Transcultural Nursing Theory and Models

APPLICATION in NURSING EDUCATION, PRACTICE, and ADMINISTRATION

Priscilla Sagar
TRANSCULTURAL NURSING
THEORY AND MODELS
Priscilla Limbo Sagar, EdD, RN, ACNS-BC, CTN-A, is a professor of nursing at Mount Saint Mary College in Newburgh, New York. She received a BS in Nursing from the Philippine Women’s University; an MS in Adult Nursing, minor in education from Pace University; and an EdD in nursing education/professorial role from Teachers College, Columbia University. She is board certified in adult health from the American Nurses Credentialing Center and has advanced certification from the Transcultural Nursing Society. Her research interests include international nursing, mentoring, partnerships and collaborations, and transcultural nursing (TCN). She serves as consultant in the areas of cultural diversity and promotion of cultural competence as well as in curriculum development, implementation, and evaluation. In addition, Dr. Sagar had facilitated several national and international conferences to disseminate TCN research and knowledge. She is a longtime member of the Transcultural Nursing Society and chairs the Eligibility and Credentialing Committee of the Transcultural Nursing Certification Commission. Dr. Sagar also teaches as an adjunct faculty for University of Phoenix Online’s School of Advanced Studies where she has assisted in dissertations with cultural diversity and transcultural focus.
Transcultural Nursing
Theory and Models

Application in Nursing Education,
Practice, and Administration

Priscilla Limbo Sagar, EdD, RN, ACNS-BC, CTN-A

SPRINGER PUBLISHING COMPANY
NEW YORK
This book is dedicated to

My loving family: husband Drew Sagar for his unconditional love and support; daughter Alexa, and grandson Andrew Michael; parents Trinidad and Mercedes Limbo and family; and to my late mother-in-law Joy Sagar-Radomski.

Dr. Madeline Leininger, founder and leader of transcultural nursing, for her tireless, courageous, and untiring effort for six decades in building transcultural nursing knowledge and for her laborious work on behalf of TCN.

Other pioneering transcultural nurses who contributed, are contributing, and will contribute to the field of TCN. Because of Dr. Leininger and these nurses, we have a wealth of knowledge for evidence-based practice in transcultural nursing. Past mentors at Teachers College, Columbia University: Dr. Sheila O. Melli, Dr. Marie O’Toole, and Dr. Caroline Camuñas.
## Contents

*Foreword*  ix  
Madeleine M. Leininger

*Foreword*  xv  
Margaret M. Andrews

*Preface*  xvii

1. **Madeleine Leininger’s Theory of Culture Care**  
   Diversity and Universality  1  
   Section 1. Review of the Theory  1  
   Section 2. Application of the Theory in Nursing Education  5  
   Section 3. Application of the Theory in Nursing Practice  9  
   Section 4. Application of the Theory in Nursing Administration  12  
   NCLEX-Type Test Questions (1–15)  17

2. **Larry Purnell’s Model for Cultural Competence**  21  
   Section 1. Review of the Model  21  
   Section 2. Application of the Model in Nursing Education  25  
   Section 3. Application of the Model in Nursing Practice  28  
   Section 4. Application of the Model in Nursing Administration  31  
   NCLEX-Type Test Questions (1–15)  34

3. **Josepha Campinha-Bacote’s The Process of Cultural Competence in the Delivery of Healthcare Services and Biblically Based Model of Cultural Competence**  39  
   Section 1. Review of the Model  39  
   Section 2. Application of the Model in Nursing Education  43  
   Section 3. Application of the Model in Nursing Practice  45  
   Section 4. Application of the Model in Nursing Administration  47  
   NCLEX-Type Test Questions (1–15)  51
4. Joyce Newman Giger and Ruth Davidhizar’s Transcultural Assessment Model 57
   Section 1. Review of the Model 57
   Section 2. Application of the Model in Nursing Education 64
   Section 3. Application of the Model in Nursing Practice 68
   Section 4. Application of the Model in Nursing Administration 70
   NCLEX-Type Test Questions (1–15) 74

5. Rachel Spector’s Health Traditions Model 79
   Section 1. Review of the Model 79
   Section 2. Application of the Model in Nursing Education 84
   Section 3. Application of the Model in Nursing Practice 86
   Section 4. Application of the Model in Nursing Administration 86
   NCLEX-Type Test Questions (1–15) 91

6. Margaret Andrews/Joyceen Boyle Transcultural Nursing Assessment Guide for Individuals and Families 95
   Section 1. Review of the Guide 95
   Section 2. Application of the Guide in Nursing Education 98
   Section 3. Application of the Guide in Nursing Practice 101
   Section 4. Application of the Guide in Nursing Administration 104
   NCLEX-Type Test Questions (1–16) 112

7. Discussion Across Models and Future of Transcultural Nursing 117
   Section 1. Across Theory, Models, and Guide: Where Are We Going? 117
   Section 2. Nursing Education 119
   Section 3. Nursing Practice 129
   Section 4. Nursing Administration 132
   Section 5. Future of Transcultural Nursing 134

Answers 143

Appendices
   Appendix A. Lesson Plan. Using Leininger’s Sunrise Model and Components Across Models 147
   ....And the River Flows 161

Index 163
Foreword

Madeleine Leininger, PhD, LHD, DS, RN, CTN, FAAN, LL
Founder of Transcultural Nursing
and
Leader in Culture Care Theory and Research

One of the most significant and revolutionary movements in nursing and the health fields during the past six decades has been the theoretical, intellectual, and research studies for educators and professional leaders to understand culture and then incorporate cultural content into health services. This new body of transcultural nursing and caring knowledge is held to initiate and to improve the quality of care to people of diverse and similar cultures. This has been a major and significant movement led by myself and a few committed nurses to incorporate holistic, broad, specific, and general culture care concepts into health services. The incorporation of culture care principles and theoretical research findings into health care practices by teaching and applying transculturally based health care has been emphasized. The movement began in the late 1970s when I realized the cultural dimensions bearing upon understanding and helping people of diverse cultures were major and missing dimensions in health care. It was through repeated direct observations that I discovered the absence of cultural factors in people care. There were missing factors influencing illness, health, wellness, recovery, and health maintenance. I chose to be a leader to change this long neglected area in nursing and health care. I also chose to stimulate other health disciplines to work toward this goal.

