Transcultural Nursing Education Strategies
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She is board certified in adult health from the American Nurses Credentialing Center and has advanced certification in transcultural nursing from the Transcultural Nursing Certification Commission (TNCC). She is a Transcultural Nursing Society (TCNS) transcultural scholar and a member of the Nursing Hall of Fame at Columbia University. Dr. Sagar is a site evaluator for the Commission of Collegiate Nursing Education (CCNE). Her research interests include transcultural nursing (TCN); mentoring; and international nursing, partnerships, and collaborations. 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 has facilitated several national and international conferences to disseminate TCN research and knowledge. She is a long time member of TCNS and has chaired the Eligibility and Credentialing Committee of the TNCC. Her other professional memberships include the Philippine Nurses Association of America and the Sigma Theta Tau Honor Society for Nursing.

Dr. Sagar also teaches as an adjunct faculty for University of Phoenix Online’s School of Advanced Studies where she functions as a committee member in dissertations with cultural diversity and transcultural foci. Her publications include Transcultural Nursing Theory and Models: Application in Nursing Education, Practice, and Administration as well as contributions to Giving Through Teaching: How Nurse Educators Are Changing the World and the forthcoming third edition of Culture Care Diversity and Universality: A Worldwide Theory of Nursing.
Transcultural Nursing Education Strategies

Priscilla Limbo Sagar, EdD, RN, ACNS-BC, CTN-A
This book is dedicated to:

My loving family; husband Drew Sagar for his unconditional love and support; daughter Alexa and grandson Andrew Michael Cass; parents Trinidad and Mercedes Limbo; sisters Virgenes, Soledad, and Cristina; brothers Ruben, Marto, Juanito, Roberto, and Virgilio Limbo; and all members of my extended family.

The late Dr. Madeline Leininger, founder and leader of transcultural nursing (TCN), for her courageous and untiring effort for six decades in building transcultural nursing knowledge, and her laborious work on behalf of TCN in general. She was a mentor who continues to inspire my work.

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.

To mentoring; my past and current mentors; my mentees, and to those they will mentor.

To the Philippine Women’s University College of Nursing faculty for the excellent nursing education that prepared me not only to be a nurse and a leader, but also a writer, through opportunities to edit both the College of Nursing and university papers.

To Professor Elisea de la Cruz, for nurturing my love of writing and for demanding excellence.

To all nurses and student nurses; to take up the challenge and lead others to bring TCN to all settings of nursing education, practice, administration, and research. TCN is the water of necessity and the settings are what I called “the villages of the world” in my poem “Who Will Fetch the Water?”
Who Will Fetch the Water [Today, Tomorrow, and in the Future]?  
(To my fellow nurses)

1
The late foundress dug the well. That well is now a river…
I will fetch the water today.
And bring it to the villages.
We are 3,063,163* strong. We could lead the throng…
Will you be coming along?

2
Will they?
Staff nurses: guardians and caregivers.
Educators: opening the floodgates to minds.
Administrators: channeling flow through organizations.
Researchers: divining into new knowledge.

3
You, and I, and them. We are privileged.
We have strength in numbers. We have been constantly trusted.
Should we all fetch the water?

4
We are ready.
We are on clear vantage points.
If we bring water to all villages
Health for all may not just be a promise.

Priscilla Limbo Sagar

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AP-1. Sample Syllabus: Introduction to Nursing
AP-2. Sample Syllabus: Health History and Physical Assessment
AP-4. Sample Syllabus: Nursing Research
AP-5. Sample Syllabus: Culturally Congruent Care: Pharmacology
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Transcultural Nursing Education Strategies is Dr. Priscilla Limbo Sagar’s most recent contribution to the body of knowledge in the fields of transcultural nursing and nursing education. This book, along with her previous work titled Transcultural Nursing Theory and Models: Application in Nursing Education, Practice, and Administration, make her among the world’s foremost experts in transcultural nursing.

This is a much anticipated comprehensive compendium of evidence-based and best practices in transcultural nursing that contains exceptionally useful and helpful material for nurse educators in academic and staff development settings and for their students. Professional nurses are expected to plan, implement, and evaluate cultural competence and diversity initiatives within their respective organizational systems while simultaneously meeting state and national accreditation mandates and/or standards of care. Dr. Sagar provides a fresh, multidimensional, and multifaceted approach to transcultural nursing education strategies by including a wide array of transcultural conceptual and theoretical models, cultural assessment instruments, and key concepts and content found in toolkits used by the National League for Nursing and the American Association of Colleges of Nursing to integrate cultural competence and transcultural nursing concepts into undergraduate and graduate curricula. Among the purposes of the book is to teach cultural competence to nurses in clinical practice settings and students in undergraduate and master’s academic nursing programs. Dr. Sagar addresses the culture care needs of individual patients across the life span, as well as families and groups from diverse cultures. Dr. Sagar’s book provides a unique perspective on the subject matter because it includes so many different types of teaching strategies and pedagogical aids, such as role-playing exercises, case studies, modules, continuing education lesson plans, and course syllabi. The stand-alone modules developed for nursing courses typically found in school of nursing curricula are also suitable for staff development in the areas of cultural competence, diversity, and transcultural nursing.

Dr. Sagar has divided the text into seven major parts. Part I provides an overview of transcultural concepts, history, theory, and models; reviews research findings and the best available evidence for culturally competent nursing and health care; presents well-researched modules for teaching transcultural nursing concepts; and examines transcultural nursing concepts in the NCLEX-RN® examination. Part II integrates transcultural nursing into foundational and introductory nursing courses such as fundamentals of nursing, nursing skills, and health assessment courses. In Part III transcultural nursing

Foreword
concepts across the life span are introduced in courses with content related to childbearing, child-rearing, adolescent and adult health, and gerontological nursing. Part IV focuses on transcultural nursing concepts in specialty courses such as mental health and psychiatric nursing, pharmacology, nutrition, nursing research, and a professional nursing transition course. Of particular interest is the unique chapter on transcultural concepts in the simulation laboratory in which Dr. Sagar discusses the use of simulation to teach diversity and transcultural nursing knowledge and skills. In Part V the chapters focus on integrating transcultural concepts across undergraduate and graduate nursing programs and in faculty orientation. Part VI is dedicated to integrating transcultural concepts into staff development and includes transcultural modules for use when orienting new domestic and international nurses and other health care workers; annual online and face-to-face modules for yearly staff updates on transcultural nursing such as those required by the American Nurses Credentialing Center (ANCC) for magnet designation; preparing policies and procedures using evidence-based and best practices that are congruent with current mandates and accreditation standards; and preparing for accreditation by reviewing transcultural concepts in the mission, goals resources, curricula, and evaluation outcomes. In Part VII, Dr. Sagar’s concluding chapter features the vision for the future of transcultural nursing, including transcultural concepts in consultation, mentoring, international partnerships and collaborations, and future trends for this increasingly vital specialty as the global society becomes increasingly interconnected while at the same time growing more multicultural.

