposed involves having professional nurses interviewed as to their level of confidence in caring for ethnically diverse clients. A copy of the questionnaire and the interview questions are enclosed for your review.

I have been advised that prior to any plans to implement my research in , I must have appropriate administrative approval. Therefore, I am requesting your permission or the approval of the appropriate research committees to proceed with plans for implementing this research at . If a meeting is indicated, I may be reached at my answering machine (617) 593-8904. If there were to be any pertinent guidelines to submitting research proposals, I would appreciate it if you would foreward a copy to me at the above address.

I am looking foreward to hearing from you, and I appreciate your time in this matter. Thank you.

Sincerely,

Katherine M. Kelly,MSN
Assistant Professor
Salem State College

APPENDIX B

COVER LETTER FOR SURVEY INSTRUMENTS

32 Woodland Avenue
Salem, New Hampshire 03079
February 12, 1991

Dear Colleague,

I know how busy you are and the last thing you want to do is fill out another questionnaire. I am a doctoral student at the University of Massachusetts, The subject of my dissertation is: "Are nurses being educationally prepared sufficiently to have confidence in their ability to offer quality care to ethnically diverse client populations?"

In today's rapidly changing world there is a heightened awareness of cultural diversity and its implications for health care. Cultural needs are just as important and real as biological and psychological needs; therefore, nursing can not be ignorant of or complacent about the urgency to comprehend the cultural needs and rights of clients/patients.

For the above reasons and my nursing experiences in Public Health and over twenty-five years as a faculty member in diploma, associate and baccalaureate nursing programs, I feel transcultural nursing concepts are one of the basic premises for today's nurse. There are a few programs offering transcultural nursing such as University of Washington and Wayne State; but more are needed. In order to assist new graduates in increasing their confidence levels when caring for ethnically diverse populations, we must incorporate these concepts early in their nursing education.

Each questionnaire will be coded, and the college/university will not be identified without its permission. Please return the completed questionnaire in the enclosed self-addressed, stamped envelope as soon as possible.

I am most appreciative of your participation and do thank you for your time. If you have any questions, feel free to contact me at either (508) 741-6000 Ext. 7261 (work) or (617) 593-8904 (answering machine).

Sincerely,

Katherine M. Kelly, M.S., R.N.

Written consent form

To the participants of the study:

I am Katherine M. Kelly, a doctoral student at the University of Massachusetts, in Amherst. The subject of my doctoral dissertation is: " Are nurses being educationally prepared sufficiently to have confidence in their ability to offer quality care for ethnically diverse client populations?" I am interviewing practicing nurses who are currently employed in hospitaLs and community health agencies in Lynn and Lawrence, Massachusetts. You are one of approximately forty participants.

As a part of this study, you are asked to participate in answering a questionnaire and an interview. The interview will be focused on your demographic background, transcultural nursing educational preparation, level of confidence in caring for clients of other cultures, and transcultural concepts that you would like to have had during your nursing education program. As the interview proceeds, I may ask additional questions for clarifcation or for further understanding, but mainly my part will be to listenand tape as you recreate your experience within the structure and focus of the interview.

My goal is to analyze the materials from your questionnaire and interview, in order to better understand your experiences and that of other practicing professional nurses. I am interested in concrete details of your experiences working with clients from different cultures and what transcultural educational preparation you would like to have had as a student. As part of my dissertation, I may compose the materials from your questionnaire and interview as a "profile" in your own words. I may also wish to use some of the material for journal articles or presentations to interested groups, or for instructional purposes in my teaching. I may wish to write a book based on the dissertation.

Each interview will be audiotaped and later transcribed by me or by a typist who will not be connected with your facility and who will be committed, as I am, to confidentiality. In all written materials and oral presentations in which I might use from your responses, I will use neither your name, names of people close to you, nor the name of your facility. Transcripts will be typed with numbers for names, and

in final form the interview material will use pseudonyms.

You may, at any time, withdraw from the interview process. You may withdraw your consent to have specific excerpts used, if you notify me at the end of the interview. If I were to want to use any materials in any way not consistent with what is stated above, I would ask your additional consent.

In signing this form, you are also assuring me that you will make no financial claims for the use of the material in your interview; you are also stating that no medical treatment will be required by you from the University of Massachusetts should any physical injury result from participating in these interviews.

I, _____, have read the above statement and agree to participate as an interviewee under the conditions stated above.

_____ _____

Signature of interviewer Signature of participant

_____

Date

APPENDIX C

SURVEY QUESTIONNAIRES

Survey Questionnaire

1. What type of nursing program do you offer?

__Associate Degree __Diploma

__Baccalaureate Degree __Masters Degree
__Generic
__Upper Division __Doctoral Degree
__RN Completion

2. Is your program:

__Integrated ___Block Courses

__Other (Please specify)

3. Do you offer a course in Transcultural Nursing?

__Yes __No

4. Do you offer any class (es) which include transcultural concepts?

__Yes (Please specify) __No

5. Do you include transcultural concepts in nursing courses?

__Yes __No
__Theory
__Seminar
__Clinical Conference

6. Do you have an Anthropology Department?

__Yes __No

7. Is an Anthropology course required for nursing students?

__Yes (please specify) __No

8. Do you require a second language for nursing students?

__Yes (Please specify) __No

9. Do you have transculturally prepared faculty?

__Yes ___No
__Educational Degree
__Certification

10. Do you offer any specific learning experiences that would help students develop an awareness of other cultures?

__Yes (Please specify) __No

11. About what percent of your nursing student population is considered to be a minority? What ethnic groups?

12. Do you actively recruit minority students?

__Yes __No

13. What types of clinical facilities do you and your students use?

__Clinics	__Hospitals	__Senior Centers
__Community Centers	__Nursing Homes	__Shelters
__Cultural Centers	__Public Health Agencies	__VNAs
__HMOs	__OPD	__Other (Specify)