Initially, this ambitious leadership goal seemed overwhelming and impossible with limited resources and virtually no prepared faculty to
teach and conduct research related to bringing culture into health care practices. However, the need for change was great and the benefits to clients seemed most promising and important. Hence, the challenges and benefits were noteworthy.

From the beginning, I held that the nursing profession with its central focus on human care could play a central role to make transcultural care possible and a substantive focus of a new field I called transcultural nursing and health care. Persistence, diligence, and creative leadership were needed to achieve this major goal and bring changes into health care. I began this movement by emphasizing the educational preparation of undergraduate and graduate nurse students into the new field of transcultural nursing study and practice. Almost immediately, I discovered that nursing students became highly motivated and excited about the actual and potential benefits of nurses to establish this new role and practice in nursing. The course content was stimulating to them and the idea spread to many nurses and health care providers who became interested to learn about culturally based care. Then I discovered that the master and doctoral nursing students were interested in transcultural nursing and wanted to be prepared in the new field. These undergraduate and graduate students led the way to make transcultural nursing a reality. They became active supporters to promote transcultural nursing care with and for cultures. These were most encouraging factors and helped carve the pathway to establish the new field of transcultural nursing. The students’ enthusiasm and vision of transcultural health care as a new field of study and practice in nursing were noteworthy.

In the mid-1960s I realized my need for doctoral preparation in anthropology and pursued doctoral study in cultural and social anthropology. Then I encouraged other nurses to follow similar preparation in order to assure in-depth knowledge of cultures. These practices opened the door for nurses, physicians, and other health professionals to study Western and non-Western cultures with a comparative focus. I was particularly interested to discover culturally based care meanings, expressions, and care practices of cultures to realize the vast wealth of untapped cultural knowledge available to study and apply to health care with a comparative focus.

By the early 1960s, human care with a transcultural focus became known and the pathway for transcultural health research became apparent to nurses and other health care practitioners, providers, and researchers. Soon the traditional focus in nursing on medical diseases, symptoms, and treatment modes was decreased and transcultural care
became the central interest. Culturally based care with cultural care meanings, uses, practices to heal, and to maintain well-being began to be emphasized by the late 1970s.

It was the development of my Theory of Culture Care Diversity and Universality that stimulated and guided many students and others to discover culture care diversities and universalities. The theory was an important guide to help investigators to enter the world of culture and to learn directly from the people about their culture. I developed and encouraged the use of qualitative research methods to tease out culture care data with the use of the ethnonursing method. This method had five ways to help investigators identify care meanings and their uses in specific cultures. It was the development and use of the Sunrise Enabler as a conceptual guide for students and researchers to grasp the scope and areas to obtain transcultural nursing data. Using the Sunrise model, students could identify appropriate decisions and actions for the application of therapeutic culturally based care. Thus, both the theory and method were essential to discover and apply transcultural nursing knowledge.

This brief overview to discover transcultural nursing took nearly 50 years to obtain and understand Western and non-Western cultural knowledge. This was an exciting and noteworthy time as students teased out the subtle, covert cultural phenomena as the new transcultural nursing care knowledge. Since then and today, transcultural nursing has become established with many nurse researchers and health professionals using this knowledge to care for cultures. Today, health care providers can provide care that is congruent or appropriate to specific cultures in accord with their cultural values and lifeways. Transcultural care has become a reality and is welcomed by many clients with positive benefits in health care, recovery, and well being. Many clients have told the author and others that providing transcultural nursing care is greatly valued and essential to them. For example, several older clients told the author, “I never thought this kind of care would occur in my lifetime. It is a joy and so helpful to me and my culture because it fits my lifeways. Thank you.”

I believe this book by Priscilla Limbo Sagar offers a further step to advance, strengthen, support, and sustain the new transcultural nursing field and health care in general. The author offers models and visual aids to assess, apply, and use transcultural nursing and related findings for improved care. Such aids in learning and practice can be used in addition to current knowledge and existing methods. These models can be helpful to build transcultural and other nursing care knowledge to transform health care practices.
I believe this book with a major focus on assessment and use of transcultural nursing theory and research findings will lead to a wealth of new principles, practices, and policies to guide health care providers for quality care services to cultures. This knowledge should build upon existing knowledge and provide choices and guides to practice. Such contributions will not only build and strengthen health care and transcultural nursing but should help guide practitioners to become global and skillful practitioners as we expand and serve people of many cultures in the world.

I believe this book will be helpful to nurses, especially baccalaureate and graduate students, as well as to interdisciplinary health students and practitioners to envision and discover many creative and effective approaches to know, understand, and serve cultures. Having new and explicated content, models, and guides will enable practitioners to move forward transcultural health care into new discoveries and beneficial ways to health and wellness. It will also help to avoid cultural biases, prejudices, destructive practices, and cultural ignorance. Moreover, transcultural nursing practice will become essential to provide quality-based health services in the near future. In the early 1960s, it was my hope that by this 21st century, health values, beliefs, and practices of most cultures would be known and fully understood, and practitioners would be able to skillfully and knowingly apply knowledge that is tailored to cultures to maintain their health care and well-being. Thus, by using appropriate theories, models, research methods, and research findings, a wealth of creative new knowledge and practices will be forthcoming.

Today, there are several transcultural nursing books, guides, principles, and research findings with practices that are focused on transcultural nursing to help newcomers and established practitioners provide culturally based nursing and health care. Newcomers can use and build upon existing knowledge and they can expand upon and reaffirm knowledge through practices based on current findings. This will greatly advance practices and assure quality-based health care services. Before long, one can anticipate that transcultural nursing with a holistic and comprehensive comparative focus on culture care will become essential, imperative, and will be required for all health practitioners to be considered professional and safe practitioners. These will be expected norms for licensure of physicians, nurses, and all health care providers. Teachers, practitioners, and administrators will be expected to use transcultural nursing-based knowledge to provide professional services. When this occurs, we will witness major transformations greatly valued by cultures. These developments will be
important for the *globalization of transcultural nursing* and quality-based health care as the desired goal of all cultures worldwide.