In closing, I would like to express appreciation to Dr. Priscilla Sagar for sharing her extensive knowledge and years of experience as a scholar, teacher, and leader in the field of transcultural nursing in Transcultural Nursing Education Strategies. This text provides valuable information for undergraduate and graduate nursing students, nursing faculty, nurse educators in staff development settings, and all other professional nurses who strive to use transcultural nursing concepts to provide culturally competent care for individual patients, families, and groups from diverse cultural backgrounds. Transcultural Nursing Education Strategies provides readers with important, state-of-the-art, well-researched, and carefully documented, evidence-based, and best practices for delivering culturally competence care.

Margaret M. Andrews, PhD, RN, FAAN, CTN
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Foreword

Our nation has seen a dramatic transformation in the demographic characteristics of its citizens and residents. From a historical beginning of a Eurocentric migrant population to our current highly diverse characteristics, this nation has evolved to include multiple communities representing the entire globe’s population. Current statistics regarding birth rates provide evidence that the term minority is no longer relevant for the description of individuals from diverse ethnic or racial groups. Moreover, the diverse other cultural perspectives that are present in the United States, including gender, religion, sexual orientation, and others, mandate that our nation’s nursing education programs prepare a professional nursing workforce capable of understanding and respecting this diversity as they seek to design and implement the highest quality care for the individuals for whom they are privileged to care.

Transcultural nursing is not a new concept; however, the extreme complexity of this nation’s diversity will challenge nurse educators to develop resources, tools, curricula, and experiences that will shape the new or advancing professionals’ perspectives and skills for providing appropriate and patient-centered care. The growing concerns related to the appropriateness of care, the need to be patient centered in that care, and the importance of health literacy in delivering good care mandates a strong focus on culture as a central element in the design of care. Patient-centered care can only occur when all clinicians have an appreciation for, and an understanding of, the cultural norms that will guide an individual’s choices and behaviors in care experiences.

*Transcultural Nursing Education Strategies* is a valuable new resource to support efforts by both nurse educators and practicing nurses in their goals to provide high-quality care that is culturally appropriate. The wide array of content, including the strong theoretical model that frames this work and the tools for implementing these, creates a framework that will stand the test of time. Moreover, the text’s appreciation and explication of the numerous issues affected by cultural norms and expectations gives the professional nurse a road map for engaging in culturally appropriate, patient-centered, and high-quality care. I am honored to be able to provide this Foreword for an enormously important piece of work that will assist us to do the right things for our nation’s diverse population.

*Geraldine (Polly) Bednash, PhD, RN, FAAN*
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Foreword

Transcultural Nursing Education Strategies, written by Priscilla Limbo Sagar, EdD, RN, ACNS-BC, CTN-A, is a welcome resource for enhancing cultural competence for both individuals and organizations. While this book is derived from transcultural nursing theory, the content is applicable to other health care professionals and their educators.

Transcultural nursing is not an academic exercise. It is critical to the provision of competent care to diverse populations and central to the survival of health care organizations.

Dr. Sagar’s first book, Transcultural Nursing Theory and Models: Application in Nursing Education, Practice, and Administration, focused on the review and application of six transcultural nursing models and provided assessment tools for nursing education, practice, and administration. This, her second ground-breaking book, provides course syllabi, lesson plans, modules, case studies, and role-plays based on Madeleine Leininger’s Theory of Culture Care Diversity and Universality, conceptual models from Purnell, Campinha-Bacote, Choi, Giger and Davidhizar, Spector, and Jeffreys, and the Andrews and Boyle nursing assessment guide. Dr. Sagar makes valuable resources available to faculty teaching at all levels.

Dr. Sagar clearly addresses the imperative for integrating transcultural concepts into both academic and practice settings. She begins the book by providing an overview of transcultural concepts, history, theory, and models. Using an evidence-based approach, Dr. Sagar summarizes the evidence for integration of transcultural concepts into nursing education at all levels; identifies the challenges inherent in training for cultural competence; describes the tools available for measuring cultural competence among faculty, students, and staff; and explores the use of modules to effectively teach knowledge and skills.

In chapters focused on the academic setting, Dr. Sagar provides strategies for integrating transcultural nursing concepts into a variety of courses: introduction to nursing, nursing skills, health assessment and physical examination, childbearing and child-rearing, adult health, gerontology, mental health and psychiatric nursing, pharmacology, nutrition, nursing research, community health, professional nursing transition, and the simulation laboratory. Each chapter is filled with essential information and creative approaches for teaching cultural competence and the care of culturally diverse clients. Dr. Sagar addresses the various levels of academic preparation for nurses, including LPN/LVN, diploma, associate degree, baccalaureate degree, masters, and doctoral programs. She also provides an overview of transcultural nursing concepts for faculty members.
Arguably the greatest contribution of this book is the rigor with which Dr. Sagar approaches the rationale for and strategies to incorporate transcultural concepts into practice settings. Today’s practicing nurses have been educated in a variety of settings, at a variety of times. Some graduated in the 1960s, before transcultural concepts were addressed in academic curricula. Others are international graduates. Dr. Sagar clearly addresses the compelling need for transcultural nursing in the practice setting, addressing both government and accreditation mandates. She provides essential tools, including education modules and policies, for practice settings.

This ambitious book is a must-read synthesis of the existing knowledge related to transcultural nursing education. Dr. Sagar has created a comprehensive collection that bridges both education and practice settings. Application of the concepts she presents will build cultural competence in individuals and in organizations, and will help to address the gap in quality that is so often seen with diverse patient populations. As a practice profession, meeting the health care needs of all people must be our ultimate goal. In this book, Dr. Sagar makes an exceptional contribution to transcultural health care and nursing and to the delivery of culturally competent care in all settings.

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The focus of *Transcultural Nursing Education Strategies* is integration of transcultural nursing (TCN) in both academic and staff development settings. Much work went into highlighting TCN amid current trends, accreditation, professional standards, government mandates and guidelines, and an increasingly diverse nation and world.

In academia, the materials and strategies in this book can be applied to all levels of undergraduate and graduate nursing education. In staff development, concepts and materials are applicable for orientation, in-service, continuing education, competency programs, evidence-based practice, and research and scholarship programs as specified by the American Nurses Association and National Nursing Staff Development Organization. There are brief discussions about Leininger’s Culture Care Theory and the models of Purnell, Jeffreys, Campinha-Bacote, Giger and Davidhizar, Choi, and Spector, and the assessment tools of Andrews and Boyle; the reader is encouraged to go back to these theories and models.

The American Association of Colleges of Nursing (AACN) uses Leininger, Purnell, Campinha-Bacote, Giger and Davidhizar, and Spector in its *Cultural Competency in Baccalaureate Nursing Education* (AACN, 2008). Recently, the AACN (2011) updated its *Toolkit for Cultural Competence in Master’s and Doctoral Education* to include the Jeffreys Cultural Competence model. The National League for Nursing (2009) utilizes the Giger and Davidhizar model in its *Diversity Toolkit*.

