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Great Suffering, Great Compassion: A Transcultural Opportunity for School Nurses Caring for Cambodian Refugee Children

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The cultural ways of Cambodian refugee families, combined with the physical and psychological health problems inherent in their refugee experience, present opportunities for nurses to engage in transcultural nursing. The purpose of this descriptive study was to understand the nature and meaning of a school district cross-cultural team's experiences of providing health care for children of Cambodian refugee families. Focus group interviews with school nurses and Cambodian liaisons were conducted utilizing S. M. Dobson's conceptual framework of transcultural health visiting as a guiding theoretical perspective. Transcultural and intracultural reciprocity as experienced with Cambodian families are explored and described. Concrete suggestions for fostering transcultural reciprocity with Cambodian refugee families are provided.

Silence in the Forest

I heard it said over and over that,
"A child knows not what death is."

But at four,

Death was the singed smell of burned flesh;
where a burned log can easily be mistaken for a body.

Death was the motionless bodies;
with wide open eyes just staring.

Death was a pile of hand, arms, legs
and heads of all sizes, shapes and shades.

Crunched there silently in the brush,
She hugged her knees against her chest motionlessly rocking
and prayed that the pounding from inside would just stop,
because it could disturb the silence once again.

    —This poem was written by a Cambodian refugee who wished to remain anonymous (printed with permission of poem's author).

In the early 1980s, large numbers of Cambodian refugees began arriving in the United States in the aftermath of Pol Pot's communist Khmer Rouge regime. The genocide of an estimated 1 to 3 million Cambodians, out of Cambodia's population of 7 million, took place between 1975 and 1979 under the Khmer Rouge reign. Executions, starvation, brutal labor camps, and separation of children from their families characterized the atrocities Cambodians endured during this period. After the Vietnamese invasion of Cambodia in 1978, hundreds of thousands of Cambodian refugees fled to refugee camps in Thailand, arriving with legacies of unfathomable suffering and trauma. It is from these camps that Cambodian refugees came to the United States.

The cultural ways of Cambodian refugee families, combined with the physical and psychological health problems inherent in their refugee experience, have presented challeng-

ing and rewarding opportunities for school nurses to engage in the process of transcultural nursing. The purpose of this descriptive study was to understand the nature and meaning of a school district cross-cultural team's experiences of providing health care for children of Cambodian refugee families. Focus group interviews of school nurses and Cambodian liaisons were conducted utilizing Dobson's (1989) conceptual framework of transcultural health visiting as a guiding theoretical perspective. The concepts of transcultural and intracultural reciprocity, as experienced in relationships with Cambodian refugees, were explored.

Historical Background

Cambodian refugees were part of a larger flood of Southeast Asian refugees that began entering the United States in 1975, in the aftermath of war and oppressive political regimes (Carlson & Rosser-Hogan, 1993). Between 1975 and 1995, 146,346 Cambodians resettled in America (Office of Refugee Resettlement, 1995). California has been the primary site for Cambodian refugee resettlement, followed by Texas, Washington, and Massachusetts. Approximately half of the Cambodian refugees arriving between 1982 and 1991 were children under the age of 18 years (Office of Refugee Resettlement, 1991).

The communist Khmer Rouge regime "struck at the fabric of traditional Cambodian life by destroying contact with the past, the religion, the educational system, and the family" (Kinzie & Sack, 1991, p. 92). Buddhist monks and nuns were killed and sacred monasteries were desecrated and destroyed. The Khmer Rouge systematically targeted educated professionals and urban dwellers for execution in their quest for a classless society (Kinzie & Sack, 1991; Miller, 1995). Professors, nurses, and doctors were murdered due to their higher educational and professional status. Consequently, Cambodian refugee families who came to the United States often originated from rural areas; many were uneducated and illiterate in their own Khmer language. (Khmer refers to either the Cambodian people or language—it is not to be confused with the term Khmer Rouge, the name given the Cambodian communist faction associated with Pol Pot.) Forced separation of husbands, wives, and children took place in the labor camps. Many women arrived in America as widows or single heads of household.

Prior to arrival in the United States, Cambodian refugees may have lived several years in Thailand's overcrowded refugee camps. Limited medical and nutritional resources in the camps provided less than basic care. Crime and rape by Thai guards, Khmer bandits, and camp residents were common occurrences (Kanter, 1995; Mattson, 1993). Arriving refugees were often unfamiliar with the Western biomedical model and health care system.

Cambodian refugee families and children suffered violence, torture, injury, malnutrition, famine, infectious disease, and poverty during the phases of predeparture and flight from Cambodia and initial asylum and resettlement in the United States. These experiences caused profound harm to their bodies, minds, and spirits. The challenge of providing nursing care to Cambodians requires knowledge, understanding, and sensitivity to their unique refugee experiences and cultural beliefs.

LITERATURE REVIEW

Worldwide Refugee Health Problems

Physical issues. Malnutrition, infectious diseases, and war injuries are common health problems of the world's refugees. Anemia, tuberculosis, hepatitis B, malaria, and intestinal parasites are found in high proportions among Southeast Asian refugees (Richardson, 1990). Acquired brain damage due to physical trauma, torture, illness, and malnutrition is another significant, yet under identified, health problem in refugee children (Westermeyer, 1991).

Westermeyer's (1991) research on malnutrition, infection, and brain damage among refugee children is salient to school nurses and special educators working with refugee children. Even after resettlement, continued malnutrition placed refugee children at risk for permanent brain damage and small stature. When cases of maladjustment at home and school occurred, permanent brain damage due to malnutrition or infectious disease was often identified as a contributing factor. Untreated ear infections caused hearing impairments. In addition, many refugee parents new to the skill of driving were involved in serious car accidents on arrival in America. Their children, unrestrained by car seats or seat belts, suffered significant injuries, including traumatic brain injury.

Psychological issues. Contributing factors to psychiatric disorders and maladjustment in refugee children include malnutrition, infection, physical neglect and abuse, racism and harassment, and identity conflicts (Westermeyer, 1991). Utilizing a stress model, Athey and Ahearn (1991) identified trauma, loss, and severe deprivation as experiences that place refugee children at increased risk for "psychiatric morbidity, dysfunctional behavior patterns (such as suicide, drug and alcohol abuse, or delinquency), or "incompetence" in love, work, or play" (p. 4).

A lack of family support is another key threat to the positive emotional development of refugee children. Family disintegration due to death and separation may be compounded by a parent's inability to meet the emotional needs of their children due to their own psychological trauma and pain (Athey & Ahearn, 1991), an important reminder that the refugee child must be viewed within the context of family. Often refugee parents are dependent on their children who are more adept at learning the language and ways of their new country. Such parent-child role reversals put refugee children at risk for having important childhood emotional needs unmet.

At school, refugee children with mental health issues may display learning disabilities, disruptive behavior, depression, and somatic complaints (Gong-Guy, Cravens, & Patterson, 1991). Due to stigmatization of mental illness within the Southeast Asian culture, refugees tend to shun mental health services due to fear of damage to family reputation, fear of deportation, and fear that such information will be shared with government agencies and their ethnic community (Gong-Guy, Cravens, & Patterson, 1991).

Cambodian health issues. The sociocultural and historical factors that place Cambodian refugee children at risk for mental health problems are extensive. War, violence, economic deprivation, torture, famine, and hardships of flight not only affected their physical health but also wounded their spirits and psyches. Untold numbers of children witnessed the execution of family members. Children were separated from their families and sent to work in labor camps under conditions of starvation and physical and sexual abuse. Separation issues continued on resettlement to the United States as children coped with the deaths and unknown whereabouts of parents and siblings.

Post-traumatic stress disorder (PTSD), depression, anxiety, and survivor guilt are mental health problems that have been identified among Cambodian refugee children (Kinzie & Sack, 1991; Rumbaut, 1991). Carlson and Rosser-Hogan (1993) studied the mental health status of Cambodian refugees living in the United States 10 years after they had fled Cambodia. Within a general population sample of 50 Cambodian refugees, 90% exhibited marked symptomatology in one or more of the following: (a) PTSD, (b) dissociation, (c) depression, and (d) anxiety. Of the sample, 80% categories met the criteria in three of the four symptom categories and 90% met the criteria in two or more of the categories. Overall, 86% of the respondents suffered from PTSD, and 80% suffered from depression.

Traditional Cambodian Health Beliefs and Practices

Buddhist philosophy is a dominant influence in the Cambodian realm of experience, which values equilibrium and harmony in one's life. Behaviors that promote these values include gentleness, the avoidance of confrontation and competition, nurturance toward the elderly and children, and peaceful coexistence (Frye, 1990, 1991). Cambodians view health as a state of equilibrium. When an imbalance occurs between energizing hot forces and calming cold forces, disequilibrium occurs leading to illness (Frye, 1990). The symptoms associated with disequilibrium are described as a state of internal bad wind and affect body, mind, and spirit (Frye, 1991).

Treatment of illness is aimed at the restoration of equilibrium through dermabrasive wind-releasing treatments (Frye, 1991; Muecke, 1983). Such wind-releasing techniques include "coining" or "coin rubbing," "cupping," and "pinch-ing." Coining is the practice of rubbing the skin with eucalyptus oil and a coin to create a reddened abrasion through which the bad wind escapes, thus restoring equilibrium. The bruising and marks have been mistaken as a form of child abuse by those unknowledgeable of this Cambodian healing practice (Frye & D'Avanzo, 1994). Massage is also used in the treatment of illness (Kemp, 1985).

Another example of folk knowledge is the use of food as an oppositional treatment to restore equilibrium. Cold states, such as childbirth and respiratory ailments, are treated with opposing "hot" foods such as meat, salt, and wine. Hot states, such as hypertension, are treated with "cold" foods such as fruits and vegetables (Frye, 1990, 1991; Kemp, 1985; Muecke, 1983). Traditional Chinese medicines and herbal infusions may also be used (Frye, 1991; Kemp, 1985).

In addition to defining illness as a state of disequilibrium, Cambodians believe in spiritual causes of illness, such as negative karma from previous lifetimes or spirit possession (Eisenbruch & Handelman, 1990; Kemp, 1985). Buddhist monks and *krous khmer*, traditional folk healers, perform spiritual rituals and prayers in the temple and home to bring about healing. Monks and krous khmer may bless lustral water into which Pali prayers are said. The water is then poured over a person in an effort to heal (Kemp, 1985; Kulig, 1994). Amulets and strings, called *katha*, may be tied around wrists to "tie in the soul" so that it does not become lost (Galanti, 1997; Kemp, 1985)(see Table 1).

Transcultural Relationships

Over the past two decades, there has been an increase in published studies on the health care beliefs and practices of different cultures. In addition, researchers have begun to focus on the nature and meaning of nurses' experiences in transcultural nursing. Murphy and Macleod Clark's (1993) descriptive study of the experiences of nurses working with ethnic minority clients revealed that nurses shared many common experiences and challenges. Communication barriers, lack of knowledge of different cultural ways and beliefs, and feelings of ineffectiveness in delivering holistic care were identified as predominant issues. The nurses' desire to connect with clients in a therapeutic relationship and to provide culturally sensitive care was a common theme, often coupled with feelings of frustration and helplessness over the challenges encountered in the process. Those nurses who believed they had positive relationships with their patients noted that it took patience and time to build those relationships.

Wright (1991) addressed the complex issues for psychiatric nurses counseling clients of differing cultural backgrounds. Wright challenged psychiatric nurses to develop an authentic and realistic approach that takes into account cultural background, yet is "flexible enough to respond to the individual and not merely his/her cultural grouping" (p. 92). Wright warned that responding to a person's culture alone, rather than to the individual, carried the danger of "losing the

TABLE 1
Traditional Cambodian Health Beliefs and Practices

Belief	Practice
Health is a state of equilibrium	Dermabrasion
Disequilibrium/illness is due to:	Oppositional treatments
Imbalance of hot and cold forces	Massage
Negative karma	Herbal medicine
Spirit possession	Spiritual healing and prayer
Symptoms are described as bad wind or loss of spirit	

person" (p. 95). Awareness of cultural diversity combined with individualization of care has been supported throughout transcultural nursing literature (Ahmann, 1994; Mason, 1990).

Concepts of cultural sensitivity and multiculturalism have given way to an expanded view, which sees transcultural nursing as a reciprocal process. By means of case studies, Harry, Kalyanpur, and Day (1999) proposed a posture of cultural reciprocity for professionals working with ethnically diverse students with disabilities. They encouraged professionals to initiate a "two-way process of information sharing and understanding . . . that can be truly reciprocal and lead to genuine mutual understanding and cooperation" (p. 7). They urged professionals working with these students to serve as a bridge between the culture of schools and the culture of diverse families.

CONCEPTUAL FRAMEWORK UNDERLYING THIS STUDY

Health visiting is a term used in British nursing to describe the method of nursing care that focuses on health promotion through interaction with people and groups in the community setting. Dobson (1989) identified meaningful and creative conceptualization of care as crucial to the development of a fundamental knowledge base for the field of health visiting.

Dobson (1989) asserted that transcultural reciprocity is a core concept in the practice of transcultural health visiting. Dobson envisioned transcultural reciprocity as:

> An inter-cultural process rooted firmly in the reciprocation of cultural respect and understanding between health visitor and client. . . . Assuming a spiralling [sic] dimension through time as the health visitor-client relationship becomes increasingly collaborative, transcultural reciprocity is viewed as a process in which both client and practitioner participate on equal terms. (pp. 100-101)

Dobson created a schematic figure of transcultural health visiting that depicted transcultural and intracultural reciprocity as spiraling and intrinsic dynamics of the relationship between health visitor and client (see Figure 1). The relationship between transcultural health-visiting education,

transcultural and intracultural reciprocity, and the goal of transcultural health visiting is clearly illustrated in this schema. The framework also demonstrates the differences between transcultural reciprocity (between health visitor and client of different cultural backgrounds) and intracultural reciprocity (between health visitor and client of similar backgrounds).

Dobson (1991) viewed caring, collaboration, and creativity as integral concepts and essential process skills within the repertoire of a nurse's clinical expertise.

> Collaborating with the client as an equal, demonstrating in words, actions and sometimes silence a warm sense of caring, and being creative and imaginative in finding ways to interweave culture and care, are part and parcel of skilful [sic] transcultural nursing. (pp. 115-116)

Acknowledging the prevalent unicultural approach in health visiting, she invited nurses to examine their own ethnocentric biases in the delivery of care. Within the context of transcultural reciprocity, nurses are offered the opportunity to gain a cultural perspective individualized to the client and family. Dobson (1991) encouraged nurses to "emancipate themselves from their own cultural view and take a metaphorical step into their client's cultural world" (p. 103).

ORIGIN OF INQUIRY

The primary author's interest in the nature of the experience of caring for Cambodians grew out of her own practice in pediatric, school, and public health nursing. Whether in a hospital, health clinic, school, or home setting, interactions with Cambodians led to enlightening shifts in perspective and worldview. It was this researcher's sense that transcultural reciprocity fit what happened between nurse and client, and this awareness invited the question of whether transcultural and intracultural reciprocity could be identified in the reports of school nurses and Cambodian liaison personnel.

RESEARCH PROBLEM

Medical and nursing research regarding the physical and mental health issues of Cambodian refugees has increased substantially since their arrival in the United States. Transcultural nursing knowledge continues to expand through investigation of themes, beliefs, and health practices of Cambodians. However, research was lacking that specifically focused on the description of transcultural reciprocity between nurses and Cambodian refugees.

Purpose

The purpose of this study was to describe the nature and meaning of school nurses' and Cambodian liaisons' experiences of caring for Cambodian refugee children and families and to explore whether those meanings validated Dobson's

(a) TRANSCULTURAL RECIPROCITY

- there is an affirmative desire to bridge and transcend inter-cultural differences

- transcultural knowledge, skills and practices are utilized to achieve this aim

- cultural knowledge and respect are reciprocated within the health visitor client relationship and this reciprocation assumes a spiralling dimension

TRANSCULTURAL HEALTH VISITING EDUCATION

Both qualifying and qualified health visitors

- develop transcultural health visiting knowledge/skills/ abilities/practices

- including the ability to

a) collect, collate, analyze and utilize data on the client's ethnic identity and back-ground

b) utilize transcultural health visiting expertise to establish and maintain inter-cultural health visitor-client relationships and for the enhancement of intra-cultural health visitor-client relationships

H V   C

TRANSCULTURAL HEALTH VISITING

GOAL OF TRANSCULTURAL HEALTH VISITING

to

MAXIMIZE
the client's health potential to achieve optimal health and well-being within the parameters of the client's own cultural traditions

- cultural frames of reference are considered to be similar and mutually understood

- cultural knowledge and respect are reciprocated within the health visitor-client relationship and this reciprocation assumes a spiralling dimension

H.V.   C

(b) INTRA-CULTURAL RECIPROCITY

H.V   Health visitor

C   Client - Individual
Family
Community
Other social group

Health visitor-client reciprocity Onus on health visitor to establish and maintain

Spiralling reciprocity

Transcendence of cultural differences

LEGEND

FIGURE 1.   Dobson's Transcultural Health Visiting-Schema.

(1989) conceptual framework of transcultural health visiting. Through reflection with school nurses and Cambodian liaisons in focus group interviews, insight into the concepts of transcultural and intracultural reciprocity as experienced in their relationships with Cambodian refugees was sought. It was hoped that examination of the groups' experiences of caring for Cambodian families could lead to a deeper understanding of the transcultural nursing process and offer insight and knowledge that would foster authentic and culturally sensitive care.

Research Question

The principal question of this study was the following: What is the nature of a cross-cultural team's experience of caring for children of Cambodian refugee families? Related questions explored the experience using Dobson's (1989) conceptual framework of transcultural health visiting (see Figure 1). When a cross-cultural team of school nurses and Cambodian liaisons provides care to children of Cambodian refugee families:

1. How do they describe their experiences?
2. How are cultural knowledge and respect reciprocated within relationships with Cambodian families?
3. How are intracultural and transcultural reciprocity manifested?
4. Is there a spiraling dimension to reciprocity as described by Dobson?
5. How do non-Cambodian nurses transcend cultural differences to establish meaningful and helpful relationships with Cambodian refugees?

METHOD

This qualitative study of health care workers' experiences of caring for children of Cambodian refugee families was based on data gathered during focus groups. Participants were members of a cross-cultural team that provides health care services in a school setting. This team included school nurses and Cambodian liaisons in a school district where the majority of the county's Cambodian community lives.

A semistructured interview guide was developed to (a) gather information about the nurses' and liaisons' experiences caring for Cambodians and (b) to look for elements of their encounters that might corroborate Dobson's conceptual framework of transcultural health visiting. Two qualitative researchers reviewed the questions. A Cambodian registered nurse reviewed the guide to determine whether there were questions that might be considered inappropriate or insensitive to Cambodian respondents.

San Jose State University's Human Subjects Institutional Review Board approved the study's research protocol. Special consideration was given to the Cambodian liaisons and to issues of confidentiality. All participants consented to being audiotaped though they were given the option of not being audiotaped.

Sample

A purposive sample of school nurses and Cambodian liaisons was recruited from a school district serving a large population of Cambodian children in California. Six of the district's eight nurses volunteered as well as two of the three Cambodian liaisons. The liaisons included a health clerk and a community liaison. Initial contact and invitation to participate were made by phone or letter. Signed consent forms were obtained prior to conducting the focus groups. The school nurses had a range of 6 to 15 years of experience working with Cambodians. The two Cambodian refugee liaisons had lived in the United States for 16 years and 24 years.

Setting and Data Collection

Two of the authors, one a non-Cambodian school nurse and the other a Cambodian registered nurse, conducted the focus groups using semistructured interview guides. The focus groups met for 1½ to 2 hours. The focus group with the Cambodian liaisons was held in the non-Cambodian school nurse's home. The Cambodian registered nurse moderated and was assisted by the school nurse. Two days later, the focus group with the school nurses was held in their school district's conference room. The school nurse moderated and was assisted by the Cambodian nurse.

Cambodian refreshments and tea were served at the beginning of each focus group. The importance to Cambodian women of a welcoming and friendly time for interacting, before addressing formal topics in gatherings, has been found to be crucial to the development of trust (Kelly et al., 1996). Therefore, a full 30 minutes was allowed for becoming acquainted and socializing with the Cambodian liaisons before the focus group began. The focus group interviews were conducted in English although at times the Cambodian liaisons would share the Khmer words for certain health practices or illnesses. If there were no corresponding words in English, they attempted to briefly explain in Khmer to the Cambodian nurse moderator. Participants received a monetary gift as a symbol of appreciation for their time.

Data Analysis Procedures

Focus groups and moderator debriefing sessions held immediately afterwards were tape-recorded and field notes were reviewed. All tapes were transcribed verbatim. Transcripts were compared with tapes for accuracy. Tapes were listened to and transcripts were reviewed several times by the moderators individually and together. The data were grouped and categorized into emergent issues and themes and also reviewed in light of Dobson's (1989) conceptual framework of transcultural health visiting.

FINDINGS

The findings are discussed in relation to the three elements of Dobson's (1989) schema: (a) transcultural health-visiting education, (b) transcultural health visiting, including transcultural and intracultural reciprocity, and (c) the goal of transcultural health visiting. Emergent themes and issues are addressed.

Transcultural Health-Visiting Education

The three components of education include (a) development of transcultural health-visiting knowledge, skills, abilities, and practices, (b) collection and analysis of data on client's ethnic identity and background, and (c) enhancement of intracultural relationships and establishment of intercultural relationships (Dobson, 1989). The findings in this section will address the ways in which the participants developed and utilized their transcultural knowledge and interpersonal skills.

Cambodian liaisons: Developing and using transcultural knowledge and skills. The Cambodian liaisons shared experiences that reflected their skill in interacting with Cambodian families at school and on home visits. The liaisons individualized their care based on family history, background, and education. One liaison advised,

> First, I think you should find out about the family. Is it a new arrival? How many years have they been here?. . . . It could be a lot different for a new arrival, than for one that's been here for two to three years.