I believe the author of this book envisioned this goal by stressing the importance of culture care assessments, diverse models, and therapeutic applications of theory-based research findings that need to be woven into care practices. Before this 21st century ends, global health care will have a significant impact on the quality of health care services rendered not only to cultures in Western and non-Western societies but also to all aspects of humanitarian care. These developments are most promising and possible if health care professionals are educated and prepared with these goals in mind. The extent of care diversity and *universals* as predicted in my Theory of Culture Care Diversity and Universality will become known and will transform health administration, national and local health policies. Such major contributions to health care will revolutionize and transform health care practices to not only improve and change health services but also become greatly valued and established as desired standards of care. They will become an imperative for cultural, social justice, and humanitarian health care practices for and with cultures. My dream and the dream of futuristic health care providers will be realized.

It is important to state that in the future we will have many books, research projects, and applications of transcultural nursing and of new practices in health care services, practices not realized today. Such contributions will help to affirm existing transcultural nursing and new knowledge in health care. They will, indeed, revolutionize current practices in teaching, research, and in administrative policies in many cultures. Cultures can then rejoice that their culture needs will, at last, be recognized and respected, known, understood, and practiced.

Such major revolutions and transformations in health care education, services, and in administrative practices will be evident worldwide. Such revolutions necessitate change in education, practice, and administration, which this book addresses. It also means we must be committed to culture care with a global vision and commitment. This book by Priscilla L. Sagar should be an important means to reach this goal. In time, the full credibility and realization of transcultural nursing by accurate assessments and the application of research findings from the Culture Care Theory and related theories will yield many benefits. The author is, therefore, to be commended in providing this book to guide nurses and other health care providers toward this goal so that culturally based care with benefits to cultural recipients can be a reality to their health and well-being. Most of all, this book should stimulate
readers to think of different ways of using appropriate models, theories, and research methods to guide their thinking and practice. As a consequence, these explorers will find a wealth of new and untapped knowledge to guide their thinking and practice. One can predict they will see the many benefits to health care services between the clients of different and similar cultures.

This book should broaden, expand, and deepen health care in general, and specifically to diverse cultures worldwide. With such refinements of knowledge for culture-specific and cultural universals comparative dimensions of cultures will become evident. The diverse health care needs and practices will be welcome knowledge to health care providers and nurse practitioners, teachers, and researchers to grasp a holistic perspective of ways of knowing, respecting, and understanding cultures. Hopefully, and ultimately, one might anticipate that cultural justice, human care, and health care refinements will be forthcoming and valued as an essential outcome to benefit cultures and the health care providers who have been part of this evolution in health care services. A life with challenges, changes, and beneficial outcomes is always a life worth experiencing and knowing. The time is now to heed those challenges and changes for the transformation of health care. It is what the public is expecting, today and in the future. Most of all, cultures will be respected and valued in teaching, research, practice, administration, and relevant public policies. This will be a great reward for all participants in this endeavor.

REFERENCES


Margaret M. Andrews, PhD, RN, CTN, FAAN
Director and Professor of Nursing
School of Health Professions and Studies
University of Michigan-Flint;
Editor
Online Journal of Cultural Competence in Nursing and Healthcare

Dr. Priscilla Limbo Sagar’s Transcultural Nursing Theory and Models: Application in Nursing Education, Practice, and Administration provides a comprehensive, in-depth examination of transcultural healthcare theory and models and critically examines their applications in nursing education, nursing practice, and nursing administration. Dr. Sagar begins this groundbreaking book by presenting Madeleine Leininger’s Theory of Culture Care Diversity and Universality. The foundress of transcultural nursing, Dr. Leininger created, continuously developed, refined, and evaluated her Theory of Culture Care Diversity and Universality during the past six decades using research on hundreds of cultures and subcultures worldwide. Dr. Sagar has crafted a scholarly overview of Leininger’s theory, Sunrise Enabler, ethnonursing research method, and Leininger’s other work in the area of culture care that has influenced the ongoing development of transcultural healthcare and nursing and the creators of the models and guides presented in the remaining chapters of the book.

Dr. Sagar has provided a systematic review of contemporary transcultural healthcare and nursing models such as Purnell’s Model of Cultural Competence, Campinha-Bacote’s The Process of Cultural Competence in the Delivery of Healthcare Services and Biblically Based Model of Cultural Competence, Giger and Davidhizar’s Transcultural...
Assessment Model, Spector’s Health Traditions Model, and the Andrews/Boyle Nursing Assessment Guide for Individuals and Families. After reviewing the primary components of the authors’ work, Dr. Sagar skillfully crafts conceptual links as she explores applications of theory and models in nursing education, practice, and administration. She also poses NCLEX-type test questions and engages in a constructively critical analysis of the key aspects of the theory and models. Dr. Sagar then invites the reader to a scholarly discussion across the theory and models and called nurses to action as proactive change agents for providing culturally congruent care to people and for promoting culturally competent organizations. She concludes the book with a reflective, thought-provoking look into the future.

Dr. Sagar’s work is a must-read synthesis and analysis of the work of key leaders in transcultural healthcare and nursing. She has created a conceptually clear, comprehensive compendium for all health and nursing professionals who are serious about transcultural healthcare models/guides and their applications in nursing education, practice, and administration. Dr. Sagar has made a substantive and important contribution to the advancement of knowledge about transcultural healthcare in this book by clearly explicating and demonstrating the relevance of the theory and models in nursing education, practice, and administration. Dr. Sagar’s conceptual linkages to education will assure that the next generation of nurses will graduate from educational programs with curricula rooted in a solid transcultural foundation. Applications to nursing practice will assure that those engaged in the clinical practice of nursing and healthcare will have state-of-the-art knowledge that will enable them to provide culturally congruent and competent care to individuals, groups, and communities from diverse and similar backgrounds. Applications to nursing administration will enable leaders of healthcare organizations, institutions, and agencies to integrate transcultural theory and models into their strategic planning, policies and procedures, responses to national and state accreditation criteria, and related initiatives, thus facilitating organizational cultural competence.