This book is organized into seven parts dealing with specific integration of TCN concepts. **Part I** covers TCN in education, both in academia and in staff development settings. Discussion is provided in the integration of TCN in existing nursing courses, as modules into current courses, or as a separate course or courses in nursing programs. While many schools of nursing and allied health have made diversity and cultural competence a priority, there is no standard method for integration of these in to curricula or in to the National Council Licensing Examination (NCLEX) blueprint. Diversity and cultural competence integration on the NCLEX and as a requirement for licensure and registration of all nurses will contribute much to the culturally and linguistically appropriate care of all clients in health care.

**Part II** comprises the integration of TCN in foundation courses. Beginning a nursing program is significant, a milestone in a student’s life. It is imperative to integrate TCN concepts very early on to emphasize the importance of culturally and linguistically congruent care and to thread it vertically and horizontally, from foundation to capstone courses.
Part III involves TCN integration in courses across the life span. Throughout the life span, every person’s culture, values, and beliefs influence the lens used for viewing health, illness, health promotion, health-seeking behavior, and acceptance of therapeutic modalities. Care of clients, families, and significant others is emphasized.

Part IV contains integration of TCN in specialty area courses. Cultural attitudes, values, and beliefs vary among and within cultures. Strategies are illustrated in integration of TCN in specialty courses such as mental health and psychiatric nursing; pharmacology; nutrition; and research. Graduating students, preparing for and on the verge of their own professional nursing practice, aptly need a strong background in culturally and linguistically appropriate services (CLAS) in nursing classes and in clinical practicum.

Part V covers integration of TCN across nursing programs and in faculty orientation and mentoring. The faculty has a daunting task of preparing graduates to care for the complex needs of a diverse population with decreasing resources. Faculty themselves—already facing critical shortages—need formal preparation in TCN to be effective at this task.

Part VI encompasses integration of TCN in staff development and the role of the nursing professional development (NPD) specialist. Strategies in weaving TCN concepts are included for staff orientation, continuing competence development, preparation of policies and procedures, and credentialing. The last chapter covers recruitment and retention of foreign-educated nurses (FENs). An overview of development of nursing education in the Philippines is included to provide a starting point in understanding the Filipino nurse. Nurses from the Philippines have persistently outnumbered other FENs since developed countries began recruiting nurses from developing countries, triggering a nurse drain that now has reached critical proportions and health implications in sending countries.

Part VII, the concluding section, embraces vision in TCN. Six decades after Dr. Madeleine Leininger founded TCN, the authors look at TCN’s history, development, and knowledge building; its increasing relevance in today’s diverse society; and the implementation of CLAS and other guidelines, and envisioned the future of TCN.

CRITICAL THINKING EXERCISES

Critical thinking exercises (CTEs) are in every chapter. The authors anticipate that these CTEs may stimulate readers to reflect on and assess their own journey to cultural competence; to critically think and integrate TCN knowledge and skills when caring for clients, families, or significant others; and to be culturally sensitive when dealing with others from diverse cultures. While the questions are addressed to undergraduate and graduate students, faculty in academia, and faculty in staff development, the questions are applicable to other learners as well.

According to Rubenfeld and Scheffer (2006), critical thinking (CT) dates back to the Socratic method of providing questions with questions—with deeper questioning entailed for ideas known as fact. CT emerged as a focus for nursing education in the 1990s (Rubenfeld & Scheffer, 2006). The American Association of Colleges of Nursing ([AACN], 2008) and the National League for Nursing ([NLN], 2010) both require CT as program outcomes, emphasizing that all nursing programs should address CT in their respective nursing curricula.
EVIDENCE-BASED PRACTICE BOXES

Evidence-based practice (EBP) boxes are in every chapter in recognition of the continuing addition to the body of professional nursing knowledge for use in practice to improve health outcomes; to increase quality and access to health care; and to improve the cultural competence of health providers. These can be used as assignments in academic and staff development settings and may be helpful when planning access of research articles for use in academic or staff development purposes. A list of research studies in EBP boxes is available in Appendix 21.

The EBP boxes attempt to encourage all nurses to be consumers of research, to promote and undertake research that will improve health outcomes for all and not just the select few, and to recruit and retain diverse participants in research and evidence-based practice. The synopsis of each research study may be helpful in the decision to go further and access the original research articles as befits the learner’s purpose. Viewing some of these research studies, hopefully, will lead to the pursuit of research studies where gaps in knowledge exist.

SELF-LEARNING MODULES

There are four stand-alone self-learning modules (SLMs) in this book: CLAS; posttraumatic stress disorder (PTSD) among women; hot and cold theory; and care of an Orthodox Jewish child with asthma. These can be used as learning tools to enhance the learner’s cultural competence in academia and staff development. The enhanced CLAS standards, implemented since 2001, need to be threaded through all academic courses and staff development initiatives. Violence against women is prevalent in any culture. The use of hot and cold theory is common among many cultures and is gaining more prominence in Western cultures using complementary and alternative medicine (CAM).

UNFOLDING CASE SCENARIOS

Two unfolding case scenarios are contained in the book. One scenario involves a school nurse providing care to a culturally diverse individual, family, and school population. The second scenario deals with caring for a migrant worker with Chagas disease. Case scenarios are widely used in nursing education to promote critical thinking and clinical judgment.

Finally, all contributors wish that educators—both in academic and staff development settings—will find this book useful in enhancing the cultural competence of current health professionals and in the preparation of the next generation of nurses.

SAMPLE SYLLABI

Sample syllabi are provided in the Appendix section (Appendices 22–25) and in the electronic ancillary package. All sample syllabi are in Word format so they can easily be revised, tailored, or enhanced based on the curricular level or the user’s need. Qualified instructors can access the ancillary package by emailing textbook@springerpub.com.

Priscilla Limbo Sagar
REFERENCES

There are so many individuals I would like to thank, without whom it would be impossible to complete the writing of my second book. My first book was Transcultural Nursing Theory and Models: Application in Nursing Education, Practice, and Administration.

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Transcultural Nursing Education Strategies
I. NURSING EDUCATION AND TRANSCULTURAL NURSING

Nursing Education and Transcultural Nursing

Priscilla Limbo Sagar

**KEY TERMS**

Boyle and Andrews: Transcultural Nursing Assessment Guides
Choi: Theory of Cultural Marginality

Giger and Davidhizar: Transcultural Assessment Model
Jeffreys: Cultural Competence and Confidence Model
Leininger: Cultural Care Theory
Purnell: Model for Cultural Competence
Spector: Heritage Assessment Model

**LEARNING OBJECTIVES**

At the completion of this chapter, the learner will be able to

1. Discuss the role of transcultural nursing (TCN) in nursing education, practice, administration, and research.
2. Compare and contrast TCN theory and models in terms of applicability at the learner’s own setting.
3. Analyze the necessity of integrating TCN concepts in academic settings.
4. Examine the necessity of integrating TCN concepts in staff development settings.
5. Compare and contrast standards and guidelines for inclusion of diversity and cultural competence in nursing and allied health curricula.
OVERVIEW

The inclusion of cultural diversity in nursing curricula is not a new phenomenon. The curricular integration of cultural diversity in nursing started in 1917 when the National League for Nursing (NLN) Committee on Curriculum published a guide focusing on sociology and social issues in nursing (DeSantis & Lipson, 2007). In 1937, the NLN Committee further included the cultural background in the guide to understand the individual’s reaction to being ill.