They noted that their approach might be more direct with a less educated parent to convey their message. "I already know this family, what I can say, what tone, what I can stress, when I can be a little harder." The liaison described some of the less educated families as not knowing what to do in a given situation and, therefore, wanting specific direction. The liaisons demonstrated the various tones and gestures they might use with parents: a very soft and polite tone versus a louder, authoritative tone accompanied by emphatic hand gestures.

As the liaisons described their interactions with families, their interpersonal skills became apparent. They described the art of gentle probing with Cambodians who are hesitant to share their problems and the ability to keep reaching out even though families do not respond. They spoke of how frequently families may react with anger when they are contacted by the liaisons because they think that such contact implies that their child is in trouble. In Cambodia, if a teacher contacted the parent, it was because the child had done something wrong. One liaison described a common response when she phones a parent. "The phone rings, and 'Hello'. . . . They'll be so rude! But that's the way they are. So they say, 'What's going on with my kid?! You blame the parent again?' " The other liaison continued:

> You have to understand. . . . They're frustrated. They don't know how to help their children. And, if you would say, [softly] "Why don't you come in and meet with us. We'll figure out what to do together. We'll have some ideas, we'll give you ideas if you need help." And then, they'll feel more comfortable and come. . . . When they're upset, they kind of cry for help. But they don't know how to ask for help, so they just show it in an angry way. So, if we don't know that, we think . . . they're very angry. But then, if we know how to approach them, saying, "Look, we're trying to help your child [voice becomes very gentle and quiet]. If you come with us, we'll show you how." Then they're very nice. I always do that.

Their understanding of the psychological dynamics underlying the anger of Cambodian families was coupled with a willingness to reach out even in the face of such anger. They understood that beneath the anger lay embarrassment, fear, anxiety, and tremendous family stress. They hoped the Cambodian families would finally trust that they cared.

One liaison described her approach with families in which members suffered from PTSD:

> There's so much post-traumatic stress disorder. Luckily, my family is okay. . . . I have both my parents. I was very lucky. And I guess I'm the luckiest one, because most of my generation, when they came over, they either lost their father, their mom, or both. And I try hard to understand that. . . . I'm not going to be angry at them. . . . I'm not going to expect way over what I used to do. You know, I know everything that my family needs to do. But I'm not going to expect that from them. I can't. If I expect that from them I won't get anything from them. So be patient. Tell them what they need.

This liaison described her varied roles, and how she utilizes her life knowledge rather than book knowledge:

> You kind of learn their behavior. In a way, like a psychologist. You have to be everything . . . nurse, psychologist, teacher, principal. You use all the knowledge you have to deal with them. . . . I mean, there's not college where we can attend class to learn about them.

The liaisons shared knowledge of Cambodian cultural ways of healing, such as coining, cupping, pinching, massage, and the use of medicinal herbs. They spoke of herbal wines used to restore a woman's health and beauty after giving birth, pomegranate leaves and bark for treatment of diarrhea, lemon grass for urinary problems, and juice squeezed from mint leaves to help with coughs. They also described a bitter herb called *tnam-maroy-mook* (medicine for a hundred symptoms) or *bondal-pech* (tip of a diamond). It is formed into little balls and swallowed with warm water. Some of the symptoms for which it is used include headache, chest pain, urinary problems, and arthritis. Medicines are brought back from Cambodia, and Chinese medicines may also be used.

The liaisons said that Cambodians tend to use Western medicine and Cambodian practices together. Antibiotics may not be taken for a full course because once symptoms disappear, the medicine is often stopped. They found that follow-up with parents regarding medication was often necessary. They also shared information about the spiritual healing practices of the elders at the temple and the roles of monks and krous khmer.

School nurses: Learning from Cambodians. For the school nurses, the Cambodian liaisons were the most important source of information about Cambodians and their culture. In describing a Cambodian liaison with whom she had worked, one nurse said, "I really learned from a master to be sensitive." Other sources of information about Cambodian culture included workshops held at local colleges. "We had the refugee clinic, and there were specialized nurses who had worked overseas, who gave workshops for us, and explained much of the history, and explained some of the conflicts which they bring over here." The nurses described the use of coining and herbs as part of traditional Cambodian health practices.

They also spoke of the effect of PTSD within the Cambodian families. One nurse described being in a public health office with other Cambodians after a schoolyard shooting had occurred in another part of the state. A gunman had come on campus and randomly shot at several children, many of them Cambodian.

> We sat around the table and the people spoke about the fear they had. . . . They thought they would come to the States, and it would be much safer, and then suddenly, everything was turned upside down for them and the memories came back.

PTSD symptoms were also triggered when helicopters sprayed pesticides over the county in an effort to combat a fruit fly infestation. "The families would say, when the helicopters were flying around with the Malathion, that they had this big rush of memories from back home. . . . It was deeply embedded in them."

To the nurses, knowledge of the Cambodians' historical background was helpful in understanding their behavior. One nurse described the barriers she encountered when identifying children who needed glasses, especially with the first wave of immigrants that arrived:

> I'd find somebody who needed glasses, and it was a real barrier because I was told people who wore glasses in Cambodia were murdered because it was a sign of being educated. . . . Parents were very, very fearful when I'd say, "Well, we really need to get an eye exam, and get some glasses." Once I understood their fear and their anxiety, then I was able to make some inroads. But if you don't know that, you'd just really see a family as being uncaring and not wanting to follow through. Yet that was not the case at all.

The nurses spoke of the acculturation issues and intense generational conflicts in Cambodian families. When the Cambodians initially came to the United States, "a lot of the things that we talked about were food, medicines, behavioral things. But then later on, it seemed there was much more about the change and the pressure of the family structure." The nurses gave examples of how the desires of the acculturated refugee youth clashed with the traditions of their elders. A nurse described eighth-grade girls coming to her for help because their families were arranging marriages for them. They did not want to marry but rather desired to continue with their high school education.

As with the Cambodian liaisons, the school nurses found it important to understand the reasons behind a Cambodian's behavior.

> That's the first question you have to ask, "Why is this behavior taking place?" You can't judge everything from our standpoint. I try not to do that at all because otherwise we jump to assumptions and conclusions that are not the case. We have to be sensitive. . . . Each one is individual. You've got to ask the right questions.

Intracultural Reciprocity

With intracultural reciprocity (reciprocity between individuals of the same culture), (a) cultural frames of reference are similar and mutually understood, (b) cultural knowledge and respect are reciprocated, and (c) reciprocity assumes a spiraling dimension (Dobson, 1989). This spiraling quality was described verbally and nonverbally in the interviews.

Cambodian liaisons: Reciprocity takes time, trust, and hospitality. The liaisons described Cambodians' hospitality and friendliness. They discussed the ways Cambodians reciprocated respect in their greetings and how they addressed each other. In Cambodian culture, people do not call each other by their first names unless they are the same age. For example, respect is shown by prefacing the name of a woman older than oneself with either *Meng*, meaning auntie, or *Bong*, meaning big sister.

> Our people are usually very nice. . . . They would greet anybody the same. To all people they're very polite. They always invite you to come into their home even though they don't know you. That's their nature. They'll say, "Please come on in. Come on in." . . . You greet them by saying, "How do you do? How are you?"

One liaison said, "Cambodians are really friendly. . . . But if we go unexpectedly, just knock on the door, they still greet you the same: 'Come in, please. . . . Have food or have some fruit.' Or, they'll have something for you to take home."

The liaisons reciprocated cultural knowledge and respect through hospitality, observance of customs, and use of a soft

voice. They used smiling, joking, and teasing to warm up and express friendliness.

The liaisons emphasized the importance of allowing time for trust to grow. "They like being greeted, they like being friendly, first, before you start telling them about their child's problem. You've got to be friendly first." Even as Cambodians, it took time for them to establish trust with other Cambodians. "Trust is very important. If they trust you enough, they'll come to you. And most of the time they'll come to us." "Sometimes they may not open up. So, be polite first, build friendship. . . . Sometimes it's too soon." And, "The first time you stop for a home visit, maybe they're not open yet to share. They're saying, 'I want to be polite. I want to be friendly, a good host, and invite them to come in.' "

They also described families not sharing problems or asking questions until the visit was over.

> Most families . . . aren't really open to asking questions until you get up and are on the way to the car. They think that it's not formal anymore, so they say, "Can I ask you a question?" But they won't ask during the visit . . . only after you get up.

A liaison described approaching Cambodian parents as equals. "I approach them at their level. I don't make myself higher. I'm not making myself lower." This practice would fit in with Dobson's schema depicting the health visitor and client on equal ground. Connections with other Cambodians were also made through sharing pride in their cultural background. One of the liaisons shared her pride in the Khmer language with Cambodian students. "I have a lot of Cambodian kids. . . . So I speak Khmer to them and they say, 'She speaks Khmer!' They were excited. They were so proud. And then they started telling me about their stories." The other liaison made many connections with the community through involving young people with the Cambodian New Year celebrations.

The liaisons expressed their care by going on home visits when a child was sick or having trouble at school. They would go because, "We wanted them to know us, that we care for their family, so that way they would start opening up to us."

The liaisons' efforts to keep reaching out reflect Dobson's depiction of the onus being on the health visitor to establish and maintain reciprocity. Through continued effort to reach out, the liaisons endeavored to send the message "We want to help, we care." They advised,

> Just try to reach out to them, no matter if they are angry at you. They'll see later on that you're not trying to harm them in any way. Just keep reaching out to them and they will trust you.

The liaisons used hand gestures to indicate the circular route they took when interacting with Cambodian families. These gestures seemed to suggest the spiraling dimension of reciprocity as described by Dobson. "You have to warm up.

You don't go straight to the point. It doesn't work that way. So you make sure that they're comfortable before you get to the point."

Once trust is established, the liaisons described the ways that families reciprocated by expressing their care for the liaisons. They described Cambodian families bringing them jasmine flowers or *chompa*, similar to what grew in Cambodia. "We kind of know everybody in the community. Sometimes they will bring her food, bring me food . . . because we didn't have time to go to their house. That's how nice they are."

Transcultural Reciprocity

Using Dobson's framework, transcultural reciprocity (reciprocity across cultures) is fostered through the nurse's affirmative desire to bridge and transcend intercultural differences. Again, there is evidence of a spiraling dimension to reciprocity.

School nurses: Reaching out across cultures through personal contact. The nurses found that the best way to connect with Cambodian families was through personal contact. Letters sent to parents, whether in English or Khmer, were not effective because many parents cannot read either language. Home visits were one of the most effective ways of establishing a direct connection and expressing care for children and their families. Teaming together with the Cambodian liaisons, the nurses demonstrated their ability to collaborate in providing services. "You really have to reach them directly. And pretty much the only way we have to do that is through our liaisons."

Cultural knowledge and respect were demonstrated in a variety of ways. The removal of shoes on entrance to a Cambodian home was one way of conveying respect. Establishing a relationship by showing knowledge and interest in Cambodia was another. One nurse shared how she tried to connect with Cambodian school children.

> I have a couple of picture books on Cambodia. . . . I've had people shocked that I know where Cambodia is. . . . We could look at in on the map. It sounds very basic, but it's a way of making a connection. Especially with the students, they're like "Wow, it's a book on Cambodia." And then we talk about where their families are from. So, some type of personal connection.

Statements that suggested transcultural reciprocity included the following: "It's a two-way street," and "I just think we need to continually keep reaching to them and helping them with little baby steps . . . we can help with this and we can help with that."

The nurses spoke of how it took time to build relationships and trust with the Cambodian families. They described a process of building on previous encounters to gradually develop trust. One nurse talked of how she gave an earthquake preparedness program for the Cambodian community:

[The presentation] really helped with my working on other levels . . . because it was my . . . community that I was trying to reach. . . . I guess [after that] they saw me as a real, live person who was reachable, and so I was able to begin to work a little bit more on individual problems.

A nurse described a Cambodian mother reaching out to her by sending an American greeting card as a symbol of thanks for helping with a special education placement of her daughter.

It was during the holiday time, and it had a poinsettia, and I opened it up and it said something about bereavement. But she, in her own way, had wanted to say, in a kind of American-ized way, "I want to thank you. You did something special for my family." It turned out she couldn't read English . . . but I surely got the message from her, and it was in a very positive approach that she was trying to share. That was very powerful for me. Whatever our group had done had met the needs.

Though the mother had sent a sympathy card, the nurse understood her intent to send a thank you card. "Even though we feel we might be walking on unfamiliar territory, I think that they're genuinely quite grateful for what we do for their kids."

Goal of Maximizing Health and Well-Being: Letting Go of One's Own Views

The Cambodian liaisons and school nurses related the importance of providing care within the parameters of their Cambodian client's own cultural traditions. The Cambodian liaisons acknowledged differences between the very tradi-tional beliefs of the elders in the community and the accep-tance of Western medicine by the younger generation of Cambodians. According to the Cambodian liaisons, one should never challenge the health and spiritual beliefs of Cambodian elders.

You don't want to object to anything. Because, even though you're learning about nursing stuff, you don't want to go in the middle . . . they're going to beat you up [laughing]. You don't want to go and do that. . . . You let them let it out. You don't go and say, "This is what I've learned in school." It's not going to work. You don't go and cut them off. No way. They would get very upset.

The nurses recognized the need to suspend their own ethnocentric views. Providing care to Cambodians encom-passed being flexible and able to let go of one's belief system: "If it's not hurting anything, support it, and leave it alone. Because we don't know. Who knows? None of us do."

ADDITIONAL ISSUES AND THEMES

As both focus group participants explored their experi-ences caring for Cambodians, emergent issues encountered

TABLE 2
Emergent Issues Affecting Cambodian Families

Intergenerational conflicts	Isolation of elders
Post-traumatic stress disorder	Gambling
Depression	Truancy
Intense family stress	Gangs
Domestic violence	Incompletion of high school
Child abuse	Teen parenthood
Large family size	

within the Cambodian community surfaced (see Table 2). Many of these issues, such as domestic violence and truancy, were psychosocial in nature and involved family and school relationships. A strong need for safety in relationships and settings emerged. Participants identified school and the tem-ple as safe places for Cambodians to gather. Given their trau-matic history, one can understand the Cambodians' longing for safety.

Multifaceted Roles of Cambodian Liaisons: We Want to Help Them in Any Way

The invaluable and multifaceted roles of the Cambodian liaisons emerged as a dominant theme from the focus groups. The liaisons are much more than translators. In analyzing the data, 14 roles were identified (see Table 3). As an example, the role of protector emerged. As one liaison said:

We want them to trust us. And we want to help them in any way. We would never do anything to jeopardize them, their families, or their beliefs. We would never try to do that. If somebody tried to do that to them, we'd stop them.

The liaisons were deeply committed to their Cambodian fam-ilies and community.

School and Home: "Caught in the Middle"

Both liaisons often felt caught in the middle when they had to explain and enforce school rules with Cambodian parents. Even though they were translating the school administra-tion's rules, parents would sometimes become angry at the liaisons. They expected the liaisons to help them bypass some of the school regulations. Some in the Cambodian commu-nity believed the liaisons had the power to change or bend rules.

Many times I feel very frustrated because I know my people. They depend on me. And yet, I have to do what they [school staff] ask me to tell them. And I feel very frustrated. And I say, "I wish I could help you, but I can't. I only work here." And they say, "Yes, you work here. That's why you need to help us." So you get caught in the middle. You're like . . . "Oh! . . . What am I supposed to do?!" "You're Cambodian. Why can't you help us?!" We get stuck.

TABLE 3
The Multifaceted Roles of Cambodian Liaisons

Protector	Role model
Bridge	Motivator
Counselor	Catalyst
Health educator	Doorway
Messenger	Behavioral interpreter
Translator	Culture bearer
Helper	Mentor

The other liaison added,

> I'm not there to put people on the spot. It's so difficult. I feel bad right there. I cry in front of the parents. Because I know that when they get out, they're going to say that I didn't help them.

The liaisons feared what disgruntled parents might say to other Cambodians in the community because their reputation was important to them, and they genuinely cared for these families. The liaisons appeared to experience significant stress when requirements of the school were in conflict with the expectations and pressure of their own Cambodian community.

Intergenerational Conflict: "It's Hard for the Kids"

Although the participants identified the interconnectedness and interdependence among Cambodian families as strengths, acculturated Cambodian youth were described as finding the Cambodian community's infrastructure restrictive and confining. In addition, the liaisons described the sense of powerlessness parents encounter raising their children in the United States. "They feel that they've lost all that power now, so it's very hard to raise kids over here. They don't speak English." In the words of one nurse, "The parent is really at the child's mercy." A liaison shared the following:

> In one family you could see two cultures. Some parents are still following the old culture at home. Sometimes if I know them well and we're friends, I'll say, "You know, it's hard for the kids to follow your culture. Don't forget that he is not Cambodian. I know in your heart you're a Cambodian family, but your kids are growing up here . . . in a different community, a different society, different civilization, and culture."

The Cambodian Refugee Experience: "Left From the Dead"

In comparing Cambodian and Vietnamese refugees, a Cambodian liaison pointed out the perceived differences:

> The Vietnamese families, the ones that come, those are the ones that are very brave and educated. They came over to start

a life. But us, we're the refugees. It's a big difference. Us, it's like "left from the dead." They call it "left from the dead." It's like nobody wants to kill you, you're dead anyway. You have no education; you can't start anything, so you might as well be "left dead."

Spiritual Healing: "It Lifts Your Spirits"

The liaisons explained the important role of the temple in healing practices of Cambodians: "Spiritual things help them."

> That's why they call it spiritual. It lifts your spirits up. You believe it works, so your body strengthens to fight the infection. It's not a medical thing. The monks don't know anything about medical terms or what to do to your body. So instead, they use the spiritual thing to help them.

Other descriptions by the liaisons illustrated the importance of friends in the healing process: "Friend visits can be medicine because it lifts your spirits," and "When I was young, when I was sick, when some certain person that knows me or some person that I like came to visit, it helped me."

Cultural Strengths: "Carried Across the Ocean"

The Cambodian liaisons and school nurses identified several strengths in Cambodians, as displayed in Table 4. One nurse remarked on Cambodian dance as a cultural asset:

> The dancing stands out . . . [as] something that can be carried across the ocean. It's within their mind and their memory, and that cannot be taken away from them. And so the elders, the people who have the skills, are working really, really hard to transfer that to the younger kids.

DISCUSSION

Dobson's (1989) conceptual framework was a useful tool in understanding the experiences of school nurses and Cambodian liaisons who care for Cambodian refugee children and families. The participants shared their transcultural knowledge and described the varied ways they reciprocate cultural knowledge and respect in an effort to establish and enhance their connections with Cambodians. Their descriptions of interactions with Cambodians suggest the presence of intracultural and transcultural reciprocity within their relationships. The school nurses and Cambodian liaisons highlighted ways that they supported traditional Cambodian health beliefs and practices. Empathy, patience, sensitivity, and a willingness to suspend one's worldview, vital in all health encounters, were essential attributes in fostering connections with Cambodian families. Though the focus of the research was on this cross-cultural team's experience of reciprocity, important insight was gained regarding issues within the Cambodian community.

TABLE 4
Identified Strengths of Cambodian Refugees

Interconnectedness of extended families and community
Cultural arts and traditions
Resiliency
Survivorship
Caring and loving attitude toward children
Close bonds between young girls
Warmth and hospitality

TABLE 5
Recommendations for Nursing Practice

Individualize care based on family's background and refugee history
Keep reaching out; trust takes time
Take a slow, friendly, nondirect spiraling approach
Gently probe
Suspend assumptions and worldview
Look beyond the behavior to understand the underlying dynamic
Support cultural traditions and share your interest
Elicit explanatory models for illness
Incorporate spiritual healing practices and the temple into delivery of health services
Encourage and mentor Cambodian role models
Provide health education: family planning, nutrition, safety, and routine check-ups
Assist with access to care
Provide support to parents and elders
Assess refugee risk factors as part of special education process
Monitor medications

IMPLICATIONS FOR NURSING PRACTICE

Reflecting on the Cambodian liaison's statement that "Friend visits can be medicine," one can likewise envision transcultural health visiting as healing medicine. Awareness of transcultural reciprocity and the importance of establishing trust may help guide other nurses in the development of meaningful relationships with Cambodian refugee children and families. Advice is best taken from the liaisons who said, "Keep your friendly face to them," "Keep reaching out," and "Never give up." Table 5 contains further recommendations from the Cambodian liaisons and nurses.

Transcultural nursing care should be incorporated into all stages of the nursing process when caring for Cambodians. Assessment should include exploring the meaning of health with Cambodian clients, and planning should integrate their cultural beliefs and practices. Implementation must be creative and support the care constructs of Cambodian culture. Evaluation should include feedback from clients regarding health outcomes as seen from their cultural perspective and worldview.

Given the recurrent theme of intergenerational conflict, efforts to strengthen Cambodian family bonds and cultural ties could promote healing at the family and community level. In partnership with the Cambodian community, interventions that target Cambodian refugee children with direct services, as well as indirect services through support of their families, are needed. Schools have the opportunity to serve as a hub for a kaleidoscope of community programs such as English acquisition classes, parent education, job training, counseling, and health services.

Cross-cultural teams are invaluable in their ability to reach out to culturally diverse communities. Leiper de Monchy (1991) asserted that

> The cross-cultural team approach offers many advantages when working with refugee children who are in the process of integrating two worlds, their homeland and the adoptive country. . . . Teams can be a visible symbol of integration, with respect for both cultures. In addition, they provide support and training to refugee paraprofessional staff whose expertise has come from experience rather than formal education in Western disciplines. (p. 170)

Collaboration with others outside the school setting is vital to creating a cross-cultural team approach of coordinated and comprehensive service to Cambodian refugee children and families. Planning of programs should involve Cambodian families, local county refugee health and mental health providers, Cambodian leaders in the resettlement community, religious leaders and traditional healers, and counselors from Cambodian cultural associations. An overall goal for programs should be the collaboration of resources, ideas, skills, and knowledge so that services from these groups and agencies could be developed in a holistic and integrated manner, incorporating traditional Cambodian folk healing and Buddhist spiritual practice. Cross-cultural teams should include bilingual and bicultural professionals and paraprofessionals from the fields of health, psychology, and sociology, as well as Cambodian community liaisons and outreach workers.