14. What are the major languages spoken in the clinical facilities?

__Black American	__French	__Polish
__Cambodian	__German	__Russian
__Chinese	__Italian	__Spanish
__English	__Japanese	__Vietnamese
__Other)Please specify)		

15. What are the major ethnic groups in your community?

__Black (Please specify) __Chinese
__Caribbean (Please specify) __Mexican
__Caucasian (Please specify) __Southeast Asian
__Other (Please specify)

Background Information

Directions: Your responses are confidential. Please answer all questions by checking (/) the appropriate catagory or filling in the information about your own background.

1. Age in Years_____

2. Sex_____

3. Ethnic/Racial Background

____ Black
____ Caucasian
____ Chinese
____ Filipino
____ Haitian
____ Japanese
____ Mexican
____ Native American
____ Puerto Rican
____ Southeast Asian
____ Spanish Speaking (other)
____ Other (Please specify)

4. Nursing Educational Background

____ Diploma
____ ADN
____ BSN
____ Generic
____ Upper Division
____ RN Completion
____ Masters(Please specify area)
____ CAGS
____ Other(Please specify)

5. Courses or Continuing Education Courses taken in

____ Anthropology
____ International Health
____ Nursing Care of Minority Health
____ Special Populations
____ Transcultural Nursing

6. Were transcultural nursing concepts included in your nursing courses?

Yes___ No___

7. How many years ago did you graduate from your nursing education program?

____0-5
____6-10
____11-15
____16-20
__ Over 20

8. Number of Years Professionally Employed

____ 0-5
____ 6-10
____11-15
____ 16-20
____ Over 20

9. Locations of Professional Employment

____ Clinics
____ Public Health Agencies
____ Community Center
____ Cultural Centers
____ HMO's
____ Hospitals
____ Nursing Homes
____ OPD
____ Senior Centers
____ Schools
____ Shelters
____ VNA
____Other (Please specify)

PLEASE PLACE A CHECK MARK (/) IF THE FOLLOWING APPLY.

10. Were you born outside of the continental United States (excluding Alaska and Hawaii)? __Yes

11. Were you raised outside of the continental United States
(excluding Alaska and Hawaii)? __Yes

12. Have you lived outside of the continental Unites States (excluding Alaska and Hawaii)? __Yes

13. Have you been or are married to someone born and raised outside of the United States (or Puerto Rico)?

14. Do you speak another language (es) besides English? Please specify.

15. Have you worked as a nurse outside the continental United States (excluding Alaska and Hawaii)? ___Yes

____ Armed Services
____ Peace Corps
____ Traveling Nurse
____ Other(please specify)

16. Have you worked with ethnic minorities in the United States? If yes, please indicate what group(s) with whom you have worked.

____ Black
____ Chinese
____ Filipino
____ Haitian
(other)
____Japanese
____Mexican
____ Native American
____ Puerto Rican
____ Southeast Asian
____ Spanish speaking
____ Other (specify)

Cultural Self Efficacy Questionnaire

Directions: Your responses are confidential and will help me to plan better holistic nursing care for culturally diverse clients. This research will guide me in developing a Transcultural Nursing course for undergraduate students.
Please indicate how much confidence you have about doing each of the behaviors listed below.

Indicate three (3) confidence ratings for each statement- One for confidence with the Black group;a separate rating for the Spanish speaking group; and a third for the Southeast Asian group.

The rating scale is as follows:

1	2	3	4	5
Very Little confidence				Quite a lot of confidence

CONFIDENCE IN MY KNOWLEDGE OF CULTURAL CONCEPTS

Distinguishing between inter and intra cultural diversity	1	2	3	4	5
Distinguishing between ethnocentrism and discrimination	1	2	3	4	5
Distinguishing between ethnicity and culture	1	2	3	4	5

	Blacks	Spanish speaking	Southeast Asian
Family organization	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Role differentiation	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Child care practices	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Utilization of health care system	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Types of social supports	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Utilization of traditional folk health practices	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Nutritional patterns	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Economic style of living	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Migration patterns	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Class structure	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Employment patterns	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Patterns of disease/ illness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Knowledge beliefs about health/illness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Knowledge beliefs about death/dying	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Knowledge beliefs toward respect/authority	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Knowledge beliefs toward modesty/privacy	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Knowledge of religious beliefs/patterns	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

CONFIDENCE IN THE FOLLOWING SKILLS

Using an interpreter	1 2 3 4 5
Entering an ethnically distinct community	1 2 3 4 5
Advocacy	1 2 3 4 5
Participant observation	1 2 3 4 5
Developing a genogram	1 2 3 4 5
Taking a nursing history	1 2 3 4 5
Taking a 24 hour nutritional history	1 2 3 4 5
Teaching medication regimen	1 2 3 4 5
Evaluating compliance	1 2 3 4 5

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