The first promotion of cultural competence integration of transcultural nursing (TCN) in academia dates back to 1965 through 1969, when Leininger not only developed the first TCN course and telecourses but also established the first PhD nurse–scientist program at the Colorado School of Nursing (Andrews & Boyle, 2012). The American Nurses Association ([ANA], 1991, 1995, 2003), American Association of Colleges of Nursing (AACN, 1998, 1999, 2008a, 2008b, 2011), and the NLN (2005, 2009a, 2009b) have all been consistently vocal in their commitment to cultural diversity and cultural competence in nursing practice, education, administration, and research. The Accreditation Commission for Education in Nursing ([ACEN], 2013), formerly the National League for Nursing Accreditation Commission (NLNAC), explicitly includes diversity among its standards under “curriculum.”

Nurses are at the front line of health care, spending more time and working closely with clients more than any other health professionals. Globally, nurses provide 80% of health services (International Council for Nurses [ICN], 2007) to individuals and communities. It is not surprising that in the United States, consumers have rated nurses as the most trusted of health care professionals for 12 years in a row according to the Gallup survey of professionals (ANA, 2011). The National Partnership for Action (NPA) to End Health Disparities (Tomer, 2012) called upon nurses for identification and responsive solutions in eliminating health disparities. There are continuing disparities not only in health status but also in health access among African Americans, Hispanics, and Native Americans (AACN, 2008a, 2011; Sullivan Commission, 2004). To eliminate disparities, the U.S. Department of Health and Human Services (USDHHS) Office of Minority Health ([OMH], USDHHS & OMH, 2013) continue to refine the culturally and linguistically appropriate services (CLAS) that it initially published in 2000.

It is then imperative for nurse academicians to prepare nurses for this role by integrating health disparities and solutions in all nursing curricula preparing licensed practical, diploma, associate, baccalaureate, master’s, and doctoral level nurses. National and global health disparities need to be included in discussions in all classes and in clinical practice in nursing and allied health care fields such as medicine, dentistry, physical therapy, pharmacy, and other professions. Policy development, an important key when working to eliminate health disparities (TCNS, 2010), must also be integrated. The Affordable Health Care Act, since its inception 2 years ago, has provided access to preventable care for 86 million people; its provision to extend parental coverage for children from age 21 to 26 further covered 2.5 million people (Tomer, 2012). While this would improve access, there remains the question of quality of care and elimination of factors that continue to show disparate results among African Americans, Hispanics, and Native Americans (Sullivan Commission, 2004).

Sagar (2012) emphasized the overlapping dynamic connections between the realms of nursing education, practice, and administration in health promotion and in the provision of equal, safe, and quality health care. The role of nurse professional development (NPD) specialist is vital in planning, implementing, and evaluating the ongoing professional development of staff nurses and colleagues. While this book concentrates on staff
settings along with academia, the role of nursing administration leadership in supporting such endeavors to promote cultural competence at the individual and organizational levels could not be underestimated. Nor could we forget nurse researchers studying health disparities in access and quality of care; these are the guardians of the recruitment, ethical treatment, and retention of participants, and discovery of new knowledge in improving minority client health outcomes. Nurse educators in academic and staff development settings need to work closely and hand-in-hand to develop culturally and linguistically appropriate approaches to students, faculty, colleagues, clients and their families, and the community. This hand-in-hand collaboration is an example of what Brown and Doane (2007) referred to as the purposeful alignment of education and nursing practice wherein both of these realms benefit.

SOME TRANSCULTURAL THEORIES AND MODELS

Leininger: Culture Care Theory

Dr. Madeleine Leininger is widely accepted as the mother and founder of TCN (Ryan, 2011; Sagar, 2012). Leininger started the development of her Culture Care Theory (CCT) in the 1940s. Leininger’s theory depiction is the sunrise enabler (Figure 1.1), a symbol of hope to generate new knowledge for nursing. The CCT—carefully refined in six decades—is applicable for individuals, families, groups, communities, and institutions, and has been used in nursing as well as health-related disciplines (Leininger, 1995a, 2002; Leininger & McFarland, 2006; McFarland & Leininger, 2002). Fanning into sunrays in Leininger’s model are seven factors that influence individuals, families, and groups in health and illness: technological; religious and philosophical; kinship and social; cultural values, beliefs, and ways of life; political and legal; economic; and educational (Leininger, 1995, 2002, 2006). There are 11 theoretical assumptions from the major tenets of CCT; the essence of two of those assumptions center on (1) caring as the essence of nursing, and (2) diversities and commonalities existing between cultures (Leininger, 1995, 2002, 2006). Nursing care sits between—and could strategically and effectively bridge—generic folk care and professional care. At this vantage point, the nurse can be most influential and effective in the assessment, planning, implementation, and evaluation of culturally congruent care.

Leininger (1995, 2002, 2006) uses three action modes in the CCT for provision of holistic, culturally congruent care: preservation or maintenance for decisions that promote helpful and desirable values and beliefs; accommodation and/or negotiation when adapting care that fits the client’s culture, values, and beliefs; and repatterning and/or restructuring as the nurse and client mutually modify or change nursing actions to promote better health outcomes. Globally and in the United States, Leininger’s CCT is one of the most widely used frameworks in nursing education, practice, administration, and research.

Purnell: Purnell Model for Cultural Competence

Initially intended as a framework for clinical assessment, the Purnell Model for Cultural Competence (PMCC, Figure 1.2) was developed in 1991 (Purnell, 2002). Foremost among the purposes of the PMCC is to serve as a framework whereby health care providers could “interrelate characteristics of culture to promote congruence and ... delivery of consciously sensitive and competent healthcare” (Purnell, 2013, p. 15). The PMCC has 12 wedge-shaped
sections as an organizing framework surrounded by four rims that signify global society (outside rim), community (second rim), family (third rim), and individual (fourth rim; Purnell, 2002, 2007, 2008, 2013). The 12 domains could be used in their entirety or their concepts could be used selectively when applying the model.