TRANSCULTURAL RECIPROCITY IN THE RESEARCH PROCESS

The researchers set out to study transcultural reciprocity between participants and Cambodian families. However, transcultural reciprocity also occurred during the research process itself on different levels. Spiraling transcultural reciprocity was experienced in interactions between the Cambodian and non-Cambodian nurse authors as they came to know one another. Transcultural and intracultural reciprocity were experienced in both focus groups as moderators and participants interacted. In the liaison focus group, the Cambodian nurse moderator used the terms Meng and Bong when addressing the liaisons. As trust developed, the liaisons brought up sensitive topics such as domestic violence, child abuse, depression, PTSD, and family planning. At the end of this focus group, the liaisons extended an invitation to the

moderators to come see the Cambodian New Year festivities, and they indicated that they wanted to stay in touch. In the school nurse focus group, the nurses began asking the Cambodian assistant moderator questions about the local Cambodian community. In that interaction, one could directly observe the school nurses increasing their cultural knowledge of Cambodians.

Validity and Reliability

Validity and reliability were sought through the moderators' encouragement of respondents to share their experiences honestly and through solicitation of differing perspectives and viewpoints from within the focus groups. Validity was sought by asking the participants to share stories of their actual experiences. Focus group research results are not intended to be generalized but are instead gathered to understand a topic in an in-depth way (Krueger, 1998). Rather than generalization, nurses may want to consider Krueger's concept of transferability when reflecting on the use of these findings in other settings.

Though Dobson's (1989) conceptual framework provided a basis to the interview guide that was used to explore the experiences of school nurses and liaisons caring for Cambodian families, the attempt was made to keep questions open ended, in an effort determine whether the participants would describe interactions suggestive of transcultural and intracultural reciprocity. The words *transcultural reciprocity* and *intracultural reciprocity* were not used by the moderators during the focus groups; nor were Dobson's (1989) conceptual framework of transcultural health visiting and the spiraling dimension of reciprocity put forth to the groups. Yet, participants described experiences that seemed to reflect the spiraling dimensions of transcultural and intracultural reciprocity as proposed by Dobson.

Limitations

Through directing the research to look for insights into the concepts of transcultural and intracultural reciprocity, the authors may not have been as open to other concepts arising from the data regarding the nature of the participants' interactions with Cambodian refugee families. In retrospect, serving Cambodian refreshments at the school nurse focus group relayed the school nurse moderator's bias of transcultural interest and empathy toward Cambodians. This bias may have limited the types of information and viewpoints shared by the nurses. In addition, they may have been hesitant to share issues in the presence of the Cambodian nurse assistant moderator. A similar inhibitor may have existed in the presence of the non-Cambodian school nurse assistant moderator with the Cambodian liaison focus group.

RECOMMENDATIONS FOR FURTHER RESEARCH

There is a need for further research into the concept of transcultural reciprocity as experienced by nurses who work with Cambodian refugee children. Continued study in this area may yield information to help nurses establish meaningful relationships with Cambodian families and transcend cultural differences. The exploration and description of transcultural reciprocity with families from other cultural backgrounds is also encouraged.

Although there is a wealth of information regarding the psychological health of Cambodian refugee children and adults, current information regarding their general physical health is often grouped under a more generalized heading of Southeast Asian refugees, which would include refugees from Laos and Vietnam. Clinicians are in need of comprehensive studies of the status of Cambodian refugees' health that utilize Cambodian explanatory models, in addition to a Western biomedical view. Involvement of Cambodians as coresearchers is essential. According to Muecke (1992), "Participatory research is necessary to help reduce the power differentials between researchers and refugees that silence the authentic voices of refugees" (p. 521).

FINAL REFLECTIONS ON TRANSCULTURAL RECIPROCITY

Transcultural reciprocity provides a realm of experience awaiting exploration by nurses. Health care workers who care for Cambodian refugees have the opportunity to bring their clinical expertise and cultural sensitivity to their encounters. In turn, Cambodian families may choose to share the wisdom of their unique history, life stories, health practices, and beliefs. Engagement in the spiraling dimension of transcultural reciprocity may uncover jewels of healing wisdom for those refugees and nurses who dare to participate.

The horror and pain that thousands of Cambodian refugee children experienced is at times beyond imagination. They witnessed the execution of family members, suffered torture and forced labor, and endured poverty and starvation. Such traumatic events in their life stories placed them at physical and psychological risk. Yet "'risk' is not destiny, and children can and do overcome adversity" (Athey & Ahearn, 1991, p. 4).

Just as we admire a beautiful lotus flower that blooms above muddy waters, so too can we behold the gentle, pure, and untouched nature of Cambodian refugee children rising above their painful past. As nurses we have the opportunity to respond to the pain of Cambodian refugee children from their own Buddhist perspective, believing that great suffering offers us the opportunity to respond with great compassion.

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Protegiendo Nuestra Comunidad: Empowerment Participatory Education for HIV Prevention

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To be effective, HIV/AIDS interventions must be culturally and linguistically appropriate and must occur within the context of the specific community in which they are delivered. In this article, the development of a culture-specific lay health advisor (LHA) program, Protegiendo Nuestra Comunidad, for recently immigrated Mexicans is described. This program is one component of a collaborative inquiry research project involving community participants and researchers working as partners in carrying out and assessing a program for the prevention of HIV/AIDS. The collaborative inquiry process was applied as an empowerment philosophy and methodology of Paulo Freire and an ecological framework was used for the development of Protegiendo Nuestra Comunidad. The use of principles of empowerment for curriculum development, teaching methodology, and program delivery are described.

To be effective, HIV/AIDS interventions for Latinos need to be culturally and linguistically appropriate and occur within the context of the specific community in which they are being delivered (Dearing, 1996; Janz et al., 1996). The U.S. Latino population is estimated to be only 11%, yet Latinos represent 18% of reported AIDS cases (Centers for Disease Control, 1999). Despite the tremendous need suggested by the disproportionate burden of AIDS among Latinos, there is a recognition that large segments of this population are difficult to reach and are underserved by HIV/AIDS prevention programs (Flaskerud & Kim, 1999). Furthermore, programs that fail to incorporate Latino cultural values and beliefs about HIV/AIDS are unlikely to be successful (McQuiston & Flaskerud, 2000).

In this article, we describe the development of a culture-specific lay health advisor (LHA) program, Protegiendo Nuestra Comunidad (Protecting our Community), for Mexicans recently immigrated to North Carolina. This training program is one component of a collaborative inquiry research project for the prevention of HIV/AIDS. Collaborative inquiry is a research methodology in which community participants and researchers work collaboratively as partners (Flaskerud & Nyamathi, 2000; Reason, 1988). In the development of Protegiendo Nuestra Comunidad, we applied the collaborative inquiry process in the context of an empowerment philosophy and methodology of Paulo Freire (1970, 1973) and an ecological framework (McLeroy, Bibeau, Steckler, & Glanz, 1988) to improve the accessibility of HIV/AIDS information to the Mexican immigrant community. It is our hope that by sharing our program development process, we can assist others in the development of culture-specific programs/interventions and encourage them to share their methodologies for cultural specificity. We view what we have learned about working with a community and program development as a resource to improve the accessibility of information for vulnerable populations, and we encourage others to share their learning.

LITERATURE REVIEW

LHA Programs: Accessing Vulnerable Communities

LHA programs originated in the 1970s to address a variety of health problems affecting communities (Earp et al., 1997). These programs train *natural helpers* in the community to inform, educate, and provide social support about health issues to members of their social circles. Natural helpers are trusted community members to whom others turn for advice and assistance (Israel, 1982). LHA programs are designed to use existing social networks of trusted friends to informally disseminate health promotion information and support in their communities.

LHAs assist community members by providing different types of social support including the following: (a) giving information and making referrals, (b) showing trust and concern, (c) providing tangible assistance such as making appointments or taking someone to the clinic, and (d) providing feedback about health care concerns or decisions (Eng & Young, 1992). Through these mechanisms, LHAs provide needed advice to vulnerable groups that might be hesitant or unable to access information and support from health care providers (McQuiston & Uribe, 2001).

LHA Programs: Cultural-Specificity

LHAs provide culturally appropriate support for community members because they are cultural insiders within the communities in which they interact and serve. They know what the community believes about health and illness and how to provide support in culturally appropriate ways (Earp et al., 1997). Garro (1994) referred to beliefs about illness as cultural models. It is important to note that cultural models frequently differ from the beliefs of professional health care providers (McQuiston & Flaskerud, 2000). Through LHA training, not only do the LHAs learn professional beliefs or models of illness, but also gain knowledge of the cultural and professional models of illness, which allows them to address community concerns based on their own beliefs while also providing key information from professional models. For example, in the area of HIV/AIDS, Latino views about prevention may be based on beliefs of casual transmission (Biddlecom & Hardy, 1991; McQuiston & Flaskerud, 2000). Beliefs of casual transmission include transmission via toilet seats, mosquitoes, saliva, and dirty objects such as silverware and cups. However, the professional model for HIV transmission is based on a biomedical belief system including transmission from mother to baby, from blood (including syringes), and sexual intercourse (Flaskerud, Uman, Rosa, Romero, & Taka, 1996). An understanding of both belief systems allows the LHA to discuss HIV/AIDS from cultural, community, and professional model perspectives.

Collaborative Inquiry: An Empowering Methodology

Collaborative inquiry focuses on (a) empowering participants, (b) collaborating through participation, (c) acquiring knowledge, and (d) building community capacity (Reason, 1988). Collaborative inquiry attempts to level the balance of power between academicians and participants in research programs and is particularly important for marginalized or vulnerable groups (Flaskerud & Nyamathi, 2000). Collaboration gives community members a voice and a role as decision makers in program development and ensures that the cultural and community context are included within the program/research (Reason, 1988). It also acknowledges community members as cultural and community experts. This serves to empower participants as well as ensure the cultural specificity of the program. The process of collaboration involves meetings with community members and researchers as equal stakeholders to identify community problems and potential solutions. Potential solutions might, for example, include programs desired by the community such as types of content and methodology. Collaboration continues through program delivery and evaluation (Reason, 1988). This article demonstrates the use of an empowerment approach involving community members who shaped the program, offers important criticism of its content and methods of delivery, and serves as a coach, helping to evaluate each session of the LHA training and shape its future.

THE PROGRAM: PROTEGIENDO NUESTRA COMUNIDAD

Program Goals and Objectives

Protegiendo Nuestra Comunidad was a 7-week 21-hour culture-specific, community-based program conducted in Spanish (see Table 1 for session content). Cultural specificity refers to a program that seeks not only to include the cultural values and beliefs of the recipients but also to go a step further by providing relevance within the context of the participants' everyday life and the community in which they live. The goal of the program was to provide a setting and experiences that would lead to empowerment of the LHAs, who in turn would help community members promote sexual health and prevent STDs including HIV/AIDS. Specifically, it was expected that the LHAs would disseminate the information they learned in the program to their family, friends, and coworkers and, if needed, refer them to the clinic for additional information, testing, counseling, or treatment.

LHAs: Program participants. We recruited participants through contacts in the Latino community and through a local Latino center and a Latino disco (see McQuiston & Uribe, 2001, for a detailed description of the recruitment process). Eighteen LHAs, ranging in age from 19 to 39 years, completed the training. Of the participants, 15 were married,

TABLE 1
Mapping the Participatory Sessions for Content and Approach

Order	Session 1: Role of LHA	Session 2: STDs	Session 3: HIV	Session 4: Testing and Resources	Session 5: Protection Options[a]	Session 6: Cultural Values and Roles	Session 7: Goal Setting
Activity 1	Where are you from? icebreaker	Name that STD and common Mexican names for STDs	HIV facts presentation and group discussion	Skit	Condom demonstration	Brainstorm characteristics of Mexican men and women and discussion	How to plan for a first communion
Activity 2	Catalina, an LHA story telling and discussion	STD facts presentation by facilitator	Video: telenovela and discussion	Sequencing HIV steps with pictures	Practice putting condom on wooden penis	Role reversal game and discussion	Planning and evaluation for LHAs' 1st month
Activity 3	Mapping social networks of group	STD facts game in 2 teams	Modes of transmission game with props	Slide show: who is at risk	Demonstration of needle cleaning	Evaluation[b]	Certificates and group photo
Activity 4	Group confidentiality pledge	LHA practice in skits with volunteer actors	How to bring it up role play with discussion	Call SIDA[c] hotline as group	Women: puppet show on condom barriers		
Activity 5	Evaluation[b]	Role-play talking to a friend about STDs	Evaluation[b]	Role plays	Women: brainstorm protection options		
Activity 6		Evaluation[b]		Evaluation[b]	Men: role-play protection options		
Activity 7					Men: brainstorm condom barriers		

a. Men and women had separate sessions.
b. Evaluation: Questions at the end of sessions about how specific information could be disseminated to community members and how the LHAs would know whether the information had been successfully received.

1 was separated, and 2 were single. The education range of the participants was from no formal education to 16 years with an average of 7.7 years. All the participants were Mexicans who planned to remain in the United States. The level of acculturation to U.S. culture was measured with a 12-item 5-point Likert-type scale with 1 representing *low* and 5 representing *high adaptation*. The average level of the participant's adaptation to the United States was 1.7 (*low*) with a range of 1 to 2.83. The participants were paid for the 7-week training but were not paid for serving as LHAs in the community.

Empowering Strategies for Health Education

The combined stresses of poverty, racism, minimal acculturation, geographic separation from families, and the threat and reality of HIV create substantial pressures that may contribute to Latinos' perceived lack of control over life events and personal and social health. Wallerstein (1992) contended that a lack of control, often generating a sense of powerlessness, is a risk factor for disease and that empowerment education is necessary to effectively promote health.

Empowerment education, rooted in the philosophy of Brazilian educator Paulo Freire, is a methodology in which groups identify problems, critically analyze the roots of the problems, and develop strategies to positively change their lives and their communities (Freire, 1970, 1973; Wallerstein, 1992). This method encompasses three stages to stimulate critical thinking and change: listening, dialogue, and action. The use of a learning cycle of listening-dialogue-action (Freire, 1973) differentiates the empowerment education model from its teacher-focused counterpart.

Within the empowerment model, the educational process begins with a phase of systematic listening used to learn the issues about which community members have deep concerns (Hope & Timmel, 1995). The second phase, or dialogue phase, uses a problem-posing method to help participants analyze their problems. Empowerment education is participatory and focuses on learners as active participants in a dialogue of equals with the teacher rather than as passive objects trying to absorb expert knowledge (Beeker, Guenther-Grey, & Raj, 1998; Wallerstein & Weinger, 1992). Because

the problems for discussion come from the community, not the expert teacher, they are embedded within a familiar socioeconomic, cultural, and political context. Thus, the learning cycle of listening-dialogue-action is the basis for the self-motivated acquisition of knowledge and critical examination of the underlying causes of problems (Wallerstein & Bernstein, 1994). In the third and final phase, the action phase, the facilitator uses structured dialogue to help participants identify and reflect on the actions needed to address problems individually and socially within the community. Empowerment is a result of this interactive process of individual and community change.

An Ecological Framework

Key to the empowerment approach is the recognition that individual and interpersonal thoughts, feelings, and actions are embedded in and interactive with the social, economic, and political context in which people live. In turn, within this approach, each of these factors or levels needs to be addressed for substantive community change (Sallis & Owen, 1997). Considered in this framework, the prevention of HIV transmission among Latinos must be viewed within a complex of multiple levels of knowledge, beliefs, attitudes, and behaviors or actions. Accordingly, an ecological systems perspective is needed to understand the interrelationships of behavior or action at individual, interpersonal, organizational, and community levels and the broader social context in which people live (McLeroy et al., 1988; Minkler & Wallerstein, 1997). In keeping with these views, there are three underlying assumptions of the ecological model. These are the following: (a) health is influenced by multiple factors of the physical and sociocultural environment, (b) these multiple factors and the environment interact, and (c) prevention is most effective when coordinated across levels (individual or intrapersonal level, family or interpersonal level, and community).

APPLYING THEORY TO PRACTICE

The Listening Phase: A Collaborative Process

Our research team used the ecological framework to guide observations and ethnographic methods and data collection as we entered the community (Agar, 1980). We collected data on multiple levels including the intrapersonal, interpersonal, and community levels. This data was used to inform program development. Community entry was facilitated by a partnership between the university-based research team and a local Latino center. This partnership grew out of the primary author's involvement with the Latino center over a 3-year period before the development of the program. Team members worked at or attended numerous community events including Latino health fairs, yard sales, religious celebrations (e.g., posadas and processions for the Virgen de Guadalupe), parties, el Dia de los Muertos, and el año nuevo.

Team members also volunteered at the local Latino center and attended meetings of a local Latino coalition and women's group, Café de Mujeres. Through these activities, we interacted with many agencies, groups, families, couples, and individuals. Participation in these events allowed team members to observe cultural practices and community interactions and to become trusted friends. Furthermore, these observations allowed the bicultural research team to deepen their understanding of the immigrant Mexican population in the community of interest.

In addition to attendance at community events, team members conducted focus groups as well as structured and semistructured individual interviews with community members (Krueger, 1998). These experiences helped team members learn the community beliefs about STDs/HIV within the context of the community (McQuiston, Doerfer, Parra, & Gordon, 1998; McQuiston & Flaskerud, 2000; McQuiston & Gordon, 2000). We also learned about the community's desire for an HIV prevention program, the type of program desired, and their preferences for presenters (ethnicity, gender, and educational preparation).

We developed the LHA curriculum based on what we observed and heard in the community as we began to understand the interpersonal factors that could influence protective practices for STDs/HIV. We learned that individual beliefs about HIV transmission varied and appeared to be influenced by education and acculturation. We identified a cultural model of HIV transmission (see McQuiston & Flaskerud, 2000, for an in-depth discussion of this model), and we repeatedly checked for accuracy of the model through interviews with community members. We used this same process to identify and verify community beliefs about prevention. In addition to identifying health beliefs at the intrapersonal level, we also explored individuals' perceived desire or ability to change: for example, to use condoms, to avoid high-risk behaviors, or to go for STD or HIV testing.

On an interpersonal level, we asked community members about the perceived ability to introduce condoms into a relationship or to ask a partner to be tested. We learned that there are many married men working in North Carolina who have left their families in Mexico and that inexpensive sex workers are readily available. We found that condom use varied, but most men believed that it was a good idea to use condoms with sex workers. We also spoke with women. Some of the women told us they were learning to drive and working outside the home and that men were often threatened by this independence. However, this change in status did not appear to translate into women asking men to use condoms in their relationships.

Curriculum Development

Objectives: Empowering strategies. Based on the listening phase and review of existing LHA and HIV/STD curricula (Bird, Otero-Sabogal, Ha, & McPhee, 1996; McDonald,

Randall-David, Ackerman, & Eng, 1999; Pérez-Stable, Otero-Sabogal, Sabogal, & Napoles-Springer, 1996), we identified major topic areas for the training. These topic areas became the main themes for the LHA training sessions. The session titles were (a) The Function and Role of the LHA, (b) Transmission and Prevention of STDs, (c) Transmission and Prevention of HIV, (d) HIV Testing and Resources, (e) Protection Options, (f) Cultural Values and Roles, and (g) LHA Goal Setting. During the curriculum development stage, we also developed general objectives to guide the training. Examples of these general training objectives included the following: to increase knowledge about HIV, to increase communication skills as LHAs, to provide opportunities for participants to practice new skills, and to develop a safe training environment that would foster dialogue within the group.

In addition to information, objectives for empowerment education focused on attitudinal change and the development of social action skills. There were four types of empowerment learning objectives: (a) informational, (b) behavioral, (c) attitudinal, and (d) social action (Wallerstein & Weinger, 1992). Informational objectives pertained to increasing participant knowledge during the training. To establish a common base of understanding, the first three training sessions for Protegiendo Nuestra Comunidad emphasized the provision of information. For example, in these sessions, objectives included learning about the role of the LHA and modes of transmission and methods of prevention for STDs including HIV/AIDS. Behavioral objectives pertained to increasing participant skills and competencies. Our LHAs needed to develop and practice bringing up sensitive topics. We emphasized behavioral objectives throughout the training such as developing communication skills to introduce and discuss HIV in various social settings. Attitudinal objectives focused on increasing self-awareness of personal feelings and beliefs about a topic. For example, these objectives focused on increasing awareness of sociocultural expectations of men and women and on gaining insight into attitudes toward people who have HIV/AIDS. Social Action objectives focused on analyzing problems, identifying solutions, and developing steps for action (Wallerstein & Weinger, 1992). Social action objectives were included in all the sessions. For example, during each session, we asked participants to identify what information would be useful to share with community members, how they would share the information, and how they would know if what they had done was successful (these activities are listed as *Evaluation* in Table 1).

In addition to the empowerment learning objectives, we developed main messages (or central themes) for each session designed to help participants focus on essential ideas. Main messages were included in the participant manual, written on flipcharts, read aloud at the beginning of the session, and repeated in various ways throughout the session. We developed some main messages based on issues and familiar concepts people raised. For instance, we related cancer, a well-known topic in Mexico, to HIV in this main message:

> HIV is very different from other STDs. HIV is a silent disease and in some ways similar to cancer, in that it can be deadly. Like many types of cancer, there is no cure for HIV, and medications are costly and difficult to take.

Teaching methodology: Addresses multiple learning styles. We developed specific activities based on program objectives and main messages. We also designed each session to accommodate different learning styles. According to Kolb (1984), individual participants have relied primarily on one of four styles of learning: concrete experience (CE), reflective observation (RO), abstract conceptualization (AC), or active experimentation (AE). These styles are also viewed as stages in the multiple cycles of learning, action, and reflection.

The training provided opportunities for participants to engage in all four learning stages. For example, participants who learn best by CE learn by being involved with others in experienced-based, intuitive problem solving based on specific examples (Kolb, 1984). To accommodate this type of learning, we relied heavily on small group activities involving participant discussions and collaborative problem solving.