Dr. Sagar is to be congratulated for her outstanding contribution to transcultural healthcare and nursing and to the provision of culturally competent and congruent care for all people.
This book focuses on the application of a transcultural (TCN) nursing theory, four healthcare models, and an assessment guide in nursing education, practice, and administration. Although there is increasing body of knowledge from TCN research spearheaded by Dr. Madeleine Leininger, there is paucity of literature applying those models. More than ever, application in the above fields of nursing is needed to provide (1) nurse educators more resources in integrating cultural competence in nursing curricula; (2) practicing nurses some guidelines to develop culturally congruent care; and (3) nurse leaders various tools to use in innovative approaches for maintaining individual and organizational cultural competence.

Diverse healthcare workers providing care to an increasingly diverse population demand a comprehensive approach to understanding TCN theory and models and their application to education, practice, and administration settings. The discussions under each theory, model, or assessment guide branch out to include current guidelines, mandates, and standards with regard to cultural diversity and promotion of cultural competence. Furthermore, the overlapping between education, practice, and administration is evident—illustrating the dynamic connection between these three realms—in health promotion and in providing equal, safe, and quality healthcare. While there is mention of transcultural research and evidence-based practice, a separate chapter in research application for each theory, model, or assessment guide is beyond the focus of this book.

This book is organized into seven chapters. Six chapters examine one transcultural (TCN) nursing theory, four healthcare models, and an assessment guide: Leininger’s *Theory of Culture Care Diversity*
and Universality; Purnell’s Model for Cultural Competence; Campinha-Bacote’s The Process of Cultural Competence in the Delivery of Healthcare Services and Biblically Based Model of Cultural Competence in the Delivery of Healthcare Services; Giger and Davidhizar’s Transcultural Assessment Model; Spector’s Health Traditions Model; and Andrews/Boyle Transcultural Nursing Assessment Guide for Individuals and Families. Chapter 7 calls nurses—as the largest group of healthcare professionals—to action, and critically examines how their academic, clinical practice, and organizational settings contribute to cultural competence and how each setting could work in harmony and synchrony with mandates and guidelines from the government, accrediting agencies, and professional nursing organizations.

National Council Licensing Examination (NCLEX)–type questions to assist in reviewing and applying key concepts of the theory, models, and assessment guide are placed at the end of Chapters 1 through Chapter 6. These questions will guide nursing educators in integrating cultural diversity and promotion of cultural competence in nursing curricula. In nursing practice, the NCLEX questions will be helpful in applying theory, model, and guide in the assessment, planning, implementation, and evaluation of client care tools and staff development programs.

In addition to the assessment guide, the book uses the five nursing models cited by the American Association of Colleges of Nursing (AACN, 2008) Cultural Competency in Baccalaureate Nursing Education: Leininger, Purnell, Campinha-Bacote, Giger and Davidhizar, and Spector. The Giger and Davidhizar’s Model is used as framework by the National League of Nursing (2009) in the preparation of its Diversity Toolkit.
Dr. Leininger, the founder and “mother” of transcultural nursing (TCN; Ryan, 2011), started the development of the culture care diversity and universality (CCDU) theory in the late 1940s. According to Glittenberg (2004), Leininger, along with her followers, contributed more than 400 scientific studies to the field of TCN. The founder of TCN pioneered research among the New Guinea Gadsup people; this and her other research became the cornerstone of the CCDU theory (Ryan, 2011). The opening on April 16, 2010, of the Madeleine Leininger Collection on Human Caring and Transcultural Nursing in the Archives of Caring and Nursing at the Christine Lynn College of Nursing, Florida Atlantic University, Boca Raton, Florida, celebrated a life of creativity, courage, and commitment to TCN (Ryan, 2011). Leininger’s work in 6 decades established TCN as a formal area of study and discipline in nursing (Andrews, 2008) and instituted its theoretical foundation (Glittenberg, 2004; Ryan, 2011).

Sunrise Enabler to Discover Culture Care

Leininger’s theory is depicted as the sunrise enabler to discover culture care (Figure 1.1), symbolic of the hope to generate new knowledge for nursing. The model shows factors such as (1) technological, (2) religious and philosophical, (3) kinship and social, (4) cultural values and lifeways,
(5) political and legal, (6) economic, and (7) educational, forming sunrays that influence individuals, families, and groups in health and illness (Leininger, 1995a, 2002a, 2002b, 2006a). As the model indicates, it is applicable in assessing and caring for individuals, families, groups, communities, and institutions in various health systems. The CCDU theory has undergone refining for 6 decades and is used in nursing as well as in other health-related disciplines (Leininger, 1995a, 2002a; Leininger & McFarland, 2006).

**FIGURE 1.1** Sunrise Enabler to Discover Culture Care Sunrise Model.  
*Source*: Reprinted with permission from M. M. Leininger.
Theoretical Assumptions

The formation of theoretical assumptions emanates from the major tenets of the CCDU theory (Leininger, 2006a). Three of the 11 assumptions cited by Leininger (2006a) are listed below:

- Care is the essence… and unifying focus of nursing;
- Culture care expressions, meanings, patterns… are diverse but some commonalities (universalities) exist among and between cultures;
- Every culture has generic (emic) and usually some professional (etic) care to be discovered and used for culturally congruent care practices (pp. 18–19).

Leininger (2002b) emphasizes that the nurse need not only be a mediator or broker but has to be “very knowledgeable about the client’s culture and diverse factors influencing… needs and lifeways” (p. 119). Shown in constantly interacting circles, nursing care bridges generic or folk systems and professional systems—two major constructs of the CCDU. She has consistently advocated for a holistic approach in nursing care long before the term was popular. According to Leininger (2006a), the culture care theory’s focus is culture and care “because they were missing…and long neglected” (p. 7) in theory development during the 1980s and 1990s.

Leininger (2002a, 2002b) places great emphasis on the role of appropriate culturalogical assessment when working with individuals, families, groups, and institutions to provide culturally congruent care. In the process of this assessment, the nurse “enters the client world to discover cultural knowledge that is often embedded within individual and family values” (Leininger, 2002b, p. 117). Acknowledging the time constraints in the acute settings, Leininger (2002b) suggested a short culturalogical assessment in five phases: recording of observations using all five senses; paying close attention and listening, including for generic folk practices; identification of patterns and narratives; synthesis of themes and patterns; and development of a culturally congruent care plan jointly with the client (p. 129).