The PMCC is one of the most widely used models in nursing curricula (Lipson & Desantis, 2007); its 12 domains could be threaded both into theoretical nursing courses as well as clinical components (Sagar, 2012). Notably, this model is not only widely used in nursing practice, administration, and research but also in other health-related fields and in international projects. The PMCC has been adopted as the framework of the Commission on Internationalization and Cultural Competence for the European Union project for the Bologna-Sorbonne-Salamanca World Health Organization declarations (Purnell, 2007).
The Cultural Competence and Confidence Model (CCC; Figure 1.3) aims to connect concepts that predict learning of cultural competence and integrate “the construct of transcultural self-efficacy (TSE) (confidence)” (Jeffreys, 2010, p. 46). Jeffreys views cultural competence as a learning process in three dimensions: cognitive, practical, and affective; as mainly influenced by the transcultural self-efficacy (TSE); and directed toward culturally congruent care. According to Jeffreys (2010), the TSE is the “perceived confidence for performing or
learning” (p. 46) TCN skills when working with clients whose culture is different from the nurse’s own. In the course of time, formal education and other structured learning experiences could affect the three dimensions of TSE and the development of cultural competence which further leads to culturally congruent care (Jeffreys, 2010).

Jeffreys (2010) emphasized that the cognitive learning dimension includes knowledge and comprehension about cultural factors and its influence on professional care of culturally diverse clients throughout the life span. Jeffreys (2010) pointed out the similarity of the practical learning dimension and psychomotor domain; in the context of TCN, this refers to verbal and nonverbal communication skills when performing cultural assessment. The affective learning dimension involves “attitudes, values, and beliefs” (Jeffreys, 2010, p. 52); this dimension is of prime importance in professional value and attitude development. The CCC is highly applicable in nursing education, practice, administration, and research, as well as in other health-related disciplines.

Campinha-Bacote (2007) developed the initial version of *The Process of Cultural Competence in the Delivery of Healthcare Services* (PCCDHS) in 1991. The PCCDHS was called *A Culturally Competent Model of Care* then, represented by four interrelated constructs of cultural awareness, cultural knowledge, cultural skill, and cultural encounters (Campinha-Bacote, 2007, 2011, p. 42). To keep up with development in TCN, to add to the four existing constructs, and to portray the interdependence of the constructs, she added a fifth construct of cultural desire in 1998 (Campinha-Bacote, 2011, 2012). It was then that Campinha-Bacote renamed her model to PCCDHS; its pictorial image denoted five Venn circles that overlap, mirroring interdependent relationships among constructs (Campinha-Bacote, 2011, 2012). Campinha-Bacote (2007) developed the *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals—Revised* (IAPCC-R), a self-assessment tool that indicates level of cultural competence. To assess the cultural competence of student nurses, Campinha-Bacote also created the *IAPCC-Student Version* (IAPCC-SV).

In recognition of the key role of cultural desire in the journey to cultural competence, Campinha-Bacote (2011, 2012) further revised the PCCDHS in 2002. At this time, her model illustrated an erupting volcano, representing the desire for cultural competence. In 2010, based on review of literature and evidence-based studies utilizing the IAPCC-R (Campinha-Bacote, 2007), the PCCDHS further evolved to portray and “center on the construct of cultural encounters” (Campinha-Bacote, 2011, p. 43). In terms of cultural encounters, health care professionals must continuously interact with clients from diverse cultures to “validate and refine values and beliefs” (Campinha-Bacote, 2011, p. 43) in order to develop the other constructs of the PCCDHS. The evolution of her model is illustrated on the Transcultural Clinical Administrative Research and Education (C.A.R.E.) website at http://transculturalcare.net.

Campinha-Bacote (2007) also developed *A Biblically Based Model of Cultural Competence in the Delivery of Healthcare Services* (BBMCCDHS) from her own earlier work in 2007, from Leininger and McFarland in 2006, and from those of Kleinman (1980) and Chapman (2005), among others (both as cited by Campinha-Bacote in 2013). When using the BBMCCDHS, it is imperative that health care professionals see the image of God (“Imago Dei”) in their clients and integrate love, caring, humility, compassion, and other virtues (Campinha-Bacote, 2013, para 1). In both the PCCDHS and BBMCCDHS, health care professionals must view themselves as becoming culturally competent rather than being culturally competent (Campinha-Bacote, 2011, 2013); both models are highly applicable in nursing education, practice, administration, and research. Notably, Campinha-Bacote’s IAPCC-R and IAPCC-SV have been extensively used in nursing education and practice to measure the cultural competence of health care practitioners and students, respectively. The BBMCCDHS is also demonstrated on her C.A.R.E.) website at http://transculturalcare.net.

Giger and Davidhizar: Transcultural Assessment Model

There were few cultural assessment tools in 1988 when Giger and Davidhizar (2002, 2004, 2008) started the *Transcultural Assessment Model* (TAM) as a solution to students’ need to provide care to culturally diverse clients. Giger and Davidhizar (2002, 2008) based the TAM on the groundbreaking work of Leininger as well as that of Spector; Orque, Bloch, and Monroy; and Hall.
The TAM espouses six cultural phenomena, namely biological variations, environmental control, time, social orientation, space, and communication (Dowd, Davidhizar, & Giger, 1998; Giger & Davidhizar, 2002, 2004, 2008, 2013, Figure 1.4). Each cultural phenomenon occurs in cultures, relates to each other, overlaps with one another, and varies in its utility and application (Dowd et al., 1998; Giger & Davidhizar, 2013). The TAM offers a functional and thorough assessment tool in planning culturally congruent care for clients (AACN, 2008; Giger & Davidhizar, 2013).

**Spector: Heritage Traditions Model**


**FIGURE 1.4** Giger and Davidhizar: Transcultural Assessment Model (TAM). (continues)

CULTURALLY UNIQUE INDIVIDUAL
1. Place of birth
2. Cultural definition
   What is...
3. Race
   What is...
4. Length of time in country (if appropriate)

COMMUNICATION
1. Voice quality
   A. Strong, resonant
   B. Soft
   C. Average
   D. Shrill
2. Pronunciation and enunciation
   A. Clear
   B. Slurred
   C. Dialect (geographical)
3. Use of silence
   A. Infrequent
   B. Often
   C. Length
      (1) Brief
      (2) Moderate
      (3) Long
      (4) Not observed
4. Use of nonverbal
   A. Hand movement
   B. Eye movement
   C. Entire body movement
   D. Kinesics (gestures, expression, or stances)
5. Touch
   A. Startles or withdraws when touched
   B. Accepts touch without difficulty
   C. Touches others without difficulty

Ask these and similar questions:
A. How do you get your point across to others?
B. Do you like communicating with friends, family, and acquaintances?
C. When asked a question, do you usually respond (in words or body movement, or both)?
D. If you have something important to discuss with your family, how would you approach them?

SPACE
1. Degree of comfort
   A. Moves when space invaded
   B. Does not move when space invaded
2. Distance in conversations
   A. 0 to 18 inches
   B. 18 inches to 3 feet
   C. 3 feet or more
3. Definition of space
   A. Describe degree of comfort with closeness when talking with or standing near others
   B. How to objects (e.g., furniture) in the environment affect your sense of space?