Learning through RO involves watching, listening, and considering different perspectives before making judgments (Kolb, 1984). For this type of learning, we provided activities such as puppet shows, slide presentations, a *telenovela*-style video, and a fictional story acted out by group participants. Learning through AC involves the analysis of ideas, planning and developing ideas to solve problems, and an orientation to detail. To accommodate this type of learning, we developed large group discussions following role plays and skits. We also developed problem-posing questions for each session to promote critical analysis, planning, and action. AE requires learning by doing. For these learners, we included skits, role plays, and hands-on activities to provide participants with opportunities to learn through experimentation with the ideas that had been presented or developed. For example, for one activity we used a speakerphone to call the Spanish language AIDS hotline. This allowed participants to directly ask questions of the counselor.

After we developed the curriculum and planned its activities, we mapped the activities across sessions to ensure that we had created an appropriate balance of activities to address all four learning styles. Once the content and activities were appropriate, we focused on methods to stimulate structured dialogue.

The Dialogue Phase: Using a Freirian Approach

Popular approaches to adult education create experiences that promote advancement through cycles of learning and action that are intended to lead to desired social change

(Arnold, Burke, James, Martin, & Thomas, 1991). Progression through these learning cycles is facilitated by structured dialogue based on participants' examination of representations of their shared problems and circumstances. Within the Freirian approach to popular education, the use of discussion triggers to facilitate dialogue is referred to as problem posing (Hope & Timmel, 1995; Wallerstein, 1994). Triggers may be scenarios, stories, or other representations that are designed to relate to themes or issues of central importance to participants. For example, we used short videos, pictures, and stories derived from what people told us in the listening phase as triggers to elicit conversation. Therefore, the triggers represented the participants' problematic life situations.

Following the presentation of the triggers, we led participants through a stepwise sequence of questions designed to create structured dialogue focusing on problem identification and analysis and development of steps for action (Wallerstein and Weinger, 1992). First, we asked participants to describe what they heard or saw in the trigger. Next, we asked questions to help participants examine their feelings elicited by the trigger. Following this dialogue, we asked participants to think about and discuss what the trigger meant to them. Last, we asked people to consider what actions they could take to create needed community change and what their roles as LHAs could be. The following example demonstrates one of these triggers and structured dialogue.

We edited "Ojos Que No Ven" (Eyes That Do Not See) (An Adinfinitum Films Production, 1987) to 15 minutes. "Ojos Que No Ven" is a *telenovela*-style video about the transmission and prevention of HIV. The trigger was used to help participants discuss cultural values and traditional sex roles in relationship to transmission. There were multiple scenes in the video including a man with a pregnant wife and a girlfriend on the side, a drug user, and a married man who had sex with men. All these characters were linked through their social relationships. A discussion using problem-posing questions followed the video, using the steps and questions listed below.

> *Problem Description*: What scenes struck you the most? Describe what was happening in the scenes that you mentioned.
> *Reactions/Feelings*: What about these scenes struck you? What were some of the problems or issues the men and women in the video had to deal with?
> *How's, Why's, and Implications*: How do you think HIV could be spread in that community? Do you think the people in the video are like other people you know in your community? Does the video hold true to what you have seen or heard from Latinos around you? What does this mean for your community?
> *Possibilities for Action*: How can LHAs address some of the cultural and gender issues related to sex, STDs, and HIV? How will these issues affect our discussions [as LHAs] with community members?

Addressing literacy: Using props. Literacy was a major concern for this training as we developed the curriculum and as we delivered the training. Therefore, we attempted to develop activities that were suitable for participants with lower levels of literacy without compromising the intellectual stimulation for participants with higher levels of literacy. To do this, we developed activities that used pictures or objects as well as words to represent ideas while requiring very little reading, yet providing reading opportunities for literate participants. For example, within an activity about modes of HIV transmission, facilitators provided written messages on a flipchart and elicited discussions by presenting participants with various objects that could or could not transmit HIV. The objects included a toilet seat, a paper-mâché mosquito, plastic lips, a syringe filled with red coloring, utensils, a manequin's hand, pictures of a pregnant woman, and a picture of two people talking about having sex without a condom (see Figure 1). Participants then told the facilitator to put objects in two piles representing true and false modes of transmission respectively.

We also addressed literacy concerns in the design of the participant manual. We kept words and sentences simple and used large fonts and spacing. In addition, whenever possible, we included pictures and visual icons next to the text (Szudy & González Arroyo, 1994).

The Action Phase: Planning LHA Involvement in the Community

In keeping with the tenets of collaborative inquiry, empowerment education, and LHA programs, we involved participants in goal setting and evaluation. Therefore, in addition to including participants in identifying action steps related to the use of the information in the community, we devoted the final training session to goal setting and evaluation for the LHAs' 1st month in the field. We used a simplified adaptation of the theory of change approach to evaluation (Connell & Kubisch, 1998) to help the group work through the process of short- and long-range goal setting and evaluation. To do this, we provided the group with a model exercise in which they planned a first communion. A very important event in the Latino community, a child's first communion requires short- and long-term planning. Participants knew what was necessary to plan a first communion and how they would know if it was a success, that is, its evaluation. Following this exercise, they were able to transfer the planning process to planning for their 1st month as LHAs. This process of goal setting and evaluation continued during our monthly follow-up meetings and provided the LHAs with opportunities to assess how they are doing in informing community members about HIV prevention using their own collectively developed criteria.

LESSONS LEARNED

Session coaches (i.e., participants who gave feedback to the facilitators at the end of each session) provided largely
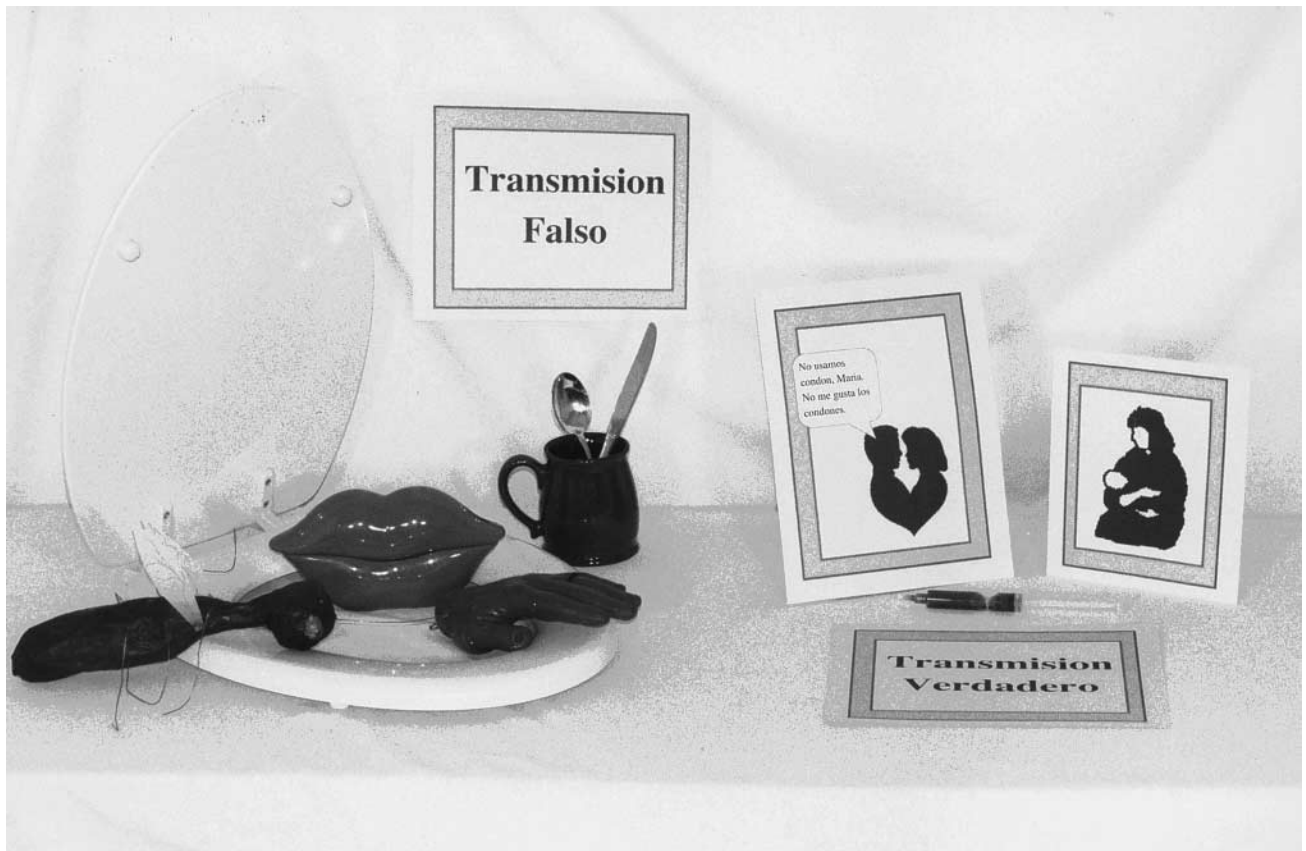
FIGURE 1.   Props used during HIV training depict false transmission (located by props used for casual transmission) and true transmission (located by the props representing biomedical modes of transmission).

positive critiques of the training. For example, when asked about the appropriateness of activities, one coach said, "The skit was my favorite, you could ask questions after each scene." Another coach reported positively on the didactic summary of STDs and the discussion that followed. Coaches also commented favorably about being able to openly discuss topics that were not typically discussed in the Latino culture.

Men and women participated together for the majority of the training. However, for some small group activities, men and women first worked separately before coming together for group discussions. The coaches felt that separation for some activities was appropriate. One session, which was entirely separate, covered protective options (barriers and facilitators to condom use, how to bring it up in relationships, and practice putting a condom on a wooden model). For this session, the male coach said, "It was good to separate the men and women for this topic because I would not have had the confidence to tell my own experiences in front of them." The coach for the women agreed that separation was necessary for this topic.

Participants appeared to be very comfortable and able to actively discuss all the topics covered. However, they were less comfortable in one session. Our observations during the

session covering sex roles and traditional values (Cultural Values and Roles—Session 6) suggested that role reversal for men and women (a skit to address traditional gender norms) was difficult for the participants and may have made people uncomfortable. The coach for this session noted that participants were not being serious during the role play. This lack of seriousness was not evident in prior sessions, and we believe it was a reflection of participants' lack of comfort with the exercise. Our Latina observer/note taker said, "This is an excellent exercise—a good example of what happens in real life and how information has to make it through the gender barrier." However, another less threatening exercise might be more useful. Before the role reversal, participants broke up into small groups to list traditional characteristics of men and women. The small-group work and discussion that followed may be sufficient to address some of the traditional gender and cultural norms that play a part in negotiations for protective practices.

Participants began to practice their roles as LHAs during the training. They were given homework assignments asking them to practice what they were learning with a friend or family member. They were able to bring their experiences back to the group for discussion and problem solving. This offered an

opportunity for the group to provide support for its members and for the research team to get a sense of how the participants were functioning in their new role as LHAs.

Implications for Clinical Practice: Suggestions

We believe that assessing the literacy level of the immigrants with whom you are working is imperative for the success of any program/intervention. Assessment of literacy is important whether your clinical practice focuses on the individual, group, or community level. We had, for example, several participants with 8 to 9 years of education who were semiliterate. Providing written information, be it how to prevent AIDS or how to take medication, may be disempowering, useless, or dangerous.

We also found that community members were actively interested in learning about how to prevent HIV and in sharing information with others. We did not encounter a fatalistic view of illness (*fatalismo*) frequently associated with Latinos (de la Vega, 1990). We believe that community members want and need information about how to maintain health and prevent illness. It is our challenge as nurses to make this information culturally and linguistically accessible.

Implication for Research: Suggestions

This article demonstrates the use of an ethnographic approach to collaborative inquiry for the development of a culture-specific curriculum for LHAs. Although an empowering process is particularly important for vulnerable groups who are typically excluded from decision-making processes, it is time-consuming and challenging. Literacy, education, and the cultural value of *simpatía*, i.e., the notion that maintaining social relations is more important than covering content (de la Vega, 1990), required skill and reassurance from the facilitators that we really did value and want the opinions of community members. However, the idea of working collaboratively for the good of the community seemed to be a good cultural fit. Indeed, *compadrazgo*, the notion that relationships include the responsibility of individuals to care for others (Bird et al., 1998), seemed to resonate with community members with regard to the LHA concept and the collaborative process of working together.

Although this is a labor-intensive method, it is exceedingly important as a strategy for empowering vulnerable populations and fits well within the paradigm of qualitative research (Flaskerud & Nyamathi, 2000). A major challenge for the future includes the development of appropriate means for participants and academicians/researchers in the community to work collaboratively in evaluating the processes and outcomes of this approach.

CONCLUDING COMMENTS

Protegiendo Nuestra Comunidad demonstrates how a philosophy of empowerment can guide curriculum development, teaching methodology, and program delivery. Community collaboration and commitment is necessary for and facilitates the development of such a program. We are presently in the process of training two of the LHAs to become peer trainers for future LHA training programs in this community. In keeping with the philosophy of empowerment, this will allow the program to continue under increasingly greater control of members of the community.

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Factors Associated With Mammography Utilization Among Jordanian Women

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This descriptive study aims at assessing beliefs and identifying factors that contributed to the utilization of mammography among a group of Jordanian women. Champion's Revised Health Belief Model Scales (HBMS) is the conceptual framework of this study. It was translated and adopted as the self-administered questionnaire utilized for the purpose of this study. The convenience sample was drawn from the women who had a mammography at a private radiology screening and diagnostic clinic in Amman over a 3-month period. Bivariate and multivariate analyses of the study variables were conducted. The results unveiled women's older age, hearing or reading about mammography, and receiving information about breast tumors from friends as factors predicting current mammography practice. Variables predictive of past mammography practice were related to the women's family or personal history of breast tumors and information about breast tumors from the media, in addition to information about mammograms from family members.

Jordan is a Middle Eastern country with a population of more than 4.5 million. The total fertility rate for the mid-1990s was approximately 5 children per couple, which is considered one of the highest in the region. Life expectancy is 68 years: 66 years for men and 70 years for women. Of the population, 92% are Muslims and 87% are literate (Jordanian Department of Statistics, 1999).

Cancer is one of the major causes of death in Jordan, with breast cancer constituting 29% of all reported cases (Ministry of Health, 1999). Statistical data from the Jordan Cancer Registry (JCR) indicate that breast cancer is more prevalent among young women less than 50 years of age (Ministry of Health, 1996). Jordanian literature on breast cancer has indicated the existence of poor screening associated with lack of awareness about the disease and delay in the diagnosis of cancer (Btoosh, personal communication, July 21, 1997).

Early detection of breast cancer positively influences early treatment and contributes to a better survival rate (Coleman, 1991; Ludwick, 1992). Screening methods used to detect breast cancer at the early stages include self–breast examination done by the woman herself and mammography performed by a radiology specialist. In fact, mammography has proven to be the only effective and reliable means of detecting nonpalpable breast cancer (Fischera & Frank, 1994).

Similar to other early health screening programs in Jordan, mammography utilization is fairly low. The health care system in Jordan is a mixture of governmental health services and fee-for-service private care. Clients have access to medical insurance and can be either insured with the Ministry of Health Services or with private health companies. Medical health services range from highly complex and quality services at tertiary centers to the ritual healing services by religious personnel. The pattern of health care utilization appears to be eclectic. Overall, health screening activities are very limited because they are not included in the insurance packages. This is especially true for mammography screening for breast cancer. Although access to mammography appears to be available, many women do not use the services for various reasons. Most women believe that mammography is used only to confirm suspicion of breast cancer.

Literature Review

The Health Belief Model (HBM) has been utilized by several researchers in their investigations of factors that are associated with mammography (Erwin, Spatz, Stotts, Hollenberg, & Deloney, 1996; Fischera & Frank, 1994, Petro-Nustas, 2001; Savage & Clarke, 1996). Savage and Clarke (1996) randomly interviewed 170 Australian women, aged 50 to 70 years, over the phone for a period of 7 weeks. The authors assessed information on selected variables including demographics, perceived benefits of early detection of breast cancer, perceived barriers to mammography, perceived susceptibility to breast cancer, concern about breast cancer, previous health behaviors, access to screening, and knowledge of mammography. The major factors that motivated women to undergo a mammogram were associated with perceived susceptibility to breast cancer, knowing another woman who has had a mammogram, and previous history of mammography and Pap smear. These factors explained 47% of variances in mammography utilization by the women in the study.

Erwin et al. (1996) designed an educational intervention model, the Witness Project Model (WPM), that was drawn from the principles of the HBM and social learning theory. Social learning theory was used to address those factors that were not integral to the HBM and included concepts such as environment, expectations, reinforcement, learning styles, and self efficacy. The researchers concluded that culturally appropriate cancer education programs are capable of changing health behaviors. This change can be achieved by programs that accommodate existing beliefs of participants.

Fischera & Frank (1994) utilized the HBM to study the 145 American nurses' practices and teaching of patients about mammography. Of the participating nurses, 76% were compliant with mammogram screening guidelines whereas 34 were noncompliant. There were no significant differences between the compliant and noncompliant nurses with respect to such variables as age, licensure, level of education, positive family history of breast tumors, and clinical practice setting. Only 25% reported teaching their patients and informing them about mammography. These nurses mentioned that it did not occur to them to do so or that they simply felt unqualified to offer this sort of teaching. All participants, however, were convinced of the importance of educating nurses of the need for teaching women about performing periodic mammography screening.

In another study, Petro-Nustas (2001), Champion's translated HBM tool was adopted to assess the beliefs of a group of young Jordanian women toward mammography utilization as a screening measure for breast cancer. The convenience sample consisted of 59 women aged 18 to 45 years ($M = 29$, $SD = 7.9$) drawn from the women who were visiting one of the largest maternal and child health care centers in Amman. Of these young women, 76% percent were in agreement about the overall benefits of mammography. The most significant barrier to utilizing mammography, identified by approximately 50% of the women, was fear of detection of breast cancer. About 25% indicated that having a mam- mogram is an embarrassing procedure, and 30% identified cost as a barrier. The author recommended that special health education programs sensitive to Jordanian young women should be implemented to raise women's awareness about the importance of early screening for breast cancer.

Champion and Menon (1997) studied 328 low-income African American women to identify variables associated with the breast cancer screening practices of mammography and self–breast exam. Anderson, Aspegren, & Janzon's (1988) theoretical framework was used, which included variables on perceived susceptibility, benefits, barriers, confidence, knowledge, physician recommendation, demographic characteristics, past experiences and healthcare, and insurance information. Results revealed the following significant predictors of mammography utilization: perceived barriers, suggestions for mammogram by health care professionals, recent thoughts about mammography, and having a regular medical doctor.

In Singapore, Seow et al. (1997) conducted a study aimed at determining factors contributing to the acceptance and frequent performance of mammography screening among a selected group of women. A self-administered questionnaire was distributed to 300 attendees and 260 nonattendees. Participants were compared with respect to demographic characteristics, previous preventive behaviors, informal social support, and attitudes toward early detection. Results indicated that attendees were more likely to be Chinese than Malay or Indian, were working outside the home, had a history of Pap smears, and perceived themselves as susceptible to cancer. The strongest independent predictor of attendance was encouragement by the spouse or a family member.

In the United Kingdom, Valdini & Cargill (1997) investigated the barriers and frequency of breast cancer screening among New England women to compare those results with the goals of the Healthy People 2000 Screening Project. Completed questionnaires were returned from 2,943 women (200 African American; 2,222 White; 370 Hispanic; and 56 Asian). Of the women, 32% were between 40 to 49 years, and 68% were 50 or older; 70% had had a breast examination by a provider within the past 2 years. More women aged 50 or older had had a mammography during the past 2 years than did those who were younger. The most frequent reason given for not having had a mammogram was the thought that it was not that important. Other reasons cited were the relatively high cost of the procedure and the exclusion of mammography from medical insurance coverage. The investigators concluded that once the cost factor is removed as one of the barriers, patients' acceptance of mammography would subsequently improve.

Miller and Champion (1997) conducted a study of 1,083 church women (78% White and 22% African American) 50

years and older with no history of breast cancer. The study examined the effects of demographic variables (race, income, and education) on perceived susceptibility to breast cancer and the benefits of and barriers to mammography. The results identified higher susceptibility rates and lower knowledge scores for African American women. African American women were more likely to identify fear of radiation and worry about getting cancer as barriers to mammography. White women, on the other hand, were more likely to state cost of a mammogram as a major barrier factor. The researchers concluded that the significance of the cost factor suggests that access barriers remain despite increased use of mammography.

Purpose

This study assessed beliefs about mammography as a screening procedure for breast cancer and identified factors related to mammography utilization among a group of Jordanian women. No prior study has previously been done on the same topic in Jordan. This study examined the effect of certain factors as perceived benefits of and barriers to mammography among attendees at a private clinic for the screening and diagnosis of breast cancer.

Hypotheses

It is hypothesized that (a) a woman who perceives that she is susceptible to breast cancer and that the disease is a serious threat to her life is more likely to have a mammography, (b) a woman who sees more benefits and has encountered fewer barriers is more likely to attend a mammography, and (c) a woman who has enough motivation to take care of her own health is more likely to have a mammogram testing.

The Theoretical Framework

The HBM is the conceptual framework used in this study to better understand personal health-related behaviors. The model stipulates that a person's perception of a certain threat caused by a certain health problem influences his or her anticipated health-related behaviors (Becker, 1978). The HBM has four major concepts: perceived personal susceptibility to a health condition, perceived personal harm and seriousness of the condition, perceived (benefits) positive outcomes of an action, and perceived (barriers) negative aspects of an action (Rosenstock, 1966). Later, Rosenstock, Strecher, & Becker (1988) identified two additional concepts of the model: (a) health motivation—a person's belief and the degree of interest related to the general health, and (b) confidence—a person's successful execution of a behavior that will enable him or her to reach a desirable outcome.

METHOD

The study utilized a descriptive correlational design with a precoded self-administered questionnaire. Data was entered into the Statistical Package for the Social Sciences (SPSS) for analysis.