The CCDU theory has three action modes for providing culturally congruent, holistic nursing care in health and well-being or when dealing with illness or dying namely preservation and/or maintenance, accommodation and/or negotiation, and repatterning and/or restructuring (Leininger, 2006a, p. 8). Preservation and/or maintenance refer to those decisions that maintain and preserve desirable
and helpful values and beliefs. Accommodation and/or negotiation are helpful in the adaptation and transaction for care that is fitting for the culture of the individual, families, or groups. Repatterning and/or restructuring involve mutual decision-making process as the nurse modifies or changes the nursing action to achieve better health outcomes.

**The Ethnonursing Method**

Leininger’s (1995a, 2002a, 2002b, 2006a) development of the ethnonursing method, a unique qualitative method that includes ethnography, reflects the richness of her blended preparation in nursing and anthropology. Her seminal book, *Anthropology and Nursing: Two Worlds to Blend* (1970) laid much of the groundwork of TCN. Leininger (1995) was emphatic not only in learning from the people but also in learning from them in their familiar environment. Many nurses have conducted research using the ethnonursing method, adding considerably to the body of knowledge in TCN.

Dismissing tools and instruments as “impersonal and mechanistic and fit with objectification,” Leininger (2006a, p. 58) prefers to use *enablers* to denote a participatory approach and friendliness in the research process. Leininger refers to these enablers as *stranger–friend enabler* and *observation–participation–reflection enabler*. When the researcher moves from stranger (etic) to friend during the ethnonursing process, it is more possible to gather accurate and meaningful data. The model is applicable for research conducted in various settings where the nurse explores phenomena of interest (Leininger, 2006a). Basing it from anthropology, Leininger (2006a) developed the *observation–participation–reflection enabler* in the 1960s, but added reflections to be in keeping with the ethnonursing method. While using these enablers, this author personally experienced this during her two stays in Vietnam in the process of completing her dissertation on *The Lived Experience of Vietnamese Nurses: A Case Study* (Sagar, 2000). As the researcher moved from a newcomer to that of a friend, the Vietnamese nurses truly opened and shared stories about their journey and their struggles to “make nursing worthy as a profession in Vietnam” (Sagar, 2000, p. 168).

Analyzing data when using the ethnonursing method is a detailed rigorous process. In this way, the research will meet the criteria of “credibility, recurrent patterning, confirmability, meaning in context” (Leininger, 2006a, p. 62) and other requirements of qualitative research.
According to Leininger (2006a), there are four phases of ethnonursing analysis:

- Phase 1 entails the collection, description, and documentation of raw data;
- Phase 2 consists of identifying and categorizing “descriptors and components” (p. 62), including coding of data and studying of similarities and differences among emic and etic descriptors;
- Phase 3 involves pattern and contextual analysis whereby data are examined carefully for “saturation of ideas and patterns” (p. 62);
- Phase 4 includes synthesizing, interpreting, and analyzing for “major themes, research findings, theoretical formulations, and recommendation” (p. 62).

Leuning, Swiggum, Wiegert, and McCollough-Zander (2002) used Leininger’s CCDU, along with Campinha-Bacote’s (2003) culturally competent model, to develop proposed Standards for Transcultural Nursing, which was approved by the Transcultural Nursing Society (TCNS) in 1999. This group of two faculty academicians, and two practitioners, made up the subcommittee from the Minnesota chapter of TCNS—who spent 3 years developing what they believed will primarily foster excellence in TCN. The standards may be most beneficial in practice but may also be helpful in curriculum development, in program and hospital accreditation, and in research (Leuning et al., 2002). Again, the CCDU depicts its applicability in nursing practice, education, administration, and research.

SECTION 2. APPLICATION OF THE THEORY IN NURSING EDUCATION

“It is imperative,” according to Leininger and McFarland (2002), “that transcultural nursing be explicitly taught in undergraduate and graduate programs” (p. 527). The root of this argument is the development of TCN and its profound effects in learning, teaching, and the use of evidence-based practice. Currently, the focus on cultural competence by the government, by accrediting bodies in practice (The Joint Commission [TJC], 2010), and in academia (American Association of Colleges of Nursing [AACN], 1998, 1999, 2008; National League of Nursing [NLN], 2009) are intensifying the call for formal courses in nursing programs.
Transcultural Nursing Theory and Models

and other health-related fields. Despite the growing evidence that graduates of nursing programs do not have the cultural competence required to care for the increasingly diverse U.S. population (Kardong-Edgreen & Campinha-Bacote, 2008), there is no standard curricular guideline or mandate as to the inclusion of knowledge, skills, and competencies needed (Lipson & Desantis, 2007; Ryan, Carlton, & Ali, 2000).

Because of its holism and systematicity, the CCDU lends itself to application in nursing education. Both Lipson and Desantis (2007) and Ryan et al. (2000) documented its adoption in graduate and undergraduate nursing programs in the United States. As the United States becomes more diverse, the CCDU will be used more frequently to guide recruitment, engaging, and retention of minority and disadvantaged nursing students.

McFarland, Mixer, Lewis, and Easley (2006) applied the culture care theory in the recruitment, engagement, and retention phases of the Opportunities for Professional Education in Nursing (OPEN) in a 3-year, federally funded project for students who were not only culturally diverse but also educationally and financially disadvantaged. This is consistent with the efforts to develop a nursing workforce that mirrors the diversity of those receiving care (Bomar & Glenn, 2004; McFarland et al., 2006; NLN, 2009; Sullivan Commission, 2004) and to eliminate disparities in health and health care as well as to promote social justice and globalization (American Nurses Association [ANA], 1991, 1995, 2003; AACN, 1998, 1999, 2008).