Ask these and similar questions:
A. How do you define social activities?
B. What are some activities you enjoy?
C. What are your hobbies, or what do you do when you have free time?
D. Do you believe in a Supreme Being?
E. How do you worship that Supreme Being?
F. What is your role in your family unit/system?
G. What is your role in your family unit/system (father, mother, child, advisor)?
H. When you were a child, what or who influenced you most?
I. What is/was your relationship with your siblings and parents?
J. What does work mean to you?
K. Describe your past, present, and future jobs.
L. What are your political views?
M. How have your political views influenced your attitude toward health and illness?

TIME
1. Orientation to time
   A. Past-oriented
   B. Present-oriented
   C. Future-oriented
2. View of time
   A. Social time
   B. Clock-oriented
3. Physiochemical reaction to time
   A. Sleeps at least 8 hours a night
   B. Goes to sleep and wakes on a consistent schedule
   C. Understands the importance of taking medication and other treatments on schedule

FIGURE 1.4  Giger and Davidhizar: Transcultural Assessment Model (TAM).  (continues)
2. Ask these and similar questions:
   A. What kind of timepiece do you wear daily?
   B. If you have an appointment at 2 pm, what time is acceptable to arrive?
   C. If a nurse tells you that you will receive a medication in “about a half hour,” realistically, how much time will you allow before calling the nurses’ station?

ENVIRONMENTAL CONTROL
1. Locus-of-control
   A. Internal locus-of-control (believes that the power to affect change lies within)
   B. External locus-of-control (believes that fate, luck, and chance have a great deal to do with how things turn out)

2. Value orientation
   A. Believes in supernatural forces
   B. Relies on magic, witchcraft, and prayer to affect change
   C. Does not believe in supernatural forces
   D. Does not rely on magic, witchcraft, or prayer to affect change

3. Ask these and similar questions:
   A. How often do you have visitors to your home?
   B. Is it acceptable to you for visitors to drop in unexpectedly?
   C. Name some ways your parents or other persons assimilated or observes own cultural practices.
   D. Have you or someone else in your immediate surroundings ever used a home remedy that made you sick?
   E. What home remedies have you used that worked? Will you use them in the future?
   F. What is your definition of “good health”?
   G. What is your definition of illness or “poor health”?

BIOLOGICAL VARIATIONS
1. Conduct a complete physical assessment noting:
   A. Body structure (small, medium, or large frame)
   B. Skin color
   C. Unusual skin discolorations
   D. Hair color and distribution
   E. Other visible physical characteristics (e.g., keloids, chloasma)
   F. Weight
   G. Height
   H. Check lab work for variances in hemoglobin, hematocrit, and sickle cell phenomena if Black or Mediterranean

2. Ask these and similar questions:
   A. What diseases or illnesses are common in your family?
   B. Has anyone in your family been told that there is a possible genetic susceptibility for a particular disease?
   C. Describe your family’s typical behavior when a family member is ill.
   D. How do you respond when you are angry?
   E. Who (or what) usually helps you to cope during a difficult time?
   F. What foods do you and your family like to eat?
   G. Have you ever had any unusual cravings for:
      (1) White or red clay dirt?
      (2) Laundry starch?
   H. When you were a child what types of foods did you eat?
   I. What foods are family favorites or are considered traditional?

NURSING ASSESSMENT
1. Note whether the client has become culturally assimilated or observes own cultural practices.
2. Incorporate data into plan of nursing care:
   A. Encourage the client to discuss cultural differences; people from diverse cultures who hold different world views can enlighten nurses.
   B. Make efforts to accept and understand methods of communication.
   C. Respect the individual’s personal need for space.
   D. Respect the rights of clients to honor and worship the Supreme Being of their choice.
   E. Identify a clerical or spiritual person to contact.
   F. Determine whether spiritual practices have implications for health, life, and well-being (e.g., Jehovah’s Witnesses may refuse blood and blood derivatives; an Orthodox Jew may eat only kosher food high in sodium and may not drink milk when meat is served).
   G. Identify hobbies, especially when devising interventions for a short or extended convalescence or for rehabilitation.
   H. Honor time and value orientations and differences in these areas. Allay anxiety and apprehension if adherence to time is necessary.
   I. Provide privacy according to personal need and health status of the client (NOTE: the perception of and reaction to pain may be culturally related).
   J. Note cultural health practices:
      (1) Identify and encourage efficacious practices.
      (2) Identify and discourage dysfunctional practices.
      (3) Identify and determine whether neutral practices will have a long-term ill effect.
   K. Note food preferences:
      (1) Make as many adjustments in diet as health status and long-term benefits will allow and that dietary department can provide.
      (2) Note dietary practices that may have serious implications for the client.

FIGURE 1.4  Giger and Davidhizar: Transcultural Assessment Model (TAM).
Spector (2013) views health as “the balance of the person, both within one’s being—physical, mental, and spiritual—and in the outside world” (p. 91). The physical, mental, and spiritual facets of health added to the personal methods of maintaining health, protecting health, and restoring health comprise the nine interrelated facets of health (Spector, 2013, p. 93). For example, to restore health, an individual may use cupping (physical), exorcism (mental), and meditation (spiritual).

**Boyle and Andrews: Transcultural Nursing Assessment Guides**

In 1989, the *Transcultural Concepts in Nursing Care* textbook was initially published from a collaboration between faculty and students at the University of Utah to clarify the application of transcultural nursing in clinical practice (Andrews & Boyle, 2012). Nursing schools preferring not to use a specific TCN model use the Andrews and Boyle textbook (Boyle, 2007; Lipson & Desantis, 2007).

Boyle and Andrews (2012a) developed the *Transcultural Nursing Assessment Guide for Individuals and Families* (TCNGIF), consisting of 12 major categories of cultural knowledge to guide cultural and physical assessment and development of culturally congruent care. The guide consists of biocultural variations and cultural aspects of the incidence of disease; communication; cultural affiliations; cultural sanctions and restrictions; developmental considerations; economics; educational background; health-related beliefs and practices; kinship and social networks; nutrition; religion and spirituality; and values orientation (Boyle & Andrews, 2012a, pp. 451–455).

To foster systematicity, Boyle and Andrews (2012b) also devised the *Andrews/Boyle Transcultural Nursing Assessment Guide for Groups and Communities* (TCNAGGC). This guide has eight major categories: family and kinship systems; social and life networks; political or government systems; language and traditions; worldviews, value orientations, and cultural norms; religious beliefs and practices; health beliefs and practices; and healthcare systems (Boyle & Andrews, 2012b, pp. 456–458).

In recognition of the need to also strive for culturally competent organizations, Boyle, Andrews, and Ludwig-Beymer (2012) developed the *Andrews/Boyle Transcultural Nursing Assessment Guide for Health Care Organizations and Facilities*. The nine areas in this guide are environmental context; language and ethnohistory; technology; religious/philosophical; social factors; cultural values; political/legal; economic; and education (Boyle et al., 2012, pp. 459–461). The cultural competence of organizations rests in every individual health care provider; this, too, is a lifetime journey and commitment (Ludwig-Beymer, 2012).