Instrument

Champion's (1993, 1997) revised Health Belief Model Scale (HBMS) was used after permission from the author was obtained. This tool was translated into Arabic and tested for its applicability to the Arab culture. The detailed description of the HBMS, its process of translation, and testing can be found in the author's other research article titled "Transcultural Adaptation and Testing of Champion's HBM Scales" (Mikhail & Petro-Nustas, 2001). After a panel of experts validated the translation, the instrument was back translated into English and pretested using a descriptive correlational survey design on a random sample of 519 female university students and employees in Jordan. The analyses included descriptive statistics, internal consistency reliability estimates, construct validity using factor analysis, and predictive validity using multiple regression analysis. The results indicated that the translated version of Champion's scales was found to be a valid and reliable tool for use in the Jordanian population (alpha coefficient range from 0.65 to 0.89).

For the purpose of this study, only three subscales of Champion's HBMS were used: mammogram benefits (six items), mammogram barriers (five items), and health motivation (seven items). Validity of these subscales was verified after translation and approved by three scholars from the University of Jordan who have adequate experience in tool construction and measurement. Susceptibility to breast cancer was measured using two questions relevant to the participant's family and personal history of breast tumors.

Cronbach's alpha of internal consistency was computed for each subscale. Values were then compared between each item of the subscales and the total scale. The subscales were found acceptable according to the following measures: subscale benefits ($M = 16.05$, $SD = 2.20$, $R = .38$), subscale barrier ($M = 11.56$, $SD = 2.19$, $R = .42$), and subscale health motivation ($M = 19.39$, $SD = 1.85$, $R = .69$).

The translated instrument was pilot tested on 20 participants who attended mammography sessions in the same clinic used as a venue for this study. This pilot study provided the investigator with an opportunity to rewrite and rephrase certain words or statements in the translated tool.

Sample

The sample consisted of 76 female attendees at one of the biggest private screening and diagnostic breast cancer clinics in Amman. Run by a female specialist in radiology, the clinic provides services to women of various socioeconomic levels, with or without medical insurance, from the various regions of Jordan. In fact, 56% of the study sample did not have any type of health insurance. The convenience sample comprised all women who attended the clinic over a 3-month period between March and June 2000.

Data Collection

A female nurse who worked as a research assistant in this study was trained beforehand in approaching women, explaining the purpose of the study, and obtaining participants' consent to participate. Oral informed consent was secured from all those who voiced willingness to participate. Respondents were assured about the privacy and the confidentiality of their responses and informed that data would be strictly used for scientific purposes. A self-administered questionnaire was distributed for participants to fill in the needed information during their presence at the clinic. The questionnaire consisted of two sections: demographics with information on family and personal history of breast cancer and 18 statements representing the three subscales of the instrument, with choices based on a Likert-type scale (1 = *strongly disagree*, 5 = *strongly agree*). Each instrument required approximately 15 minutes to complete.

RESULTS

Demographics

Participants' ages ranged from 15 to 69 years ($M = 43$, $SD = 11.9$). Of the participants, 9% were between 15 and 25, 16% between 26 and 35, 33% between 36 and 45, 26% between 46 and 55, and 19% between 56 and 69 years. In terms of education, 25.3% of the participants had 12 years of schooling up to the secondary level, 31% had a post–high school diploma or some university education, and 44% attended or were pursuing graduate studies. Of the participants, 21% were single, 70% married, and 9% divorced; 30% were working outside the house. Of the women, 28% indicated a positive family history of breast tumors in female relatives (9% mothers, 9% aunts, 5% cousins, 10% sisters, and 3% grandmothers), and 17% had a personal history of breast tumors. Reasons given for having a mammogram included recommendations by their gynecologist (50%), advice from general practitioner (11%), advice from friends and relatives (6%), and own decision (33%).

Practice, Knowledge and Sources of Information

Of the attendees, 54% stated that they had had mammograms before (47% for one year, and 23% for two years). The majority of the attendees, 95%, stated that they had heard or read about breast tumors before from mass media (63%), health team members (13%), and family and friends (18%); 85% heard or read about mammography from mass media (52%), health team members (20%), friends and family (21%), and other information sources (8%).

Participants' Health Beliefs

The participants' average responses to the items of the three belief scales of the instrument are summarized in Table 1. Of the participants, 82% perceived more benefits in undergo-

ing a mammogram versus 18% who either disagreed or were not sure about its benefits. Although 85% felt motivated to have a mammogram, 61% saw more barriers to having a mammogram whereas 13% were not certain about these barriers. All participants believed that doing a mammogram would help in the early discovery of any mass or lump in the breasts.

Relationship Between Beliefs and Mammography Practice

Pearson correlation values of the subscales demonstrated the presence of the following: (a) weak but rather significant correlation between the benefits subscale and the current practice of mammogram ($r = .17$, $p < .05$), (b) strong positive and significant correlation ($r = .38$, $p < .01$) between the benefits subscale and past practice (within the past 2 years) of mammography, (c) weak yet significant correlation between current mammogram practice and the motivation subscale ($r = .18$, $p < .05$), and (d) high correlation between motivation subscale and past practice of mammogram ($r = .23$, $p < .05$). The barriers subscale correlated highly but negatively with the current practice of mammogram ($r = –.60$, $p < .05$) and past practice of mammogram ($r = –.67$, $p < .01$), thus attesting to the fact that as barriers to mammogram increase, past and current practices also decrease.

Personal history of breast tumors ($r = .25$, $p < .04$), knowledge about breast tumors ($r = .026$, $p < .03$), and hearing or reading about mammograms ($r = 0.37$, $p < .001$) have all shown positive and significant correlation with current mammogram practice. Family history of breast tumors was the only factor that showed strong and significant correlation with the practice of mammography within the past 2 years ($r = .51$, $p < .002$).

Relationship Between Demographics and Other Independent Variables With the Practice of Mammography

The demographic variables (age, education, marital status, working status, personal history, and family history) and cues to action (health insurance, hearing/reading about tumors and mammograms, and source of information on tumors and mammograms) were tested for their significant associations with the dependent variable (the current practice of mammography and the past practice of mammography within the past 5 years). Chi-square tests were used to assess the independence of mammogram practice with each single independent factor. Table 2 shows that the variables of older age ($p < .0001$), hearing or reading about mammogram ($p < .002$), and family members as sources of information about mammogram ($p < .002$) had highly significant association with current mammography practice. Knowledge about tumors ($p < .03$), having friends as sources of information about tumors ($p < .03$), and personal history of breast tumors ($p < .04$) recorded significant associations with the current prac-

TABLE 1
**Percentages of Responses to the Health Belief Model
Subscales by Mammography Attendance**

Subscale	% Disagree	% Uncertain	% Agree
Benefits	11.0	6.8	82.2
Barriers	25.8	12.8	61.4
Motivation	5.7	9.9	84.5

tice of mammography. A much weaker association was noted between the current practice of mammography and married women ($p < .07$) and those women who identified newsletters as their source of information on tumors ($p < .07$). Neither education level nor work status showed any significant relationship with current practice of mammography. In contrast, family history of breast tumors ($\chi^2 = 9.29$, df $= 2$, $p < .01$) and family members as sources of information on mammogram ($\chi^2 = 6.50$, df $= 2$, $p < .04$) were the only two variables that showed significant association with past mammography practice.

Stepwise regression tests were performed to investigate the effect of all demographic and other independent variables simultaneously. Table 3 shows that a multiple $r^2 = 0.43$ was obtained with about 34% of the age variable ($f = 32.8$, $p < .0001$), accounting for the largest portion of the current practice of mammography. Moreover, participants' identification of friends as their source of information on breast tumors accounted for about 5% of the variance, and hearing or reading about mammogram accounted for another 4% of the variance in current mammography practice. On the other hand, Table 4 indicates that having a family history of breast tumors ($p < .0007$) and TV/radio as a source of information on breast tumors ($p < .0007$) have a significant contribution (20% and 16%, respectively) to the variance of past practice (within the past 2 years) of mammograms. Moreover, the stepwise regression analysis revealed that having a personal history of breast tumors accounted for 2% of the variance, and identifying family members as the major source of information on mammogram accounted for 1% of the variance. Thus, cumulatively, all variables did significantly account for about 55% of the variance concerning past mammography practice.

DISCUSSION AND CONCLUSION

This study showed the effects of a woman's older age, hearing or reading about mammogram, and receiving information on breast tumors from friends on current practice of mammography. Because more than half of the women (61%) indicated that they were having mammograms based on their medical doctors' advice, presumably these women are having mammograms for diagnosis of breast cancer rather than as a screening test. The older age of the participants ($M = 43$) indicates that they are at a much higher risk for breast tumors, thus, seeking information on breast tumors before attending

TABLE 2
**Results of Chi-Square Values for the
Demographic and Other Independent Variables
With Mammography Current Practice**

Variable	χ^2	df	p
Age	23.50	3	.0001
Education	2.76	2	.25
Marital status	3.25	1	.07
Working status	0.20	1	.64
Personal history	4.39	1	.04
Knowledge about breast tumors	4.91	1	.03
Friends as a source of information about breast tumors	4.86	1	.03
Newsletters as a source of information about breast tumors	3.12	1	.07
Heard/read about mammogram	9.94	1	.002
Family members as a source of information about mammogram	5.39	1	.002

mammography is a natural process after the medical doctors suspected presence of breast tumors. This observation supports the notion that mammography utilization in Jordan is restricted to being part of the diagnosis process for breast cancer.

Mammography, which has been identified in other countries as an important screening for early detection of breast cancer (Fischera & Frank, 1994; Savage & Clarke, 1996), is not used for the same purpose in Jordan. This is supported by the fact that breast cancer patients in Jordan are being diagnosed in the late stages of the disease (Dajani & Al-Jitawi, 1987). In 1997, 467 cases of breast cancer were diagnosed with 25% of the patients under the age of 40 (Ministry of Health, 1997). Approximately 25% of the attendees in this study were 23 years of age or younger. For such young women to attend mammography mostly based on a medical advice is an alarming finding that indicates that breast cancer is indeed affecting young women in Jordan. This is further supported by the findings reported by Petro-Nustas, Norton, and Al-Masarweh (in press) based on 100 cases of women with breast cancer examined in 1998. Thirty-seven percent were younger than 45 years of age, which is a different demographic pattern of age distribution from most Western countries. The authors contended that because cancer cells take between 8 and 10 years to be fully developed, these Jordanian women had breast cancer at a much younger age. Because early detection of breast cancer does improve the chances of treatment and survival (Jardines, Haffty, & Theriault, 1999), the above findings call for immediate utilization of sensitive and appropriate screening measures to detect breast cancer at an early stage. Therefore, national awareness programs with the objective of enhancing women's utilization of screening measures (such as mammography) should be encouraged. Past practice of mammography was found to be mainly influenced by the woman's personal and family history of breast

TABLE 3
Stepwise Multiple Regression of the
Demographic and Other Independent Variables
on Current Mammography Practice

Variable	R	R^2	R^2 Change	F	p
Age	.579	.336	.336	32.82	.0001
Heard/read about mammogram	.616	.380	.044	4.57	.036
Friends as a source of information on breast tumors	.653	.427	.047	5.15	.027

TABLE 4
Stepwise Multiple Regression of the
Demographic and Other Independent Variables
on Past Mammography Practice

Variable	R	R^2	R^2 Change	F	p
Family history of breast tumors	.444	.197	.197	8.34	.0007
TV/radio as a source of information about breast tumors	.597	.356	.159	8.16	.0007
Personal history of breast tumors	.682	.465	.108	6.47	.016
Family members as a source of information about mammogram	.741	.549	.084	5.80	.022

tumors. Consistent with the concepts of the HBM, a woman who feels susceptible to a serious condition (breast cancer) is more likely to perform action.

In another study (Petro-Nustas & Mikhail, in press), on factors associated with breast self-examination (BSE) among Jordanian women, it was found that most women were not practicing BSE simply because they did not feel themselves susceptible to having breast cancer. Evidence exists that belief in fatalism and the will of God are common among the various Arab cultures (Meleis & Meleis, 1998). Belief in fatalism may have contributed to a lack of perceived susceptibility and seriousness of the disease, which in turn affected the women's attitudes toward early detection (Petro-Nustas & Mikhail, in press).

In this study, the barrier subscale correlated strongly and negatively with both current and past practice of mammography. Fatalism could have been a factor for the attendees' perceptions of more barriers and perceptions of benefits of mammography. This fatalistic belief may have been a factor for the poor correlation between the benefits and motivation subscales in relation with current practice of mammography. When the study variables were tested simultaneously using stepwise multiple regression, neither subscale of benefits nor barriers was able to explain the variance in mammography practice. This finding may be congruent with Champion and Menon's (1997) observation of African American women who did not perceive benefits of mammography due to their pessimistic belief about whether surgery or treatment can restore health. The weak relationship between benefits and motivation may also support the cultural fatalistic view of cancer held by Jordanian women. This author suggests that the concept of fatalism and its influence on health practices be further studied within the context of Jordanian culture.

The same subscales (benefits and motivation), however, showed strong positive correlation with the practice of mammography within the past 2 years. This may indicate that because those women had survived the last mammogram, they feel motivated enough to have another one. In other words, their perception of the benefits of their past mammogram experience may have prompted them to go through another screening. This same explanation is congruent with Savage and Clarke's (1996) report that previous mammogram history significantly explains the current practice of mammography.

Most women significantly recognized the influence of friends and family members in disseminating such information and in encouraging them to have a mammogram. In some cultures, as in Jordan, the influence of media as well as friends and family members in shaping health behaviors is perceived as more important than is the influence of health team members. Seow et al. (1997) reported the same finding among Singaporean women. They concluded that, "For women in Singapore to be persuaded effectively to participate in mammography screening, it is important to convince family members of the benefits of the test" (p. 771). This calls for more research focusing on understanding the role of health workers, especially in early detection of diseases associated with high mortality, such as breast cancer.

The role that the media (TV, radio, and newsletters) play in keeping women informed about breast tumors and mammography was evident in this study. Receiving knowledge about breast tumors and mammograms from the media should be taken with caution. Media sources, though very widespread and convincing, may not provide accurate scientific information to the public. Information on sensitive topics, such as breast cancer, should be part of educational programs that are culturally appropriate. Such programs are likely to be effective in changing behaviors because cultural life ways are integrated in their design. Programs addressing culturally specific barriers to mammograms (fear of cancer and fatalism) should be encouraged to increase mammography utilization for screening purposes. They should focus on providing accurate information on breast tumors, emphasizing the importance of mammography in improving patients' chances of survival, and increasing women's confidence and knowledge. These recommendations are in agreement with what has been suggested by other researchers (Champion & Menon, 1997;

Erwin, et al., 1996). Erwin et al., for example, stressed the importance of developing culturally appropriate education programs that are able to change behavior by meeting the beliefs of women rather than by attempting to change their already existing beliefs. Furthermore, Champion and Menon (1977) emphasized the need for addressing culturally specific barriers to increase compliance with screening.

Only 13% of the attendees received information about tumors from health team members, and 20% were informed by their health provider about mammography. Likewise, Petro-Nustas, Norton, and Al-Masarweh (in press) found that only 18% of the cases reported that their physicians perform routine breast checkups for them. Because about 60% of this study sample received some kind of medical advice to attend mammography sessions, it is important that health care providers become aware of the need to suggest mammography to appropriate women. This thought is supported by similar recommendations by other researchers (Champion & Menon, 1997).

The most important predictors of current mammography practice that collectively explained 43% of the variance were women's older age and information about breast tumors and mammograms gained through personal effort or from friends. Information about breast tumors and mammograms and influence by family and personal history of breast tumor significantly predict 55% of the variance on past practice of mammography.

In this population, neither marital status nor having medical insurance was related to mammography. These results are similar to some of the findings of research on African American women (Champion & Menon, 1997). These findings reflect that among Jordanian women, utilization of mammography is associated with either their feelings of susceptibility (old age and personal or family history) or the knowledge they have about tumors and mammograms (provided by friends, family, or the media). The implication of these results are threefold: the need to address culturally specific barriers, such as the belief in fatalism, which influence perceptions of susceptibility and compliance with screening measures; the need to increase women's confidence in and motivation for mammography through specific education programs on benefits and cost effectiveness of screening for breast cancer; and the need to increase women's knowledge about breast tumors and screening measures, with special emphasis on mammograms, through consistent well-designed educational programs.

Study Limitations

There are some limitations inherent in this study. Participants were all chosen from one radiology clinic, which does not represent the entire population of women who attend mammography in Jordan. Participants were included out of convenience. Although there is a possibility of an acquiescent response, measures were taken to safeguard against this phenomenon by training the research assistant in data collection and allowing the participants to respond to the questionnaire in a special room in the clinic, thus limiting influence of others on their responses.

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Korean American Family Experiences of Caregiving for Their Mentally Ill Adult Children: An Interpretive Inquiry

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The purpose of this cross-cultural qualitative study is to describe and interpret the Korean American families' (KAFs') caregiving experiences for their mentally ill grown children. Seven KAF caregivers were purposefully sampled. In-depth audiotaped interviews were conducted in Korean, and Korean metaphors, images, and dreams were translated into English. This allowed for a rich explication of this study's complex caregiving phenomena. Five major themes were identified: (a) realization of children's illness, (b) battling the disease of incompetence, (c) poignant processes of caregiving, (d) suffering as a way of life, and (e) journey toward spirituality. In conclusion, incorporating transcultural nursing into core nursing curricula, recognizing the spiritual dimensions of care in nursing, and establishing culturally congruent community-based day treatment modalities and programs integrating other cultures are recommended.

Americans society is becoming more multicultural and is far from homogeneous (Ingoldsby & Smith, 1995). As such, health care organizations are treating ever more diverse clients. As of 1998, minority groups made up 28% of the U.S. population, and this percentage will increase to 40% by year 2030 (Gonzalez, Gooden, & Porter, 2000). Korean Americans are one of the most rapidly growing immigrant populations in the United States (Boult & Boult, 1995; Kim, 1995). Prior to the passage of the Immigration Act in 1965, there were only 7,000 Korean Americans living in the United States. By 1993, that number had grown to 2 million; about 30,000 Koreans were coming to the United States each year (Korean Overseas Information Service, 1993).

A growing need for mental health services for this population residing in the United States has been identified (Uba,

1994). An increasing number of Korean Americans are seeking mental health services in the community. Korean Americans have great difficulty in finding appropriate community programs and utilizing existing American community mental health services. Language problems and unfamiliarity with mental health systems impose difficulties in accessing community resources, creating further stress and confusion. Consequently, Korean Americans are uncertain about how to seek help. American mental health professionals often interpret this as resistance or noncompliance toward treatment (Sue, 1994; Uba, 1994).

Korean American clients have problems engaging in an ongoing treatment process, and they often decompensate in American day treatment programs rather than improve. There are high drop-out rates and problems of finding suitable adult home placements for Korean American clients discharged from psychiatric hospitals. Because of these problems, it is common for Korean American families (KAF) to assume 24-hour caregiving responsibility for their mentally ill family members.

Consumer perspectives of client-focused quality care (Oermann & Templin, 2000) have demanded family participation, and families have been viewed as essential for rehabilitating psychiatric clients in the community (Palmer, Erbs, & Anthony, 1995; Rimmerman, Treves, & Duvdevany, 1999; Robinson, 1997). But little attention has been given to the caregiving experiences of culturally diverse families (Hernandez, 1991; Kim, 1995). To date, no empirical studies to address this concern have appeared in the literature, including Korean Americans' experiences of caregiving for mentally ill family members. This is the first study looking at KAF's caregiving experiences for their mentally ill grown children, although one descriptive study (J. H. Kim & Theis, 2000) looked at Korean American adults' caregiving for their elderly parents in general.

Any system of health care exists within a cultural context (Capra, 1992). Culture is like a cognitive map; cultural knowledge serves to guide peoples' actions and to interpret experiences (Eliason, 1993; Spradly, 1979). KAF hold deeply ingrained traditional Korean beliefs about mental illness, which influences their caregiving experiences as they confront their family members' mental illnesses. This is especially important because the Korean family plays an important caregiving role and is a key factor in following through with treatment (Do, 1988).

METHOD

The purpose of this study was to gain an understanding of KAF's caregiving experiences. The specific research questions addressed were the following: What are the Korean American parents' belief systems and concepts of mental illness? How does the acculturation process influence the KAF's experiences of caregiving for their mentally ill grown children? As Andrews and Boyle (1999) stated, one's beliefs or values differ from culture to culture depending on one's worldviews. In this study, belief systems and concepts of mental health are defined as beliefs about mental illness or health as well as what fosters psychological well-being or illness. Acculturation is the process of changing value orientation (Wilkerson, 1982) and learning how to take on the behavior of another cultural group (Leininger, 1996).

This study is based on the assumption that health beliefs, family caregiving, and concepts of mental illness differ from culture to culture. The theoretical underpinning of the study is culture and Heidegger's hermeneutic phenomenology, which is interpretive and ontological and discloses a broader horizon by uncovering the researcher's presuppositions, as all understanding is mediated by interpretation (Heidegger, 1962).

Initially, this study was designed utilizing Giorgi's (1985) psychological phenomenological methodology, but due to specific cultural and linguistic issues that surfaced following data collection, it soon became evident that the phenomenological descriptive method alone seemed too limited to illuminate the essential meaning of the KAF caregivers' experiences. Furthermore, reduction (bracketing) of the researcher's own culture became impossible from the view of holism (Capra, 1991). Therefore, an additional level of analysis, an interpretive method, was adapted in this study.

Because Korean Americans tend to communicate metaphorically and rely on nonverbal communication (Uba, 1994), the researcher determined that the essence of meanings could not be adequately explicated through a quantitative or descriptive method (Donnelly, 1992). Employing a qualitative interpretive methodology enabled the researcher to enter the participants' world, reflecting KAF's beliefs, values, and assumptions, and to interpret the participants' nuances of speech, gestures, metaphors, and subtle meanings.

Sample and Setting

As a purposive sample, the participants consisted of 7 first-generation immigrant Korean American parents, identified as primary caregivers who have major responsibilities caring for their mentally ill grown children. The researcher recruited the participants from a family support group in an Asian Mental Health Clinic (AMHC). All care recipients were adults, 18 years or older, and their illnesses had developed after they immigrated to the United States; they had psychiatric diagnoses of schizophrenia, major depressive disorder, or bipolar disorder with severe psychotic features.