Few baccalaureate programs have separate transcultural courses; other programs rely on the integration of diversity and the promotion of cultural competence in nursing courses. Nursing students from diverse cultures need understanding and caring (Leininger, 1995c) as they navigate academia in their journey to completion of the nursing program. The task of preparing culturally competent nurses falls on the faculty who must educate themselves in cultural competence in order to be effective in their teaching, mentoring, and role modeling. According to Leininger (1995c), less than 20% of faculty are prepared in TCN. About 40% of baccalaureate students and 17% of master’s students have had formal courses in TCN (Leininger, 1995c). In 2000, Ryan, Carlton, and Ali’s survey of 610 (36% return) baccalaureate and higher programs revealed that 43% baccalaureate and 26% of master’s students had formal courses in TCN. Of those reporting formal courses in TCN at the baccalaureate program, 87% have one course and 13% have several courses; at the master’s level, 86% have one course and 14% have several courses (Ryan et al., 2000).
In Project OPEN, 12 out of 200 prenursing and nursing students were recruited for the qualitative evaluation. Student-focused care was used with Leininger’s three modes of actions. The students found the interventions beneficial as they successfully navigated through the nursing program (McFarland et al., 2006). For example, in culture care repatterning, students were encouraged to use financial aid and decrease their working hours, thereby increasing chances of academic success.

In her nontraditional undergraduate retention and success model, Jeffreys (2004) emphasized the multiple roles nursing students play—such as parent and wage earners—in addition to pursuing nursing. Nursing education is laden with western European values and has changed slowly to reflect the values of increasingly diverse students (Jeffreys, 2004). An issue that has not received much attention is the actual racial bias in nursing textbooks. Byrne (2001) pointed out the racial bias in the portrayal of African Americans through a content analysis of three fundamentals of nursing textbooks in areas of history of nursing, cultural content, and physical assessment and hygiene. When working with these nontraditional, diverse students, Leininger’s theory could be highly applicable; the characteristics of these nursing students are similar to those in the Project OPEN. Integrating concepts to promote cultural competence among educators and students will be contributing factors in student retention and in preparing a nursing workforce that is more representative of the clients being served.

The AACN (2008), with funding from the California Endowment, developed Cultural Competency in Baccalaureate Nursing Education: End-of-Program Competencies for Baccalaureate Nursing Program Graduates and Faculty Toolkit for Integrating These Competencies into Undergraduate Curriculum. This document, which uses Leininger’s culture care diversity and universality theory along with four nursing models namely Campinha-Bacote’s model of cultural competence, Giger and Davidhizar’s model of TCN, Purnell’s model of transcultural health care, and Spector’s health traditions model (AACN, 2008), is vital in promoting cultural competence among baccalaureate nursing graduates. Leininger’s textbook Transcultural Nursing: Concepts, Theories, Research, and Practice, in its third edition, and deemed a classic in the field (Leininger & McFarland, 2002), was instrumental in the development of TCN (Glittenberg, 2004). The textbook, along with Culture Care Diversity and Universality: A Worldwide Nursing Theory, second edition (Leininger & McFarland, 2006), is widely used in nursing schools. Academia has begun to embrace the field of diversity and the promotion of cultural competence (AACN,
1998, 1999, 2008; NLN, 2009)—as more and more schools offer separate courses in TCN or continue to integrate the cultural competence in nursing and related courses—recognizing its primacy as the key to reducing disparities in health care and as patients and health care providers continue to equally get more diverse.

Although the effort from the AACN and the NLN is commendable, challenges will continue in the difficult task of integrating TCN concepts in the curriculum for those schools without a formal course in cultural competence. The difficulty stems from “overloaded curriculum and the reluctance of faculty” (Leininger, 1995c, p. 14). In light of inclusion of TCN concepts in the National Council Licensure Examination (NCLEX) and in program and hospital accreditation standards, more hope is envisioned ahead. This dawning will be a tribute to Dr. Leininger whose work in TCN spans more than 6 decades. Leininger’s work and those of other TCN experts constitute a remarkable body of knowledge for evidence-based practice.

While teaching Vietnamese nurse leaders from the education and administration sectors, it was apparent that respect for elders and focus on the group were important (Sagar, 2000; Sagar, 2010). The instructors of the 2-week course applied Leininger’s (1995a, 2004, 2006a) preservation and maintenance mode. The instructors accommodated and negotiated as they taught nurse leaders and educators with the aid of an interpreter and translator. In repatterning and restructuring, the instructors reviewed standards from the United States and guided the nurse leaders to develop their own philosophy of nursing (Sagar, 2000). This example proves CCDU’s applicability in various formal and informal educational settings. The following role play further illustrates the theory’s applicability in academia.

**Sample Role Play Scenario**

Student A is dressed as a faculty member, wearing a suit and seated at her desk. The meeting between faculty and student is for discussion of the student’s failing grade in the first exam for nursing skills. Attempting to make the student feel better, the faculty member stood up and touched the student’s head.

Student B is a Vietnamese American student in a baccalaureate program. The student is dressed in low hanging denim pants and loose shirt. His head is lowered and he is avoiding eye contact; his shoulder is hunched. When his head was touched, he suddenly jerked his head.
Student C is the certified transcultural nurse. She will moderate the discussion following the role playing and will use the following questions as guide:

1. What culture care preservation and maintenance modes could the faculty use? Explain.
2. What culture care accommodation and negotiation modes could the faculty use? Explain.
3. What culture care repatterning and/or restructuring modes could the faculty use? Explain.

Instructor/Educator: Debriefing

1. Reflect on the scenario. How did you feel?
2. Discuss what you learned. What other learning needs do you have? Discuss.
3. Discuss the application of this role play in your clinical rotation.
4. Reflect on the changes needed in your own knowledge, skills, and behavior in order to incorporate culturally congruent care.

SECTION 3. APPLICATION OF THE THEORY IN NURSING PRACTICE

The United States has one of the most diverse populations in the world. In 2008, the U.S. Census Bureau predicted that the nation will further increase in racial and ethnic diversity throughout the mid-century. There is widening disparity in health care quality and access among minority populations (Agency for Healthcare Research and Quality [AHRQ], 2008) especially among African Americans, Hispanic Americans, and American Indians (Sullivan Commission, 2004). Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2011) has as one of its goals the elimination of these disparities. While accounting for 33% in 2000, racial or ethnic minority groups will comprise almost half of the U.S. population by the middle of this century (AHRQ, 2008; U.S. Census Bureau, 2008). Recognizing that barriers exist for diverse populations, the USDHHS Office of Minority Health developed national standards for culturally and linguistically appropriate services (CLAS) (OMH, 2001; USDHHS, 2001).
Along with CLAS and other guidelines, the Leininger’s CCDU offers a structured approach to promoting culturally congruent care.