**Choi: Theory of Cultural Marginality**

Choi (2008, 2013) developed the *Theory of Cultural Marginality* (TCM) to foster understanding of the unique experiences of immigrant persons who are living between two cultures. Choi called this complex living “straddling of cultures” (2008, p. 243). Choi is hopeful that TCM will assist health care providers and offer them directions for culturally congruent care of immigrants.

The three major concepts of the TCM are marginal living, across-culture conflict recognition, and easing cultural tension (Choi, 2008, 2013). Marginal living entails passivity and feelings of being in between two cultures—living and shaping new relationships in the midst of the old culture—simultaneously being in conflict and in promise (Figure 1.5). Feeling of passivity and being in between are primary attributes of marginal living (Park, 1928).
Across-culture conflict recognition signals the initial understanding of differences between contradiction in “cultural values, customs, behaviors, and norms” (Choi, 2008, p. 250). To resolve across-culture conflict, the individual resorts to adjustment responses. Choi adapted Weisberger’s (1992, as cited in Choi, 2013) four responses from his study on marginality among German Jews: assimilation, reconstructed return, poise, and integration. The process of assimilation entails absorption into the majority culture, striving hard to adopt its new language, customs, and ways of life. The pattern of reconstructed return happens when an individual chooses to return to one’s own culture either due to conflicts with the new culture or as a consequence of longing for the old culture (Choi, 2001, 2008, 2013; Choi, Meninger, & Roberts, 2006). Overidentification with the old or new culture are common manifestations in reconstructed return. The characteristic pattern response of poise is its tentativeness; the cycle of emotional conflicts and struggle may return. The response pattern of integration signifies adjustment; the individual forges a third culture through the blending of the old and new cultures (Choi, 2008, 2013). Research among foreign nurses from India conducted by DiCicco-Bloom (2004) painfully reflects the marginality of individuals as “a foot here, a foot there, a foot nowhere” (p. 28).

To explore marginal living experiences of immigrant children in South Korea, Choi (2013) developed the 13-item Cultural Marginality Scale (CMS). Choi adapted the CMS from the Societal, Attitudinal, Familial, and Environmental Acculturative Stress Scale for Children (SAFE-C; Chavez et al., 1997 as cited in Choi, 2013). Choi is currently conducting cognitive interviews with young children from age 10 to 13 years; this is in preparation for testing the brand new CMS.

HISTORY: TCN IN ACADEMIA

The NLN Committee on Curriculum initiated the integration of sociology and social issues in nursing in 1917 (Desantis & Lipson, 2007). Aimed at understanding individual reaction to illness, the NLN Committee further added the individual’s cultural background in its guide in 1936 (Desantis & Lipson, 2007). The ANA (ANA, 1991, 1995, 2003), AACN (AACN, 1998, 1999, 2008, 2011), and NLN (NLN, 2005, 2009a, 2009b, 2011) have been steadfast in their commitment to address cultural diversity and promotion of cultural competence in all levels of nursing education. The AACN offers two vital premier documents for member schools: *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* (2008) and *Toolkit for Cultural Competence in Master’s and Doctoral Nursing Education* (2009, 2011).

HISTORY: TCN IN STAFF DEVELOPMENT

Academia and practice are intertwined. It is imperative that a two-way feedback loop exist, mutually feeding and energizing each other. Practice ought to actively inform academia in terms of the latest practice innovations and the performance and areas of graduate preparation needed for an ever changing health care delivery system. Academia must actively inform practice of educational innovations and new knowledge generated in research. In so doing, we will dispel the ivory tower of academia and the muck of practice riddled with complex problems (Schon, 1987); instead, we will be fostering a powerful two-way feedback loop.

To serve as a forum for discussion of national issues by college and university providers of continuing education (CE), the initial national conference on nursing CE was held in 1969 (ANA and National Nursing Staff Development Organization [ANA & NNSDO, 2010]). While the Commission on Continuing Education was established by the ANA in 1972, the standards for CE in nursing were not published until 1974 (ANA & NNSDO, 2010). The NNSDO was established in 1989, the same year when the ANA Council on CE evolved into the Council of Continuing Education and Staff Development. ANCC, an ANA subsidiary, was founded in 1991 to implement the credentialing process including specialty nursing certification and CE accreditation (ANA & NNSDO, 2010). The NNSDO (ANA & NNSDO, 2010) works to advance the staff development practice specialty with an end goal of improving health care outcomes. Staff development, basing its standard on research, is essential to enhancing patient and organizational outcomes (ANA & NNSDO, 2010). The NNSDO published its third edition of *Core Curriculum for Nursing Staff Development* in 2009.


The model of nursing professional development specialist (NPD) practice (Figure 1.6) has seven areas surrounding evidence-based practice (EBP) and practice-based evidence (PBE): inservice, continuing education (CE), career development and role transition, research and scholarship, academic partnerships, orientation, and competency program (ANA & NNSDO, 2010). In its inservice area, TCN concepts may be offered for nurses in all shifts. CE offerings may be offered face-to-face or online in the forms of modules. The NPD specialist may also be helpful in supporting other nurses in career development, in role
transitions, and in succession planning. For example, the NPD specialist may guide other nurses in TCN certification, in planning to return to school for baccalaureate and graduate degree completion, or in mentoring other nurses for leadership roles. When partnering with academic institutions, collaborative TCN scholarship and research may be pursued in addition to diversity and cultural competence initiatives that would benefit all partners. The area of orientation presents a timely opportunity to offer TCN workshops and modules. During periodic competency evaluations, online and face-to-face TCN CE offerings may be required. Self-learning modules (SLMs) are another method of delivery for staff competency and to ensure organizational compliance with accreditation and government mandates and guidelines. Chapter 3 provides discussions and two examples of SLMs.

**INTEGRATION OF TCN CONCEPTS**

Although many advocate for the formal teaching of TCN concepts in nursing curricula, there are no standard curricular guidelines or mandates for content integration (Lipson & Desantis, 2007; Ryan, Carlton, & Ali, 2000; Sagar, 2012). Furthermore, there is a growing evidence that graduates of nursing programs are not prepared to care for increasingly diverse U.S. populations (Kardong-Edggreen & Campinha-Bacote, 2008).
Ryan et al. (2000) conducted a national survey of 610 National League for Nursing accredited schools. With a return of 36%, Ryan et al. (2000) indicated that 89 undergraduate and 27 graduate schools had formal courses in TCN. It is interesting to note that TCN concepts had varying degrees of inclusion: integrated in existing courses (197); modules in courses (135); and formal courses (89). Among the graduate schools in the survey, TCN concepts were integrated into existing courses (86); modules (56); and formal courses (27). Furthermore, Ryan et al. (2000) showed integration of TCN concepts in a wide variety of degree content and depth.