The AMHC is located in an urban community and has provided psychiatric treatment and counseling services in the Korean language to approximately 50 to 60 Korean American clients since 1980. The bilingual staff at AMHC consists of two social workers (one is the director), one part-time psychiatrist, and one secretary. With permission from the director, the researcher conducted the participant interviews at the AMHC to allow for privacy, freedom from interruption, and a quiet environment for tape recording.

Originally, 10 potential participants were interviewed; however, 2 participants were excluded because they were not the primary caregivers, and another was excluded after reaching redundancy of information. As Crabtree and Miller (1992) emphasized, significance in a qualitative study is the richness of information but not the size of the sample. The sample ranged in age from 42 to 73 years, with a mean of 61 years; 5 were women and 2 men, 6 married and 1 widowed, and all but 3 were 4-year-college graduates. Their education level was higher than the average Korean's. The participants included 5 mothers and 2 fathers, all but 2 of whom held full-time jobs. All had resided in the United States a minimum of 10 years. Their caregiving experiences ranged from 2 to 13 years (see Table 1). All caregivers signed a written consent form ensuring confidentiality. In this study, fictitious English names were used to avoid calling the participants by their first names (Korean adults should not be called by their first names) and calling caregivers by their last names, such as Mr. Park or Mrs. Lee, or Kim in Korean

Data Collection

In-depth, tape-recorded interviews were conducted in the participants' native Korean language. In all cases, at least two interviews were performed that ranged from 1 to 3 hours. To facilitate the process, the investigator used prompts to provide further insight into the participants' experiences. Each participant was asked to describe his or her experience in caregiving through reflective thoughts and feelings.

Field notes, telephone conversations, observations, and demographic data proved invaluable in complementing the data acquired on audiotape. As a written account of the participant's nonverbal communication behavior, the field notes were compiled and recorded following each interview. All

TABLE 1

Caregiver	Age	Marital Status	Level of Education	Religion	Relationship	Occupation	Time of Care	Time in U.S.
Mike	73	Married	High school	None	Father/daughter	Retired	13 years	15 years
Cherry	58	Married	4-year college	Protestant	Mother/daughter	Business	9 years	9 years
Pamela	55	Widowed	High school	Protestant	Mother/son	Factory	5 years	10 years
Pearl	42	Married	4-year college	Catholic	Mother/son	Business	2 years	10 years
Victor	55	Married	2-year college	Protestant	Father/daughter	Business	5 years	11 years
Essie	74	Married	High school	Buddhist	Mother/son	Retired	9 years	10 years
Natalie	53	Married	4-year college	Catholic	Mother/son-daughter	Business	7 years	10 years

interactions with the caregivers, including "third ear" nuances and hunches, were retained in a journal.

Data Analysis

In this study, the researcher developed a culturally congruent interpretive approach to analyze the data. Proper understanding of a culture requires an insider's knowledge (Munhall, 1994). Because the Korean language was neither as descriptive nor as expressive as English, the participants did not reveal their concerns through direct statements; therefore, the analysis depended largely on contextual nuances and nonverbal communication. In contrast to the practice of English-speaking people to communicate clearly, the use of language in the Korean tradition involves an expectation of the listener (or interviewer) to understand intuitively and interpret the response (Donnelly, 1998).

Therefore, the unique method of data analysis in this study rested on certain ways of translating, transforming, and interpreting the caregivers' experiences. The stories related by the caregivers, expressed in their dreams, Korean metaphors and images cannot be translated adequately into English without losing the linguistic nuances and meanings. Such a process was extremely difficult, however, particularly the managing of complex data in a qualitative cross-cultural study when no equivalent word exists (Twinn, 1997; Yom, 1998).

The Processes of Data Analysis

1. The researcher listened to the audiotaped interviews in Korean several times to get a general sense of the whole and the emotional tone of the participants' voices. Then, the audiotaped interviews were transcribed verbatim in Korean.
2. The organization of the data was accomplished according to the psychological context, with emphasis on the phenomenon of caregiving. The researcher eliminated redundant information and searched for the core meanings and essences.
3. The Korean texts were translated into English after fully comprehending them. In this translation stage, the researcher imagined and situated herself within the participants' perspective of the world as a means of understanding their lived experiences.
4. For some Korean words that could not be translated the researcher searched for core Korean concepts and themes and then transformed and interpreted them into English language to capture subtle meanings. In this translation stage, the researcher often returned to the tape-recorded interview to review it closely and identify the participant's emotionality and tone of voice by visualizing each participant at the time of the interview. The challenge was to convert the metaphorical communication into English because the Korean participants' naive descriptions were multiple realities expressed in metaphors, images, or dreams in Korean. (See Figure 1)
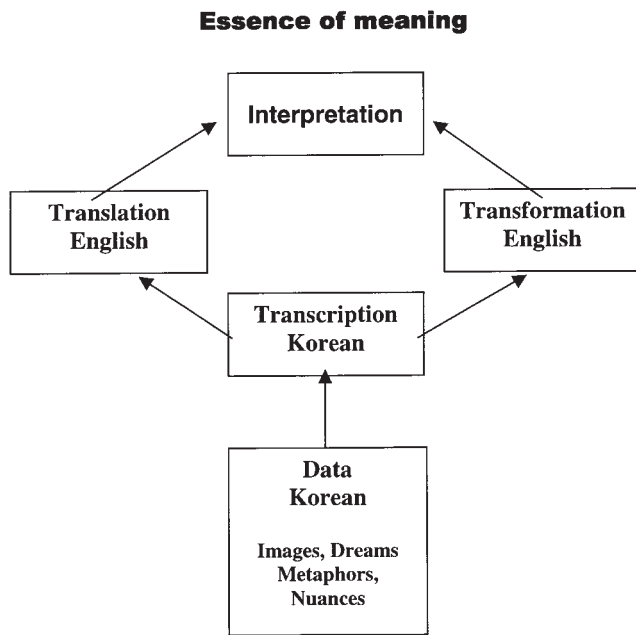5. The essences of the caregiving experiences were extracted from each participant's description and synthesized into common themes. Emerging common themes were interpreted and conceptualized. Each participant's experience of the caregiving reflected uniqueness in its expression yet shared generalities in the essential meaning. All participants' experiences were integrated into five themes (see Figure 2).

The translated and transformed English texts and Korean transcriptions were mailed to two Korean American doctoral nursing students for validation. Korean proverbs and metaphors that were unfamiliar to the researcher were searched for in the Korean dictionary, and the researcher consulted with the aforementioned nursing students for the correct meaning. Their suggestions and recommendations were incorporated into the data. Finally, two doctorate-level psychiatric nurses and three expert faculty members examined the process for fittingness, auditability, and credibility (Beck, 1993).

FINDINGS

Theme 1: Realization of Mental Illness

This theme, "realization of mental illness" describes the Korean American family caregivers' (KAFCs) realization of their children's mental illness. The realization that their children were mentally ill developed with varying degrees and at different levels, leading parents to challenge their own values and understanding about a serious health problem. This observation represented a critical turning point in parents help-seeking behaviors within the context of caregiving. When their traditional healing methods appeared to be no longer effective in managing their children's psychiatric symptoms, parents questioned their ingrained beliefs about mental

Essence of meaning

FIGURE 1.   PaJa's Method: The Process of Data Analysis Used to Explicate Essential Meanings of the Caregiving Experiences.
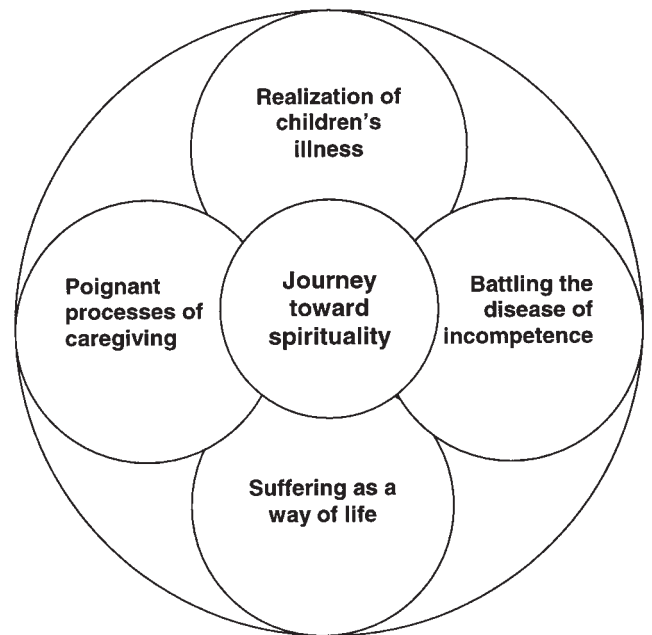
FIGURE 2.   Five Major Themes That Emerged From This Study Illuminated the Essential Meaning of Korean American Families (KAF) Caregiving Experiences.

illness and, subsequently, generated an awareness of the need for Western treatment. This process evolved gradually and in three stages: (a) becoming alarmed, (b) awakening, and (c) acknowledging.

Becoming alarmed. The KAFCs became alarmed by their children's psychotic behavior, such as suicide attempts, persecutory delusions, severe insomnia, and aimless wandering into the streets. When the caregivers' children were hospitalized in the psychiatric unit and the initial diagnosis of schizophrenia was confirmed, the participants were stunned and bewildered to learn that the symptoms reflected mental illness. The participants expressed these concerns:

> When my daughter disappeared for 3 months, it was as if the sky was falling down on me. (Victor)

> Everything was falling down on me like a thunderbolt out of the sky. (Essie)

> One day my son left home did not return. He went to the mountain to hunt a rabbit at the middle of the night. He was found by a police who took to the hospital. (Natalie)

> Phil wouldn't eat any food unless I eat first. He was afraid his food was being poisoned. He broke everything inside the house, radio, TV, and video. (Pamela)

Awakening. This stage marks the caregivers' beginning understanding of the seriousness of mental illness and the need to expand their help-seeking. Initially, without under-

standing the nature of mental illness, participants sought help from various resources. At first, they sought help from Oriental physicians for tonic medicine, acupuncturists to balance *Qi* energy, and ministers to chase away Satan. The failure of these traditional healing systems created a crisis. The only option remaining for them was to seek Western treatment. Participants no longer adhered to their sole cultural concept of interpreting mental illness as a "divine or crazy" disease (Barcus, 1982). The reality of the problem awakened them to shift their beliefs from folk medicine to other treatments.

> I went to a dispensary of Chinese medicine and bought tonic. It didn't work at all and his symptoms got aggravated. So I took him to my church to pray. Nothing worked for him. Then, I took him to the AMHC. He was diagnosed as having schizophrenia and has been treated with medication. (Pamela)

Acknowledging. The process of becoming aware and acknowledging their children's mental illness was a critical aspect of the caregiving experience and represented a major cognitive shift for the caregivers' help-seeking behavior. Acknowledging involved recognition and awareness of the complexity and chronic nature of children's illnesses and the necessity for parents to play an active role in treatment. The increased understanding about children's illnesses helped caregivers to recognize that their children's strange behaviors were symptoms of mental illness that could not be controlled by conventional folk medicine.

Western diagnosis of mental illness was foreign to the KAFCs. Culture influences one's understanding of illness, attitudes toward health, and help-seeking behaviors (Marsella & White, 1982). The expression, interpretation, and explanation of mental illness are dependent on the cultural theories available. Eventually, they turned to the AMHC or Western-trained psychiatrists. The AMHC support group helped them to understand the value of Western medicine and to learn about the Western diagnosis of schizophrenia and treatment processes. Subsequently, the KAFCs actively monitored their child's psychotropic medication at home. Some adopted Western treatments along with acupuncture, whereas others completely curtailed the use of folk remedies. Acknowledging became apparent as revealed in the comments of one participant referring to her daughter:

> I really thought she would get better just like an ordinary cold. When I observed people praying in church, I began to have different thoughts; praying to God alone cannot cure Sandra's illness. I didn't have the slightest idea that she has mental illness. (Cherry)

KAFCs' acknowledgment that their children's illnesses were not ordinary medical diseases shifted their view and set the stage for change. They were now able to seek other ways to solve their problems because their conventional ways of treating illness were no longer effective. Watzlawick (1974) referred to change as a dynamic process. The parental caregivers' concept of mental health changed through their experiences of caregiving and the processes of seeking help. The caregivers' experiential knowledge, coming to realize that their children were mentally ill, was a change that was part of the process of the caregivers' acculturation.

Theme 2: Battling the Disease of Incompetence

This second theme describes the caregivers' changed concept of mental illness, which was different from their original Korean concept. "Crazy disease" (Barcus, 1982) and emotional illness or psychiatric problems were seen by Koreans only in terms of psychotic illness (Donnelly, 1992). In the process of caring for their mentally ill grown children, participants recognized that mental illness is incurable and that their children were unable to function in the society without supervision. Thus, participants in this study labeled mental illness as a disease of incompetence.

> I believe my son's illness is a disease of incompetence. (Pamela)
>
> Karl has no confidence to do things and he has no living skills. (Pearl)
>
> Sandra cannot function as she used to. She is not capable to do things independently. I always have to observe her. . . . She lost confidence to stay out away from home. She said she is afraid of running away. (Cherry)

> Siwon even cannot write an address on the envelope. (Essie)
>
> I believe my son's disease is an incompetent one. (Natalie)

Schizophrenic negative symptoms, such as their children's idle behaviors and lack of interest, confidence, and motivation, were initially interpreted as poor role performance by all the caregivers. Thus, parents anguished about their children's lifestyle and struggled to correct it. Eventually, caregivers realized that although their children's schizophrenic symptoms of acute psychosis had been stabilized by psychotropic medication, their illnesses were incurable, and many negative symptoms remained (Harrison, 1998). Therefore, the Korean concept of mental illness as a crazy disease (Barcus, 1982) was replaced by the participants' conception of mental illness as a disease of incompetence, based on their experiences.

The conceptualizations of mental illness in Asian society are different from Western biological models. Similar illness events may be interpreted differently, depending on the cultural theories available for reasoning about the illness (Marsella & White, 1982). For instance, there are no Korean words equivalent to the English words for psychotherapy and psychotherapist (Donnelly, 1992). The interpretation of mental illness, based on the Korean concept of health and illness rooted in folk medicines originating in China, are different from Western concepts (Kim, 1995).

Before their children were initially diagnosed with schizophrenia, the caregivers thought their children's illnesses were casual symptoms like those of a common cold or a neurosis. Neurosis is known as a nerve disease in Korea, referring to psychological disturbances. Initially, the parental caregivers did not acknowledge the seriousness of their sons' and daughters' mental illnesses because they had no knowledge regarding the Western diagnosis of mental illness, but they learned about the extent of their children's illnesses, Western diagnoses, and treatments through the AMHC family meetings. From their experiences, caregivers recognized that their children's mental illnesses were very different from what they had assumed based on their previous cultural knowledge and beliefs of mental illnesses as divine diseases or crazy diseases.

In traditional Korean society, the terms *crazy disease* and *crazy people* portray the image of a naked street person who, possessed by a devil, exhibits bizarre behaviors in a confused state. After their children were diagnosed as mentally ill, the caregivers no longer used the word *crazy*, even in casual conversation because their children's mental illness seemed to be more a disease of incompetence than a crazy disease. They also didn't want to associate their children with the word *crazy*, which is socially stigmatizing in Korea.

Theme 3: Poignant Processes of Caregiving

This theme explicates the caregivers' cultural values and beliefs as well as distressing nodal events in the caregiving process. From a holistic perspective, the families and their

mentally ill grown children were interrelated and interconnected with each other as a whole. Battista (1992) postulated that "human beings can be understood as the manifestation of the synthesis of parts since they are interdependent and interrelated to each other" (p. 212). From this perspective, parental caregivers' experiences of poignant caregiving processes were reflections of their children's distressful symptoms (Saunders, 1999). The two subthemes illustrate parental caregiver's empathic responses toward their children's behaviors and their changed relationships.

Sharing pain. As an interconnected whole, parental caregivers shared profound pain with their children, particularly in response to suicide attempts and expressions of their children's wishes to die. As caregivers, they experienced the children's confusion and sudden disappearance, lasting from several days to 3 months.

When participants visited their children in the hospital, they found the distressful scene of their sons being restrained in the ward. Caregivers endured intolerable pain witnessing their children's pain as their own. They interpreted the unfamiliar practice of restraining aggressive patients in the hospital as a punishment to their children and characterized the psychiatric institution as a jail cell. In the Korean family system—an interconnected web—one family member's pain is not simply felt by the whole family system: It is the whole family system's pain.

If Korean American caregivers were better acculturated to or better understood the reasons of restraining psychiatric clients in the hospital, those times of poignant anxiety and anguished feelings might be expressed differently. Witnessing and sharing their children's pain and confusion was an unforgettable moment-to-moment existence for the parental caregivers.

> I couldn't die together with her. How painful it can be if she dies in front of me. (Cherry)

> When my son was in the hospital, he was drooling all the time and could not move his arms or legs at all. I felt so sad, he has always been such a good son. (Natalie)

> When he was in the hospital he was being tied up like prisoners. He looked so stiff and immobilized. (Essie)

Altered relationship. In the process of dealing with the losses, Korean American caregivers had to redefine their altered relationships with their mentally ill grown children. Parents were forced to initiate their new role as a family caregiver in the midst of confusion and crisis. They had to compromise their own personal and family lives to be caregiving parents. According to Surrey (1991), it is important for mothers to have mutually empowering relationships with their daughters that include emotional sharing, empathy, and taking care of each other. In this study, the participants did not use the term relationship, but they often expressed their anguished feelings by using the Korean phrases "daughters' loyalty to their mothers lasts forever" or "filial (loyal or dutiful) daughters."

Theme 4: Suffering as a Way of Life

This theme explicates cultural beliefs and the Korean value orientation reflecting the Taoist acceptance of suffering as a way of life, the Buddhist teaching of endurance, and Confucian principles of family values. The lifestyles of all the parental caregivers changed drastically because their children's mental illness profoundly affected family life. The theme, "suffering as a way of life" was Mike's term, describing his experiences of caregiving. Caregivers suffered a great deal of pain, shame, stigma (Hashizume, 1998; Park, Kim, Kang, & Kim, 2001), and feelings of self-blame about their children's illnesses. The traditional Korean concept for mental illness, crazy disease, implies that mental illness is a stigma for the family. These feelings followed caregivers like a shadow because their children's mental illnesses brought shame and dishonor to the family (Dai & Diamond, 1998). The degree and intensity of suffering were varied, depending on the severity of their children's illnesses. Two subthemes emerged, illuminating the theme of suffering.

Sacrificing one's life. This subtheme illustrates the caregivers' relinquishing of their own desires and dreams to care for their mentally ill grown children. Caregivers' placed their mentally ill children's needs before their own which overshadowed their lives with the overwhelming responsibility in the caregiving process. Caregivers gave up their hobbies, dreams, and social lives to care for their mentally ill grown children and felt trapped, with no hope of escaping their situation. Parents were challenged to accept their caregiving roles and to redefine their altered relationships with their children. Personal and family lives underwent compromise, resulting in a new role for parental caregivers. Their commitment to become caregivers was a long process of suffering. They faced uncertainty and ambiguity in providing care during the progression of the illness, which was a long process of suffering until they found meaning in caregiving and peace of mind.

> I cannot even cry; tearing is luxury; tearing means you really did not experience deep pain, and it means you have a long way to go. (Cherry)

> I am suffering. I don't think I have the will power to live. I experience my life as a misery. I am in and out of hell, just before my death. Is hell as terrible as to live what I am going through now? (Pearl)

> If my daughter had not gotten sick, I would return to Korea to do my business, enjoy my old age, and travel with my friends. (Mike)

> I cannot even live my own life. I am stuck. (Mike)

Suffering became the caregivers' daily routine and way of life. A strong sense of family obligation and commitment to care for their mentally ill grown children imposed heavy

burdens on the parental caregivers. The caregivers were over-burdened with continuous demands and responsibilities. Korean parents accepted their fate and misfortune as a way of life, based on their cultural orientation of Taoism, the eternal way of the universe (Capra, 1991), and the Buddhist view of suffering (Rubin, 1996). Koreans tend to have a fatalistic attitude toward life in their value orientation, which is different from the values of mastering one's own fate in the West (Donnelly, 1992; Sohn & Ja, 1982). Caregivers in this study accepted their role as a parental caregiver and attended the AMHC support group as they went through their grieving process.

The loss of hopes and dreams. Caregivers grieved for their own losses: their lives of sacrifice and their previously healthy children they had once cherished and been proud of. In the present study, mothers, particularly, grieved for their daughters.

> My once energetic daughter pursuing ambitiously to be an architect. Sandra didn't have a chance to get married and to have a child. (Cherry)
>
> When I see other people enjoy their son-in-law, I feel really sad. (Natalie)
>
> I feel terrible, our family line will be stopped at his generation. (Essie)

Parental caregivers of first-born or only sons had to face the discontinuation of their future family generations and the loss of their sons' potential financial accomplishments, which are very important in Korean culture. All parental caregiver's grieved for the loss of dreams and pleasures in their children's success and happiness. Grief is a highly individualized process (Cowles & Rogers, 1991). In this study, the phenomenon of dealing with the loss was not a time-limited event. A person's anticipatory loss may occur unceasingly throughout life (Schneider, 1984). The caregivers' grief in this study evolved gradually and progressed continuously as they realized the severity of their children's mental illness. It was a long, continuous process of suffering and grieving for the loss. As the mental illness progressed, the memories and dreams of their once healthy children began to fade away.

Theme 5: Journey toward Spirituality

The spiritual dimension of human experience in healing emerged as a strong component that flowed throughout the study's findings. Spirituality is defined as "personal views and behaviors that express a sense of relatedness to a transcendent dimension or something greater than one's self" (Kay & Robinson, 1994, p. 218). McGlone (1990) viewed spirituality as being in relationship with God.