Leininger (1995b, 2002b, 2006b) warned about cultural imposition, the tendency of health care workers to impose their own belief system and values to other people or groups because of notions of superiority. This imposition may happen while providing care here in the United States or when working with developing countries in partnerships and collaborations. People have deeply ingrained cultural values and beliefs; the success of educational outreach or technological support may depend on the “applicability or fit” (Sagar, 2000) in a particular country. Leininger’s CCDU (1995a, 2002a, 2006a) and sunrise model’s depiction of nurses bridging generic folk practices and professional nursing is truly telling of the immense role of nurses. Furthermore, nurses are with patients 24 hours a day, 7 days a week, creating that potential for rendering culturally congruent care that enhances health care outcomes. For this reason, it is of utmost importance to promote cultural competence among all nurses (Bomar & Glenn, 2004).

Three Action Modes

Imbedded in every cultural group is a vast area of generic folk healing practices, beliefs, and traditions. Bridging generic and professional nursing care is a prerequisite to culturally congruent care (Leininger, 1995a; Leininger & McFarland, 2002, 2006). The role of a bridge is challenging and rewarding, especially the task of connecting two markedly different cultures. Wehbe-Alamah (2008), for example, showed how knowledge of traditional Muslim generic (folk) beliefs, expressions, and practices obtained from research and other sources could be integrated to professional care. Folk care included in the article pertain to caregiving, health, illness, dietary needs, privacy, modesty, death and bereavement, and other areas followed by a discussion of the use of Leininger’s three modes of actions to provide culturally congruent care (Wehbe-Alamah, 2008).

Leininger’s (2006a) three action modes may be used as a framework in various practice settings along with the nursing process. Employing Leininger’s three action modes will call for the utmost clinical judgment and critical thinking as the nurse diagnoses, assesses, plans, implements, and evaluates care that is culturally congruent. Examining the first step of the nursing process, Munoz and Luckmann (2005) suggested revisions of some nursing diagnoses to make them
Chapter 1. Madeleine Leininger’s Theory

Culturally sensitive. One example is noncompliance (North American Nursing Diagnosis Association, 2005, as cited in Taylor, Lillis, LeMone, & Lynn, 2008), which needs to be modified to “non-adherence to clinical appointment schedule related to inability to access public or private transportation” (Munoz & Luckmann, 2005, p. 232). The preservation and maintenance approach may be implemented when there are generic ways that are beneficial in care. Some examples include encouraging direct care such as bathing, feeding, and other activities of daily living performed by family members who wish to directly participate in care along these areas.

Leininger’s (2006a) negotiation and accommodation modes may be employed by the nurse when nursing interventions would include adaptation and negotiation with individuals and groups in order to promote culturally congruent care to promote health, prevent illness, or to cope with illness or death—for example, teaching a Filipino American patient that although garlic may lower her blood pressure, she needs to consistently take her antihypertensive medications as prescribed. The nurse also implements this mode when allowing a Muslim patient’s bed to face Mecca as long as it does not interfere with another patient in a semiprivate room or with safety issues in terms of equipment hook-ups and other necessary fixtures.

When employing Leininger’s (2006a) third mode, repatterning and restructuring, the nurse sets mutual decisions with the patient to use change or modification in the plan of care in order to achieve better health outcomes. For example, Table 1.1 represents the use of the repatterning/restructuring mode for a Filipino American client who is postoperative and is reluctant to take pain medication and hesitant to

<table>
<thead>
<tr>
<th>Belief that pain is ‘punishment for sins.’</th>
<th>Nurse teaches patient about pain control; waiting too long makes pain more difficult to alleviate and control. Relief of pain may allow the patient more time for prayers to atone for sins.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is hesitant to take pain medication.</td>
<td></td>
</tr>
<tr>
<td>Belief that advance directive is not necessary since “Death is up to God.”</td>
<td>Nurse teaches patient about having her wishes followed when she is unable to verbalize them, her preferences honored when she no longer could verbalize them. Setting up proxy ensures that her wishes are fulfilled.</td>
</tr>
</tbody>
</table>

Applying Leininger’s CCDU Theory to a 70-year-old Filipino American patient who is first day postoperative for right radical mastectomy.
compose a living will as well as to designate a proxy despite this being offered during admission.

As TCN becomes more and more an important area in accreditation standards, both in academia and practice, the area of certification and recertification in TCN needs revisiting and emphasis. This could further encourage nurses to learn more about TCN (Leininger, 1995a; Leininger & McFarland, 2002). Although the Certification Committee was originally established in 1988 (TCNS, 2011) there are only about 85 nurses with current certification (P. Sagar, personal communication, March 2011). Created in 2006, the Transcultural Nursing Certification Commission developed the advanced certification (CTN-A) examination for nurses with master’s degrees or higher, using guidelines to make this examination on par with other specialties (TNCC Minutes, July 8, 2006) and replacing the original certification process. Presently, a task force is in the process of developing the basic certification examination (CTN-B) for implementation in 2011 (TCNS, 2011).

SECTION 4. APPLICATION OF THE THEORY IN NURSING ADMINISTRATION

The CCDU theory is needed and is quite important in nursing academic and practice administration (Leininger, 2002c, 2006b). Leininger (2006b) outlined three reasons for using the CCDU in nursing administration: shift from uniculturalism to multiculturalism, need for reexamination of organization values in recruitment and retention practices, and development of organizational structures and function consistent with cultural and gender differences in nursing. The changing demographics among patients, students, and other health care workers bring in unique needs. Truly a visionary, Leininger was way ahead of her time in predicting how TCN could impact health care and how the CCDU could be a framework in developing culturally competent care to ensure quality and equity in health care organizations.