There has been increasing research about cultural competence in education. Among these researchers are Grant and Letzring (2003) on intensive review of cultural competence content, teaching strategies used by faculty, and tools used to measure cultural competence; Kardong-Edgreen (2007) on cultural competence of faculty; Kardong-Edgreen and Campinha-Bacote (2008) and Kardong-Edgreen et al. (2010) on cultural competence of graduating baccalaureate students; McFarland, Mixer, Lewis, and Easley (2006) on recruitment, engagement, and retention of diverse nursing students; and Mixer (2008, 2011) in the use of Leininger’s CCT to explore faculty expressions, patterns, and practices in teaching culture care.

Kennedy, Fisher, Fontaine, and Martin-Holland (2008) modeled a School of Nursing’s (SON) long-time commitment to diversity, as well as its ability to critically appraise its progress and proceed on its journey toward goal attainment. An intensive curricular evaluation was conducted by Kennedy et al. (2008) to appraise their university’s initiatives for addressing diversity (EBP 1.1).

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Kennedy et al. (2008) used a mixed method evaluation to examine the University of California at San Francisco (UCSF) School of Nursing’s (SON) attainment of its goal of addressing diversity. UCSF has a long history of seeking diversity among its students, faculty, and staff. The SON established a Diversity in Action Committee (DIVA) in 1994; this volunteer group of faculty has mentored faculty and students to offer diversity programs.

The mixed method consisted of four steps: (1) content analysis of all SON syllabi; (2) comparison of content analysis to students’ evaluation of diversity in their education; (3) survey of 2006 graduates; and (4) an analysis of responses from faculty to the findings (Kennedy et al., 2008). From an institutional database, codes developed by the DIVA committee were used to analyze 262 syllabi in the first step: basic nursing (11), masters (192), and doctoral (60) courses. Included in the concepts list were cross-cultural comparisons, disabilities, end of life, ethics, health/social policy, language barriers, power, and social determinants of health, among others. Each course received a diversity concept (DC) score. The final code, reflecting the analyst’s evaluation of the integration of diversity (ID) throughout the syllabus, was given a yes or no score. The DC score for each syllabus ranged from 0 to 437; median was 6 with an interquartile range of 25. Thirty-six out of 262 (14%) courses received a yes for ID content in the syllabus.

(continued)
EBP 1.1  (continued)

In the second step, all SON students were requested to complete the online course evaluation of the 262 courses using a 4-point Likert-type scale. The researchers used Spearman’s Rho to assess the association between the DC and ID scores with the students’ evaluation average for the course. The mean for all course evaluation was 3.25, ranging from 1.7 to 4.0. The association between students’ evaluation and the DC score was .196 two-tailed Spearman’s Rho; \( p < .05 \) (Kennedy et al., 2008). The investigators’ findings also included higher ID scores for basic nursing and doctoral courses than master of science (MS) courses; they attributed this to the assumption of some faculty that clinical placement in diverse settings will ensure skill development.

In the third step, 143 graduates were sent several e-mail invitations to complete an electronic survey. The survey contained questions about the graduate’s perception of effectiveness of courses in addressing diversity in health care. Of the 31 (22%) respondents who completed the survey, 84% were MS and 16% were doctoral students. Twenty-six (26) out of 31 respondents provided qualitative data for the question that asked them to identify the three courses that best addressed diversity and the reasons for choosing those courses.

In the fourth step, when findings were presented to the faculty, the primary investigator deleted the actual name of courses so there was no identification of the faculty members. The strength, weakness, opportunity, threat (SWOT) analysis was revealing: 53 strengths, 57 weaknesses, 62 opportunities, and 55 threats. More than a third of the faculty admitted they did not possess the skills and preparation to tackle diversity in the classroom. More than half of the faculty had challenges to increasing diversity in course content. Faculty verbalized appreciation in discussing examples of creative integration of diversity in courses; this gave them ideas for their own courses in the future.

Kennedy et al. (2008) acknowledged the following limitations of this study: syllabi only represent a “one dimensional aspect of the course” (p. 369), some syllabi on the databases are abbreviated versions, and there was a low response rate from graduates (22%), hence only representing a small portion of students. While limited in this assessment, information was useful for the SON in continuing to work toward the goal of fostering a climate of inclusion and embracing diversity. This research clearly pointed to the ongoing commitment of an SON in addressing the principles of diversity and preparing graduates who are ready to care for the increasingly diverse U.S. population. The researchers pose a challenge to other schools to reflect how they evaluate their own diversity initiatives. As SONs integrate diversity in nursing curricula, they move toward the AACN (2009, 2011) goals of cultural competence.

Applications to Practice

- Investigate your nursing program’s mission and philosophy in terms of diversity and cultural competence. Is it congruent with the mission and philosophy of your parent institution?
Case study 1.1 outlines the arduous task of adding a separate TCN course in a packed baccalaureate curriculum. Truly, the journey to cultural competence could be difficult and demanding, much like “scaling the mountain” (Campinha-Bacote, 2007, p. 7). In the end, perseverance, commitment, and passion for TCN could overcome resistance.
CRITICAL THINKING EXERCISES 1.1

Undergraduate Student
1. You often hear faculty at your school say that you need to be prepared to care for culturally diverse clients for your clinical rotations and when you graduate. Have you felt this readiness?
2. Do you think there is enough content of cultural diversity and promotion of cultural competence integrated in your classes (theory) and in clinical?
3. Would you be in favor of including a 3-credit TCN course in your current curriculum? If yes, which course would you be in favor of deleting from your BS in Nursing curriculum? Why?

Graduate Student
1. How many credits do you need to complete in your masters or doctoral program?
2. How many TCN courses do you need to complete in this program? Do all courses in the program integrate TCN concepts? Describe.
3. As a nurse leader, how would you meet the challenge of promoting cultural competence among staff and colleagues? Describe.
4. As an advanced practice nurse (APN), how do you plan to manage culturally and linguistically appropriate services to your clients? Explain.

Faculty in Academia
1. How many credits do you have in the BS in Nursing program at your school?
2. If you were to add a 3-credit TCN course, which current course would you delete? Why?
3. How do you critically appraise diversity in your curricula?
4. Analyze strategies that you could implement according to the enhanced CLAS standards. Describe.

Staff Development Educator
1. Do you require a yearly module in cultural diversity and promotion of cultural competence?
2. What follow-up activities that celebrate diversity do you have for the nurses and ancillary staff? How often are these activities held?
3. How long has it been since you attended a workshop/conference on cultural diversity and promotion of cultural competence? When are you planning to attend a workshop/conference on this topic?

SUMMARY

This chapter provides an overview of TCN along with some theories and models. These theories and models are highly applicable in academic and staff development settings. Academia has the gigantic task of preparing practitioners primed to care for the diverse clients and their families or significant others in today’s complex health care system. Staff development picks up from program completion and licensure to maintain continuing competence among practitioners. There is a brief history of integration of transcultural concepts in academia and the formation of professional staff development to oversee continuing education and competence. Partnerships between academia and clinical affiliating institutions are strongly encouraged to enhance consistency and harmony in theoretical and practice expectations and to improve client care outcomes.
REFERENCES


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