In the Asian healing system, the universal Qi energy, the person's mind, body, and spirit as a whole, is based on a holistic view of man. Illness is seen as a manifestation of a person's Qi balance, which depends on the phenomenon of Yin and Yang (Andrew & Boyle, 1999; Capra, 1991). This cosmic life force is conceptualized as the interdependence of the person with social, supernatural, and climactic conditions. Because illness is seen as the manifestation of cosmic forces, the concept of health is expanded into another dimension of spirituality (Sheikh & Sheikh, 1989). Thus, treatment in the Asian healing system often focuses on restoring the balance of Qi energy by coordinating the physical, mental, emotional, and spiritual resources of the whole being (Do, 1988; Sheikh & Sheikh, 1989). In the theme of the journey toward spirituality, two subthemes emerged: praying to God and transcendence.

Praying to God. As a form of meditation, a path for spirituality, and healing, the caregiving parents prayed to God, hoping for a miracle to heal their children's mental illness. Turning to the church with an expectation of recovery, they thought that the minister could chase Satan away at the beginning of their children's illness. Regardless, dialogue with God in prayer helped the caregivers to deal with the daily stressful situation as a coping strategy (Johnson, 1998; Kay & Robinson, 1994). Korean American caregivers prayed for their children's recovery from the onset of their children's illnesses to the present. At the beginning, based on their beliefs of mental illness, the participants prayed with a minister to chase away Satan, who was causing their children's illnesses. Later on, they prayed to God for their children's recovery and to relieve the caregiver's own suffering.

> I tell Sandra to pray with me together. God loves you even if you act so strange. God's sprit will be with you when you pray to God. I truly believe miracles can happen. If 1 out of 100 mentally ill people can be cured, in that case, it is worthwhile to pray to God for a cure. I pray to God early in the morning, at home, to find peace in my mind. I have a conversation with God. God is everywhere. (Cherry)
>
> I am waiting for the miracle for her to be cured. I pray to God every day. (Mike)

Another aspect of the caregivers' prayer reflects their own journey toward wholeness. Prayer was a dialogue and a form of spiritual behavior. Four caregivers prayed for their children's recovery daily before they went to work, and 2 caregivers prayed at home regardless of their children's lack of recovery. O'Brien (1999) defined the term *prayer* as "a petition or request" (p. 106). The family caregivers prayed for their children's healing and for forgiveness for whatever they might have done wrong. A special prayer room was designated in Victor's house because of his daughter's mental illness.

Dialogue with God in prayer enhanced the caregivers' sense of hopefulness for their children's healing. Mike and Cherry, especially, believed in the infinite possibilities of miracles. Prayer, as one of five main coping mechanisms (Jalowiec, 1993), alleviated stress and helped caregivers deal

with the situation (Kaye & Robinson, 1994). Lazarus and Folkman (1984) described coping behavior as a cognitive and behavioral effort to manage a stressful situation. Korean American caregivers' prayers were not only used for coping but also for their child's healing, for the possibility of a miracle, and for finding inner peace. Participants shifted their view of suffering when different light was shed.

Participants' beliefs of praying to God for healing of their mentally ill children is similar to a finding from a study by Donnelly (1992) that 50% of Korean American clients preferred to have spiritual guidance and to pray during their therapy sessions. Spiritual aspects of healing and their beliefs about the power of prayer (King & Bushwick, 1994) emerged as a strong theme.

Transcendence. The participants transcended their pain in a unique way. An enhanced meaning was attributed to their daily experiences of suffering. This became a critical event in their path toward personal transformation and wholeness (Achterberg, 1990) and paved the way to their own spiritual journey. Spirituality has a transcendent dimension (Summer, 1998). Caregivers found some purposes and meanings in their daily caregiving experiences. Transcending their suffering was exemplified as follows:

> I accept my situation as a test of God, who is trying to make me a good person for my son. It is the way of life. (Pamela)
>
> Caring for my daughter is my mission in life. (Cherry)
>
> I am awakening for my spirituality. (Victor)
>
> Suffering is a way of life and my daily routine. (Mike)

Participants in this study shifted their view of suffering when a different light was shed on their day-to-day caregiving experiences. Transcendence occurred when caregivers shifted their view, moving beyond the ordinary caregiving experiences of their roles and responsibilities toward finding unique personal meanings in the experiences. Transcending their own suffering and pain became for these caregivers a path on their journey toward spirituality. Most of the caregivers transcended their anger toward God, disappointments in their children, and despair in life on their journey to spirituality, whereas some other caregivers still blamed God, suffering and struggling to find meaning in their caregiving experiences. In transcendence, one reaches "beyond to the actual, contextual situation" (Parse, 1985, p. 29) toward change.

Transcending their pain is a change, which is a dynamic, moving process that can lead to a transformation, expanding caregivers' consciousness. One's expanding consciousness in the process of caregiving (Yamashita, 1999) opens up new possibilities. This expanded consciousness led to Cherry's changed view of the suffering of others, particularly the homeless. Once, she saw them as beggars who contaminate society, but now that she understands how they might have come to this situation, she cares compassionately for them.

Thus, experiences of caregiving encompassed their own spiritual journey to the path of wholeness.

DISCUSSION

The findings of the study illuminated the underlying conceptual perspectives of Korean culture. KAFCs described their experiences based on their embedded cultural knowledge, values, and beliefs. As Eliason (1993) stated, culture is the basic road map for understanding the world, and "the idea of the background is critical because it provides conditions for human actions and perceptions" (Munhall, 1994, p. 16).

This study demonstrated that cultural factors contributed to the KAFCs' failure to use existing community mental health resources appropriately and to the inappropriate use of emergency rooms for treatment instead of ambulatory health clinics (Boult & Boult, 1995; Uba, 1994). If the family caregivers had been better acculturated into this society, their children might have received Western modes of treatment earlier. Korean immigrants' difficulties with the English language became a major obstacle to utilizing community resources because Korean American's acculturation is often a slow and difficult process (Do, 1988; Kim, 1995).

In this study, the researcher's psychiatric nursing background and bicultural-bilingual knowledge of Korean communication patterns proved to be crucial in advancing the purposes of the study. As language is the presence of reality (Laudan, 1990), Korean metaphors and analogies became an important part of the information-gathering process and the data analysis because the participants' communication heavily relied on these analogies. Metaphorical language as a powerful and creative method of communication in Korean language shed light on the meaning of complex caregiving experiences. In addition, the application of the interpretive qualitative method made it possible to acquire substantive data.

It is hoped that this study has contributed to the understanding of KAF's beliefs, values, and concepts of mental illness. And that knowledge gained from this study will assist mental health professionals in designing and developing culturally congruent community-based treatment modalities for Korean psychiatric clients and their families.

IMPLICATION FOR NURSING

The findings indicated that KAFCs belief systems and values are grounded in a holistic view of the world and the unity of human beings as a whole, which includes spiritual dimensions of being. The current health care system focuses on client-centered care, which requires that the treatment be based on the client's perspective, incorporating culture and religion. Therefore, nurses need to understand clients' and families' worldviews to provide client-centered culturally congruent care.

First, transcultural nursing courses need to be integrated into core curricula. As Leininger (1996) pointed out, nursing is transcultural care phenomena, and cross-cultural issues affect every aspect of nursing practice. This study's findings, KAFCs' understanding of mental illness, supported Herberg's (1999) view that health and illness are culturally determined.

Second, spiritual dimensions of care need to be acknowledged in nursing (Farrell, 1991; O'Brian, 1999). The spiritual aspect of human experience in healing was a strong component of this study's findings. Spirituality is an important factor in the healing process and an integral part of holistic care (Summer, 1998). Spirituality reflected the Asian healing system that conceptualizes cosmic life force and Qi energy as the interdependence of the person. The KAFCs' concept of mental health incorporated a spiritual dimension of healing, and mental illness was seen as a manifestation of supernatural forces. The KAFCs believed that health and illness are dependent on aspects of spirituality. Hence, spiritual aspects of KAFCs' worldview influenced their caregiving process. According to Sheikh and Sheikh (1989), spirituality is etiologically related to health, "health promotes spirituality and spirituality promotes health" (p. 30). Therefore, spiritual aspects of care need to be considered and incorporated into treatment plans, particularly when caring for culturally diverse clients and families in the multicultural society.

Third, nursing needs to develop innovative, culturally congruent day treatment modalities, and community-based programs. In fact, there are no day treatment and adult home programs available for Korean American psychiatric clients in the New York metropolitan area. In this study, all KAFCs assumed 24-hour caregiving responsibility directly or indirectly for their mentally ill grown children. Current psychiatric nursing practice and the focus of treatment for chronically mentally ill patients have changed from inpatient to community settings (Kelly, 1991; Tamara, 2000). Families are viewed as a potential resource and a cost-effective source of treating mentally ill clients in the community. Specifically, the traditional Korean family plays an important role and is a key factor in following through with treatment (Do, 1988). Families' collaboration in caring for the mentally ill member is in great demand (Reinhard, 1994).

The worldviews and beliefs of culturally diverse clients and families can be incorporated into the existing American psychiatric rehabilitation programs in the community. The integrated culturally congruent treatment modalities and programs will share new and different cultural values, beliefs, customs, and meanings.

RECOMMENDATION FOR FURTHER STUDY

This study should be replicated with Korean American caregivers that do not have access to Korean mental health professionals or family support groups and receive treatment only in an American mental health system. Also, it would be useful to conduct interpretive qualitative research involving the parental caregivers of mentally ill grown children in Korea to compare their caregiving endeavors and belief systems about mental health.

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Being Trapped in a Circle:
Life After a Suicide Attempt in Taiwan

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The purpose of this hermeneutic phenomenological study was to understand how suicidal patients experienced their lives after attempted suicide. Ten participants were recruited from a medical center in Taiwan and were interviewed over a 5-month period about their experiences and feelings after their suicide attempts. Participants suffered from "being trapped in a circle" through three main avenues: (a) being controlled by others versus striving to live for oneself, (b) being rebuffed by others versus seeking company and being loved, and (c) wanting to leave family versus feeling responsible for family. These three themes were conceptualized under a broader theme of alienation versus connectedness. Cultural values, mientze *(saving face), and* hsiao *(filial piety) influenced where those Chinese who had attempted suicide were located in the dimension between alienation and connectedness.*

Suicide is a self-selected behavior to stop one's life and is not simply an event but a process. Thus, care provided by health professionals is not limited to resolving a single event. On the contrary, health professionals need to continue to provide interventions after suicidal patients go back to the community. However, most suicide research focuses on suicide rates, assessment and diagnosis, risk factors for suicidal behaviors, suicide prevention and treatment, and the bereavement of survivors. Although such research helps health professionals to identify populations at risk for suicide, the reports include many individuals who have little likelihood of considering suicide; that is, the data may provide too many false positives for clinical practice (Fawcett et al., 1987).

According to the latest report of the Department of Health in Taiwan, suicide was again the 9th leading cause of death in Taiwan (Department of Health, 2000). On average, in Taiwan, one person dies every 4 hours because of suicide. Clearly, suicide has become a critical mental health issue in Taiwan. Epidemiological studies show that poisoning, hanging, and jumping from a high place are the three most common methods of suicide in Chinese culture, whereas 59% of suicides in the United States are by firearms (Yip, 1996). The male-to-female suicide death ratio is 4.6 to 1 in the United States (National Center for Injury Prevention and Control, 1997), whereas the male-to-female suicide death ratio is 2.09 to 1 in Taiwan (Department of Health, 2000) and 1.3 to 1 in Hong Kong (Yip, 1996).

The previous research on Chinese suicide has only focused on epidemiological perspectives and described the differences between Chinese and other groups but has not explained why these differences exist. However, social controls and cultural values must be considered to explain the phenomenon of suicide (Farberow, 1975) and to provide a deeper understanding of suicide through a theory that incorporates the dialogue between person and culture (Kral, 1998).

Searching for meaning in life is the primary source of motivation to live (Frankl, 1962). For a human being, goals are not only to find meaning in one's own life but also to live a meaningful life. To work with suicide attempters and to help them search for meaningful lives, it is important to explore and understand their lived experiences after attempting suicide. Clearly, today's suicide research must explore how suicide attempters rebuild their lives from a culturally-specific perspective. Therefore, the purpose of this study is to explore this gap in our current knowledge of suicide to better inform the health care providers who care for suicide attempters.

METHOD

Van Manen's (1997a, 1997b) hermeneutic phenomenological approach was used to understand lived experiences after a suicide attempt. The purpose of phenomenological research is to grasp the essential meaning of something: "A good phenomenological text has the effect of making us suddenly 'see' something in a manner that enriches our understanding of everyday life experience" (van Manen, 1997a, 345). Van Manen's six research activities guided this study: (a) turning to the phenomenon of life after a suicide attempt, (b) investigating experiences as suicide attempters lived, (c) reflecting on the essential themes that characterized the phenomenon of suicide attempters' lives, (d) describing the phenomenon through writing and rewriting suicide attempters' and the researcher's own lived experiences, (e) maintaining a strong and oriented relationship to the phenomenon, and (f) balancing the research context by considering parts and the whole (van Manen, 1997b).

Suicide Attempters

A purposive sample of 10 mentally ill patients who had made one or more suicide attempts within the previous 2 to 8 weeks were interviewed for this study. Participants were identified and referred by four psychiatrists in a medical center in Taipei. Of the participants, 5 were women, and 5 were men. They ranged in age from 20 to 52 years. Regarding marital status, 2 participants were married, 1 was divorced, and the others were single; 2 participants had an intense mother-son relationship. Of the participants, 3 had graduated from university or college, 4 had completed senior high school, 2 had completed junior high school, and 1 was an elementary school graduate. All communicated in Mandarin with the researcher.

One participant was diagnosed with schizophrenia, 2 with adjustment disorder, and the others with major depression. None had psychotic symptoms, bereavement, substance withdrawal or intoxication symptoms, or medical illness. In respect to their suicidal behaviors, 4 ingested an overdose of pills, 3 attempted to jump from a high building, 2 put themselves in front of moving cars, and 1 attempted to cut her wrists. They were receiving treatment in the following settings: hospitalized in an acute inpatient psychiatric ward (4); hospitalized on a subacute ward (1); day care center (1); outpatient, living with family (3); outpatient, living with boyfriend's family (1).

Procedure

All of the participants were identified and referred by their psychiatrists. If the patient expressed interest, the researcher introduced herself and provided him or her with detailed information, including a consent form, the amount of interview time involved, the use of audiotape during interviews with the participant's consent, and a review of the medical record for past psychiatric history. The participant then signed the consent form to indicate his or her willingness to be interviewed. Semistructured interviews were conducted in interview rooms in a Taipei medical center between August and December 1999. Each interview lasted for about 90 to 120 minutes. Participants were encouraged to explore their experiences and feelings after suicide attempts. In addition, participants were free to talk about anything that had meaning or relevance to their lives. All interviews were audiotaped with the participants' agreement. Field notes, methodological journals, and personal logs were written to keep track of the researcher's observations, feelings, thoughts, and considerations during fieldwork, analysis, and writing up the results.

Analysis

All interviews were transcribed verbatim and then translated into English. Thematic analysis was used to experience and understand each participant's life story using van Manen's (1997b) and Colaizzi's (1978) methodological approaches. The procedure was as follows: (a) interviews were reviewed several times to gain a whole sense of the suicide attempters' lived experiences; (b) significant statements, directly related to the phenomenon of life after a suicide attempt, were identified from each interview; (c) these statements were read and reread to formulate conceptual meanings of the suicide attempter's lived experiences; (d) emerging themes were clustered into the three categories of self, interrelationships, and cultural meanings of life and death; (e) the context of innercategories and intercategories were generated through small group discussion in a qualitative research class, including nursing doctoral students and faculty members experienced in both culturally competent care and phenomenological research; (f) the essential structure was synthesized to describe the phenomenon based on participants' narratives of their lived experiences; and (g) the credibility of the final text was tested in March 2000 by asking for 2 participants' responses to the findings and presenting them to psychiatrists who helped identify possible participants.

FINDINGS

The desire to commit suicide and the expressions of feeling bored, uncertain, anxious, pressed, terrible, and sad were ever present in the suicide attempters' accounts. Some had difficulty concentrating on reading or work, easily forgot what they just encountered, and felt that their heads were "empty;" others complained that their bodies were vulnerable, and they felt "coughing, dizziness, and palpitation." Most of them had difficulty sleeping at night and were easily awakened by unpleasant dreams. Some, including the male participants, cried every day after attempting suicide. Chii-Jeng, a male second lieutenant who had ingested pills with wine on his 24th birthday, exemplified the lived experience after a suicide attempt:

I still have a strong desire to commit suicide. I feel I am very nervous all over my body. I don't want this feeling. I can't focus my attention for a long time. Sometimes, I try to read books, but I can't focus my attention, and I don't know what I have read. . . . Now, I keep thinking about what happened in the past. It's there. . . . Whenever I think about it, I feel insecure and scared. I can't get rid of it. . . . Often, I don't know why, but I just can't control my moods. I am gloomy. And I can't sleep well, even when I sleep at home. All my dreams are about unhappy things in the military.

Another participant, Sheu-Yu, a female editor who had jumped from a high building and took air trips, hoping to die in a plane crash, stated that her current life was trapped in a problematic, triangular framework of family, love, and work:

I am trapped in a circle, no way out. I hate to be at home, but I have no money to pay rent. If I pay the rent, I will have no money left. If I am involved in a car accident, my mom will never pay for me. In love, I'm the joke because I can't get married. No boyfriend. How can I do it when no one wants to marry me? At work, no matter what I do I have always been bullied. I just keep my mouth shut. I can't think of anything, and just do nothing.

The above narratives demonstrate that these suicide attempters felt trapped and that their lives were in disorder, causing them to endure physical and psychological distress. Three main themes emerged characterizing the phenomenon of being trapped in a circle among the ten participants: (a) being controlled by others versus striving to live for oneself, (b) being rebuffed by others versus seeking company and being loved, and (c) wanting to leave family versus feeling responsible for family.

Being controlled by others versus striving to live for oneself. There was a strong perception that these participants' lives were not controlled by themselves but by other persons, such as families, psychiatrists, and colleagues, as well as such unseen factors as God, devil, fates, or cultural values. Wei-Ren, a young male soldier who had jumped from a high building and swallowed pills to attempt suicide, vividly described how his life was controlled by others.

I don't know, this feeling, just like . . . it's like I have been controlled by the physicians. I should take the medicines they prescribe. It makes me feel very scared . . . [I feel] very bored every day. I am controlled by medicines. I don't know anything. If I am not controlled by medicines, I feel that I am controlled by other people, controlled by . . . sort of controlled by the devil. So, I feel life is meaningless, because I am always frightened.

Although Ai-Ling, a female laborer who had taken an overdose of pills to attempt suicide, was a Catholic previously, she felt that her life was managed by the Buddha. She believed that she had the confidence to complete suicide in the beginning but because of the Buddha, she had been rescued. She was still suffering with painful pharyngitis and festering mucous membranes due to her allergies to psychiatric medications as well as drug overdoses. However, she explained that all of the pain was punishment from her Buddha, because suicide was not permitted in Buddhism. Her words—"the dead sin has been pardoned, but the lived sin is ineluctable"—meant that her life was rescued because her dead sin had been pardoned by the Buddha. However, she had to suffer in pain, because she could not eschew the lived sin. Finally, she stated that she had comprehended that her life was "not decided by [herself]" from this experience of suffering. She realized that she could not reject rewards (her life was rescued) and punishment (the suffering after her suicide attempt) from the Buddha:

This is the secret of heaven. Still, it's said that human life is a kind of impermanence. Oh, it's out of your imagination. Perhaps, something will happen after I have been discharged from this hospital. It's hard to say, isn't it? Yet, I don't know. . . . I really don't know if it's true. . . . Life is arranged in an inscrutable way. It's impossible for you to control it.

Her story also described ambivalence about accepting versus rejecting the fate that is embedded in the Chinese mind. Living in this situation, suicide attempters worried about their present and future. For example, Sheu-Yu worried about whether she "would continue to live in the same life; being laughed at, looked down upon, and never ending her poor life," because she could not stop her mother's, sister's, and colleagues' backstabbings. Gwo-Chyr, a male patient in a day care center who attempted to jump from a high place, feared that his psychiatrist would not permit his discharge from the hospital, and therefore felt that "[his] life would be ruined, and [his] future was also ruined." Sheau-Ming, a male mandatory soldier who had driven at high speeds and encountered traffic accidents, had striven to be discharged earlier from the military to make money for his family because he was the only economic provider in his family. However, he was afraid that "[his] officers would not help [him] in the process, and on the contrary, intended to delay his application." In these descriptions, most of their fears derived from the feeling of being controlled by others.

Some feared that they had become fools because they did not know what they could do under the control of others. Consequently, they had no wishes, no hopes, and no achievement. Wei-Ren said that he had "already died," and "had nothing," but "a body." Chii-Jeng also stated that "[he] was not living for [himself] but for [his family, relatives, and friends]." Therefore, it can be understood why May-Yu, a trader's wife who had attempted to jump from a high building, related that she had "no energy," "no motivation," "did not wfant to face the reality," "hoped to hide herself," and "envied others' lives."

Seeing that they had no power to control their own lives, suicide attempters considered killing themselves as a method to manage their lives. Yeong-Jye, a male soldier who repeatedly attempted suicide over 2 months by ingesting pills, claimed that "[ending one's life by suicide] was better than those who died in traffic accidents because the latter did not know when they would die." Although participants still believed that the use of suicide gave them the power to control their own lives, they started or planned to change themselves or their environment after attempted suicide because of the influence of cultural values or the mirroring of others' actions and words.

Participants described that they felt embarrassed after attempting suicide because they wanted to die; however, on the other hand, they were afraid of losing face because of their suicidal acts. Sheu-Yu admitted that because of *mientze* (saving face)[1] and *hsiao* (filial piety)[2], she could not commit suicide.