Hubbert (2006) emphasized the vital role of TCN theoretical knowledge and skills to “guide administrators and leaders in their relationships, decisions, and skills relevant to changing organizational structures” (p. 350). The use of the CCDU presents endless possibilities in staff recruitment and retention, daily operations of clinical units, conflict management, and strategic planning. The CCDU with
utilization of the ethnonursing method of research and transcultural evidence-based practice could contribute tremendously to culturally congruent care and improved outcomes of health care. There is a vast body of knowledge generated through the research of Dr. Leininger and her followers (Glittenberg, 2004; Hubbert, 2006; Leininger, 2002a, 2006b; Ryan, 2011).

A nurse administrator has the responsibility of not only promoting self-cultural competence but also making the focus of having regularly scheduled educational offering in cultural competence for all the nursing staff. Offering continuing education (CE) hours has the advantage of providing the education component required in licensure registration, for certification or recertification and for self-development. Appendix A offers a sample CE for a workshop using Leininger’s CCDU and some components of other TCN models.

Assessment of individual cultural competence has been more prevalent than organizational assessment; there is a lack of tools measuring organizational cultural competency. LaVeist, Relosa, and Sawaya (2008) conducted a validation study of the Cultural Competency Organizational Assessment (COA360), a tool for assessing and benchmarking cultural competency of health care organizations as well as its progress in managing diversity issues. The researchers invited 186 experts to rate how well COA360 questions measured CLAS standards; ratings ranged from 4.5 to 5 on a 5-point scale, equating to “well” or “very well” (LaVeist et al., 2008, p. 263).

The ANA (1991) reiterated that the interaction of provider and client involve three cultural systems namely that of the health care provider, the client, and the organization. These interactions may create conflict and barriers to health care, creating further disparities. Therefore, it behooves nursing administrators to foster cultural competence in organizational settings. Ludwig-Beymer (2008) implemented Leininger’s CCDU theory to conduct an assessment of a hypothetical hospital. The CCDU provided a framework to assess the organization, which then could be compared with the values and beliefs of the groups served by the organization. Ludwig-Beymer (2008) also outlined the process of creating a culturally competent organization using assessment tools such as Leininger’s (2002a, 2006a) CCDU and the forces of magnetism by the American Nurses Credentialing Center (ANCC, 2009). Ludwig-Beymer emphatically reminded us that the mandates from regulatory bodies such as TJC and accrediting groups such as the much sought-after ANCC magnet designation both require culturally competent organizations.
REFERENCES


Chapter 1. Madeleine Leininger’s Theory


NCLEX-TYPE TEST QUESTIONS (1–15)

1. In her theory of culture care diversity and universality (CCDU), Leininger developed which of the following research method?
   A. ethnography
   B. ethnonursing method
   C. qualitative method
   D. domain of inquiry

2. A Filipino American woman takes fresh garlic to lower her blood pressure. The nurse teaches her to take antihypertensive medication regularly. This is an example of:
   A. preservation/maintenance
   B. repatterning/restructuring
   C. accommodation/negotiation
   D. brokering

3. The nurse is caring for a postsurgical patient who believes that “pain atones for sins.” The nurse reviews the plan of care with her patient, emphasizing the difficulty of pain control when an individual waits too long before taking pain medication. According to Leininger, this mode is an example of:
   A. preservation/maintenance
   B. repatterning/restructuring
   C. accommodation/negotiation
   D. culture brokering

4. The nurse systematically implements visits from family members and allows them to assist in feeding and bathing their elderly mother. This is an example of:
   A. preservation/maintenance
   B. repatterning/restructuring
   C. accommodation/negotiation
   D. brokering
5. While discussing folk medicine with an Amish client, the nurse remarked: “In the long run, Western medicine is best!” This remark is an example of:
   A. stereotyping  
   B. ethnocentrism  
   C. brokering  
   D. racism

6. The transcultural nurse is teaching new staff nurse about Leininger’s sunrise model. As she discusses the three circles of generic or folk system, nursing care, and professional system, it is important to point out that nursing care is the:
   A. division between generic and professional systems  
   B. collaboration between generic and professional systems  
   C. demarcation between generic and professional systems  
   D. bridge between generic and professional systems

7. The nurse moved the Muslim patient’s bed so he could face east to Mecca when he prays. This is an example of:
   A. preservation/maintenance  
   B. repatterning/restructuring  
   C. accommodation/negotiation  
   D. brokering

8. The nurse knocks on the door and pauses prior to entering the door of a female Muslim client to give the client time to cover her head. This is an example of:
   A. accommodation/negotiation  
   B. preservation/maintenance  
   C. repatterning/restructuring  
   D. brokering

9. According to Leininger, health care workers may have a tendency for notion of superiority and may impose their own belief system when working here or abroad. This process is referred to as:
   A. accommodation/negotiation  
   B. repatterning/restructuring  
   C. cultural brokering  
   D. cultural imposition
10. The nurse educator encourages her academic advisee to use more financial aid and work less hours to be able to devote more time studying. This is an example of:
A. accommodation/negotiation
B. preservation/maintenance
C. repatterning/restructuring
D. brokering

11. The nurse supervisor approves a 4-week vacation for a staff nurse from India requesting 6 weeks vacation to care of a sick relative at home. This is an example of:
A. accommodation/negotiation
B. preservation/maintenance
C. repatterning/restructuring
D. brokering

12. The Leininger CCDU theory is illustrated as the sunrise model to depict:
A. hope to generate new ways of knowing in nursing
B. hope to generate more theory in nursing
C. hope to generate new knowledge in nursing
D. hope to generate more caring in nursing

13. The Leininger CCDU theory is focused on culture and care. According to Leininger, culture and care:
A. were the focus in theory development during the 1980s and 1990s
B. were long neglected and missing in theory development during the 1980s and 1990s
C. were returning in theory development during the 1980s and 1990s
D. were the trend in theory development during the 1980s and 1990s

14. Leininger cited which of the following as the cause for the difficulty in integrating transcultural concepts in nursing curricula?
A. overloaded curriculum and reluctance of faculty
B. overloaded curriculum and indifference of faculty
C. overloaded curriculum and refusal of faculty
D. overloaded curriculum and lack of motivation of faculty
15. Leininger acknowledges which of the following concepts within and between cultures?
   A. similarities only
   B. differences only
   C. similarities and differences
   D. comparison only

   (Answers to these questions can be found on p. 141)