> Because of my family, not wanting my parents to collect my body, so we can't do this. . . . As long as my parents are alive, I will never jump [from a high building]. After my parents are gone, I will have no more worries. . . . I'm alive now, and I'm angry when I think of [being defamed by others] (laughs). Whenever I hear others talk about me I am angry. I can foresee what will happen after I die. Now I can explain when I hear it. I can prove the truth by my actions. However, it is not possible after death, except writing a dying letter, but a dying letter. . . . If I don't care about it, my parents will have to collect my body after I die, and others will still scold me for lacking hsiao. . . . You can see that I don't want to lose face, even after I die.

Shiow-May, Chii-Jeng's mother, who had attempted to cross the road to be hit by a car, also indicated how mientze influenced her when she encountered the critical issue of her life versus death.

> I also want to keep my mientze. I'm afraid my suicide will fail, and I'll be rescued. If that really happens, I know I'll feel regretful. If I want to die, nobody can rescue me.

In addition to mientze, participants also forced themselves to change by mirroring others' actions and words. Sheau-Ming revealed that when he heard that his officers would not permit him to apply for early discharge, his mood fell to the bottom. However, mirroring one of his neighbor's actions in the hospital helped him to stand up again.

> Like one of my neighbors, his movements looked quite well on his first day here. I felt his words sounded normal . . . and also read books in the room. Yet, he depends on his bed longer and longer now. I just feel that . . . um . . . I have to force myself to stand up. In fact, I have no ability to feel happy. Additionally, it's my first time to lie in bed all day. It's true that people want to hide themselves in that world when they feel

depressed. Finally, I understand why they hide themselves in the cotton quilts.

Similarly, Chii-Jeng's self-reflection let him accept others who were in bad moods and realize how others would see him after his suicide attempt.

> Before I went into military service, I couldn't understand why my mother was so worried about what I considered unimportant. After I was in military service, I felt I had the same trouble as my mother had. Maybe others had the same thoughts. They couldn't figure out why I had become this way. But now, I can touch that feeling more than before. It becomes that . . . I know what it feels now.

This mirroring helped suicide attempters more clearly see themselves and comprehend how relationships between themselves and others influence their lives after suicide attempts.

Being rebuffed by others versus seeking company and being loved. Although human beings connect with each other, one may live with one's family but may not say a word when one is at home. In contrast, even though one lives alone, one may have the feeling of being with others because of having good relationships. For instance, Chii-Jeng worked as a mandatory officer and stood in front of soldiers and yet felt that he did not belong to either the soldiers' group or the volunteer officers' group in his military unit. Therefore, although he lived with a large number of people in the military, he did not have the feeling of being with others.

Yeong-Jye felt that no one wanted to talk to or care for him when he was in the troop. His colleagues always ridiculed him, saying that he "acted just like in a play," "pretended to die to avoid attending classes or drills," and "was a fool." Similarly, Sheau-Ming felt disappointed and hopeless because no one understood or wanted to help him. Instead, his colleagues used to question the truth of his story. Yet, what emerged were deeper feelings of being different from others and excluded from their peer group. Yeong-Jye angrily expressed this in the following statement:

> They didn't let me touch guns. I think it's straight to say that I shouldn't have to serve in the military. Besides holding a gun, what else can I do? I feel that if you let me go back to the troop after all, you should let me work the same as others do. If you let me be different from others, won't others rebuke me? At that time, I thought you could let me either apply for early discharge from the military or go back to be trained with others. The result wasn't that. After going back there, I didn't have to work and wandered around every day. Of course, some would speak, saying you were pleasant and didn't work, blah, blah, blah.

Although May-Yu went out with her friends when she felt distressed, she still could not share her feelings with her friends.

> Because I had many friends around this area, I went to visit them often. However, I felt ashamed to talk about my situation. . . . I was good at pretending, and tried my best to pretend. I felt that I was in winter and did not want to bring others into the winter too . . . everyone has her business. Some would like to hear your problems, but others don't want to know your affairs.

In contrast with May-Yu's pretending to be happy, Sheu-Yu described what her friends meant to her:

> Just making jokes, we hang out together smoking, drinking, then talking. When we feel sad, we cry together. I just want someone to keep me company . . . with someone close. Not somebody who always bugs you about why you keep changing jobs. No, he understands, he's been stabbed in the back before. Bad luck comes and goes. Calling him and crying, he would be with me. When he was unlucky, I would go to him. When we were both unlucky, we were together. Although we don't call each other often, whenever one of us needs something, we all are with that friend.

The reason why May-Yu had different feelings from Sheu-Yu's was because the latter could sense the feeling of "we are the same" when she was with her friends. Sheu-Yu stated that the similarity she shared with her peers was the intersection of three issues: "having no smooth work," "being cheated in love," and "being nagged at home." Meanwhile, instead of sharing experiences with her intimate friends, Shwu-Huey, a female nurse who had attempted suicide by cutting her wrists, told her story to one of her former colleagues because this colleague's life story was similar to her mother's: "having given birth when [she] was very young," "having a husband who was always asking for money," and "always chatting about loves and feelings with [her]." Therefore, "seeing her, I felt I saw my mother," which allowed Shwu-Huey to make friends and share her worries with this colleague.

In addition to friends' company, family support and care also helped suicide attempters feel that their lives were valuable. After Chii-Jeng's suicide attempt, his family members rearranged their schedule to support his plans. For example, his family would go hiking during the holidays before he attempted suicide, but at least one of them would keep him company after his event because he wanted to stay at home. His sister cancelled her trip abroad and visited him every day while he was hospitalized. Soon after Wei-Ren was sent to the hospital, his mother came to see him. In addition, he felt that his mother used her mind to advise him to accept his fate. Gwo-Chyr's parents gave him a different kind of love after his suicide attempt:

> My mom went to a temple . . . that is Taoist. The people there said that me and my ancestors . . . Our ancestors have two different positions. Those two different ancestors with two different last names contended for their posterity. This was the reason for my illness. Later, my parents held a surpassing ritual for me and prayed to the Buddha to bless my physical condition.

Because Gwo-Chyr's family only asked the Buddha for an oracle when they encountered serious situations, Gwo-Chyr sensed that his being alive was very important in his extended family due to the love he had obtained from his ancestors, parents, and Buddha. In addition, even though he was physically well, his parents also cooked some herbs for him because they believed that the herbs could help replenish his energy, which had been exhausted during his suicide attempt.

Wanting to leave family versus feeling responsible for family. Based on a unique blood relationship, affections among family members are hard to disrupt. In addition, affections are shaped and influenced by cultural values. In this study, suicide attempters related feelings of love and hate toward their families in their narratives. I describe these affections of family to highlight the embarrassment experienced by participants after their suicide attempts.

Every participant had difficulty in communicating with family before the suicide attempt. However, their problems did not resolve after they attempted suicide. Most stated that their family did not understand their feelings and that they were very often scolded by their family members, particularly their mothers. Sheu-Yu was very bored at home and did not want to go back there, because of her mother:

> I really dislike my mom. I can say it directly. I hate her, because I think she's got a bad mouth. When she can't win a fight with me, she laughs that no one will marry me, saying things behind my back. . . . My mom always thinks that not getting married is a shame (raising her pitch). Her talking makes me start to feel I am losing my face. I don't even dare to go to the school reunion, because I'm not married.

Although Sheu-Yu had difficulty loving her mother, she still stated that "as long as [her] parents were alive, [she] would never jump [from a high building]. After [her] parents are gone, [she] would have no more worries" because "[she did] not want [her] parents to collect [her] body." Similar situations happened in other participants' families. Gwo-Chyr felt bored and treated unfairly when his mother called him stupid, but he still hoped to recover soon and wanted to let his parents live more comfortably in their later lives. Ai-Ling also stated that her mother's health and two children's affairs were her present and future concern although she was disappointed due to her children's neglect of her.

May-Yu thought that all of her endeavors were for her family, and also did not want her husband to worry about their financial problems due to his poor health. However, poor

communication between her and her husband did not help her obtain her husband's support but made her husband angry. As a result, her body left home when she felt bored, but her mind still stayed at home and worried about her husband and their financial problems.

No matter how a participant complained about his or her family member(s), he or she always thought of family after a suicide attempt. Shwu-Huey expressed that she wanted to move out because of her family violence. However, when she really left home, she always worried about her family. She also said that, "I feel death can solve anything. But after I was rescued, I thought about my parents. I thought I shouldn't have no sense of responsibility." When she talked about her concerns and obligations and sensed that she was the major support for her mother, she forgave her father's violent behaviors.

The beliefs of "not letting my mom bear hardship," "not letting my mom worry about me," and "not letting my family be humiliated in front of our relatives" forced Sheau-Ming to be responsible for his family. Sheau-Ming described his role in his family:

> I'm the only one who is satisfied with the laws and regulations to make money in my family. An 18-year-old man just can make money. I'm the economic provider in my family. It's up to me to make money for the four of us . . . it's true that my family depended on me. It feels like I'm a father, and both my wife and my sons are dependent on me . . . it's up to me to be responsible for my family. I have taken this responsibility for 2 years. I got used to it. I feel it's my responsibility.

Therefore, we can understand that suicide attempters' ambivalent feelings toward their families pushed them to leave their homes and even the world, but these affections also pulled them back from death. In particular, having responsibility for their family forced them to live in the world.

DISCUSSION

In Chinese culture, once an individual chooses a certain rule for social exchange, his or her social actions usually follow two main cultural values, mientze and hsiao, based on his or her social relationships (Hwang, 1997). The self of a Chinese person is not the self of an individual in Western societies: The self-contained individualism of Western countries encourages an individual to define the boundary between the self and others by the surface surrounding one's physical body (Sampson, 1988). In Chinese culture, in contrast, an individual has two different types of self, physical and social. The individual's "physical self" is called the "small self," while the "social self," particularly including one's family members and close friends, is termed the "great self" (Hwang, 1997). Although a Chinese individual's physical self is separate from others, his or her social self is strongly embedded in a social network. Thus, one's achievement or being alive is not only for the physical self but also for the social self.

Chinese people are taught by elder family members from childhood that the first principle of hsiao is that one should not damage one's own body, hair, and skin because those are given by one's parents. If the reason for suicide is due to one's small self, such as an inability to endure an unhappy life, one will be censured by his or her community for lacking hsiao. Meanwhile, one's family members will feel that they lose face because they represent one's great self. In contrast, if the reason for suicide is related to societal needs, such as loyalty to the family or community, then suicide is more accepted by his or her family because he or she saves face for the great self. From this perspective, suicide is viewed as a shameful act, bringing dishonor to a family, and also an honorable act, upholding ethical standards in Chinese culture (Shiang, Barron, Xiao, Blinn, & Tam, 1998).

This study revealed that because of mientze, suicide attempters felt embarrassed when they chose between life and death. Although they would feel shame and guilt after they die from suicide, suicide attempters were more afraid of losing face because of an unsuccessful suicide. This study also found that suicide attempters were in pain and blamed themselves for having no sense of responsibility for their parents after being rescued. In addition, although participants had conflicts with their families, their sense of responsibility for their families helped to instill new meaning into their life journeys.

In comparison with emotional suffering, powerlessness, and the feeling that no one cares, found in Moore's (1997) study, suicide attempters in this study reflected lives of "being trapped," which made them feel embarrassed after attempting suicide: being controlled by oneself versus others, being understood versus being rebuffed by others, and feeling responsible for versus wanting to leave family. They wanted to commit suicide but, on the other hand, were not reconciled to others' arrangements or rebuffs before they tried to die. Another voice in their minds cried out, yearning to live for oneself rather than for others, a quest to be loved rather than rebuffed by others, and a will to be responsible for, rather than part with, family. In this study, participants felt embarrassed because they wished to rebuild connectedness with the self, others, and the world that had been broken before or after suicide attempts, but they did not know how to repair it.

This perspective indicates that participants are striving to change their lives from alienation to connectedness by living for oneself, seeking company with others, and feeling responsibility for their families. This assumption is based on Debats, Drost, & Hansen's (1995) previous work: One's meaningful life is generated through connecting with the self (beliefs), others (relationships), and the world (being, transcendence). Reed (1991) asserted that self-transcendence is an inward expansion of personal boundaries, through introspection, and outward, through investing oneself in relationships with oth-

ers and the surrounding environment, as well as a temporal expansion through integrating one's past and future to enhance the present life. In this study, participants' self-awareness was evoked by mirroring others' actions and words, which also reminded them of taking responsibility for their family. In addition, self-transcendence facilitates healing (Coward & Reed, 1996), self-worth, connectedness, and personal growth (Haase, Britt, Coward, Leidy, & Penn, 1992). Therefore, this study suggests that health professionals must understand suicide attempters' embarrassment and use themselves as patients' "other(s)" to help suicide attempters visualize their potential and remodel their relationships with the self, others, and the world to attain self-transcendence.

Finally, this study reveals that mientze and hsiao influenced Chinese suicide attempters to locate themselves in the dimension between alienation and connectedness. Because of these two cultural values, Chinese suicide attempters differ in their specific lived experiences from persons of other ethnicities. Therefore, health professionals working with Chinese populations cannot directly copy suicide interventions that are generated from other cultures and apply them to their clinical practice because these interventions are not sensitive to the needs of Chinese suicide attempters. On the contrary, this study implicates that health care providers must support endeavors done by suicide attempters for their families before or after their suicide attempts. In addition, health care providers should learn from suicide attempters and engage in frequent self-reflection to avoid harming suicide attempters' faces during the healing process.

This study is limited to the phenomenon of suicide in a small area of Taiwan. However, the findings raise some critical questions: whether connectedness, self-transcendence, and/or cultural values influence suicide attempters' lives in different parts of Chinese societies; whether gender is a factor of caring about mientze or hsiao; whether different reasons for desiring death generate different life perspectives; whether different meanings-in-life are generated by different stages after suicide attempts; and whether the occurrence of different life events before or after suicide attempts influences suicide attempters' lived experiences. Therefore, a longitudinal design should be considered to explore these processes after suicide attempts.

In addition to two cultural values that have been discussed in this article, religious beliefs also appeared in 3 participants' accounts. Ethnographic research will be considered to further discover the relationship between suicide and sociocultural issues in Taiwan. Besides, after the effect of political change and large-scale migration in the late 1940s, Taiwan has undergone a rapid political economic transformation from an agricultural society into an industrial country. This modernization brought economic prosperity but, at the same time, created conflicts between modern and traditional ways and Western and Chinese values for people in Taiwan (Kleinman

& Kleinman, 1999). From this perspective, the experience of Taiwan's Han Chinese people has been different from those in Mainland China or other Chinese societies. Thus, investigating suicide attempters in different parts of Chinese societies is also a task for future studies. The meaning of life and death from the Chinese cultural perspective should be continually examined in further studies.

NOTES

1. *Mientze* is a self-image formed by self-concept and others' feedback. In Chinese culture, people strive to comply with group norms to obtain their mientze.
2. *Hsiao* is a belief that orients adult children's filial attitudes and behaviors toward their parents. The characteristic of Chinese hsiao is incorporated into the patterns of care that are exchanged between the parent and child.

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Health-Culture Reorientation of Registered Nurse Students

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There is a need for a health-culture reorientation of nurses from acute care to community-based care if the profession is to respond effectively to sociocultural, political, economic, and educational forces moving health care and decision making back into the community. Concepts from anthropology, international health, and transcultural nursing provided the basis for initiating a health-culture reorientation of acute care–oriented (RN-BSN) students enrolled in a population-based community health nursing course given in a weekend format. The course centered on developing a primary health care project from assessment data gathered via the community-as-partner model. Problems encountered, methods of evaluation, and ongoing project development are discussed.

In the spring semester, 1998, multiple internal and external sociocultural forces converged on the University of Miami School of Nursing administration, faculty, and registered nurse-bachelor of science in nursing (RN-BSN) students that necessitated a health-culture reorientation to nursing, teaching-learning methodology, and the responsibilities of the university and its professional schools to the communities in the region. What resulted was a bold teaching-learning experiment that essentially necessitated the RN-BSN students enrolled in the course NUR 420, Community Health Nursing, to undergo a health-culture reorientation from nursing in acute care institutions to population-based community health nursing. The following are the four major sociopolitical and economic trends that collectively shaped the situation in which NUR 420 was to be given.

Declining Enrollment

Enrollment in the RN-BSN transition track was declining primarily due to the weekday scheduling and the changing nature of the learner. Most RN-BSN students were older adults working full-time, supporting or raising a young family and/or caring for elder parents, traveling long distances to clinical sites or to the university campus for classes, and experiencing an inability to consistently free themselves from work to attend class/clinical on a regular weekday basis. In response to such forces and to survey results of current and prospective students and employers, a weekend option for the RN-BSN transition track began in fall semester, 1997.

Health Care Reform

Changes that occurred at all levels of health care under the guise of what has been variously termed *health care reform*, *market reform,* or *insurance reform* rocked the traditional physician-dominated, acute care, institution-focused health care delivery system in the United States. The reform movement refocused health care delivery on health promotion, primary care, disease control, cost effectiveness, and health maintenance of chronic conditions (Ayers, Bruno, & Langford, 1999; Leonard, 2000; Rohrer, 1999). Health was to be addressed in the community by a variety of primary care health professionals working in collaboration (Ayers et al., 1999; Institute of Medicine [IOM], 1996). Client recovery shifted largely to the community with family, kin, and friends providing much of the care once given by nurses in hospitals and intermediate or long-term care facilities (Ayers et al., 1999).

Community-Private Partnerships

Universities, especially their professional schools, became increasingly dominated by the business model and had to attend to the business and academics of health care. They also were challenged by funding and accrediting agen-

cies, social scientists, community activists, and organizations, such as the IOM and Pew Health Professions Commission, to provide innovative models of community-based health care centered on community-private partnerships and empowerment of community groups (Baer, Singer, & Susser, 1997; Farmer, 1999; Fee & Brown, 2000; Freund & McGuire, 1995; Hahn, 1999; Mullan, 2000; National League for Nursing [NLN], 1993; Pew Health Professions Commission, 1991, 1993; Rodriguez-Garcia & Akhter, 2000).

Curriculum and Accreditation Guidelines

In its 1993 vision statement, NLN articulated the need to move to community-based care, which is a "realignment of professional allegiance and accountability away from institutions and toward populations" (NLN, 1993). The NLN considered such care to be the domain of generalists and challenged basic nursing education programs to ensure that all graduates were capable of functioning in community settings. The vision statement became a national guideline for curriculum revision and a criterion for evaluation of schools of nursing desiring accreditation or continuing accreditation through the NLN. Faculty at schools of nursing throughout the country, including the University of Miami, began to integrate more community-based experiences into the curriculum. However, such efforts focused more on community-based nursing (CBN) than on population-based community health nursing (CHN). In many cases, what was termed CHN was really primary care or home health care that remained centered on the individual and family. Witness the 1996 IOM definition of primary care:

> Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. . . . *Health care services* refers to an array of services that are performed by health care professionals or under their direction, for the purposes of promoting, maintaining or restoring health. The term refers to all settings of care (such as hospitals, nursing homes, clinicians' offices, intermediate care facilities, schools, and homes. . . . *Clinician* means an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health services to patients. . . . *Patient* means an individual who interacts with a clinician either because of illness or for health promotion and disease prevention. . . . *Context of family and community* refers to an understanding of the patient's living conditions, family dynamics, and cultural background (pp. 2-4).

From the perspective of CHN faculty, CBN was viewed in much the same manner as that articulated by Ayers et al. (1999), Zotti, Brown and Stotts (1996), and Hunt (1998). All reflected the IOM definition of primary care:

> The acute and chronic nursing care of individuals and families that enhances their capacity for self-care and promotes autonomy in decision making. This care takes place in the community where clients live, work, and play. The focus of community-based nursing care is the individual with an acute or chronic illness. (Ayers et al., 1999, p. 9)
>
> CBN is characterized by an individual and family-centered orientation, the development of partnerships with clients, and an appreciation of the values of the community (Zotti et al., 1996, p. 211)
>
> Community-based nursing describes a philosophy of care applicable to all nurses in all settings, reflecting how nursing care is provided - not where. It's directed toward individuals and families within any community setting, and is designed to assist patients as they move between and among health care settings. . . . Community-based nursing recognizes that health and social issues are interactive, and when planning care, the patient's culture, values, and all external and internal resources including social support and family are considered. (Hunt, 1998, pp. 45-46)

In contrast, CHN faculty at the University of Miami conceptualized population-based CHN as essentially synonymous with public health nursing as defined by the public health nursing section of the American Public Health Association (1981, 1996), The Quad Council of Public Health Nursing Associations[1] (1999), and Zotti et al. (1996):

> A nursing approach that merges the body of knowledge from the public health sciences with professional nursing theories for the purpose of safeguarding and improving the health of populations. It is based on the principle of social justice, which maintains that everyone is entitled to basic necessities, such as adequate income and health care. . . . Community health nurses use a population-focused approach rather than direct care to individuals and families. . . . Population-focused practice is concerned with aggregates, which form many subpopulations within the entire community. (Ayers et al., 1999, pp. 10-11)
>
> The goal of public health nursing is the prevention of disease and disability for all people through the creation of conditions in which people can be healthy. . . . Public health nurses assess the needs and strengths of the population, design interventions to mobilize resources for action, and promote equal opportunity for health. Strong, effective organizational and political skills must complement their nursing and public health expertise. (Quad Council, 1999, p. 2)

The above definitions and concepts became the guidelines for the development of NUR 420 for the weekend RN-BSN transition track. All required a health-culture reorientation of faculty and the RN-BSN students who had largely been schooled in acute care nursing and nursing in other types of institutional settings. In contrast, community health nurses (CHNs) work primarily with well individuals and concentrate on the health promotion and illness prevention of aggregates.

The majority of CHNs' time is spent on group assessment, communication, and education rather than on direct physical care of individuals, which is emphasized in acute and long-term care facilities. For CHNs, the client is the community or some aggregate therein that is or should be actively involved in its own health care planning due to its greater autonomy and control of the setting. As a result, clients of CHNs have greater choice of alternative interventions than nurses usually provide or allow clients in acute care settings. Communication and interviewing skills and techniques of group teaching/mobilization are necessary and fundamental skills of CHNs, more so than for acute care nurses who value and are evaluated more for their psychomotor skills and technical knowledge of machines (Ferguson & Calder, 1993).

Cultural and health-culture differences, the effects of sociodemographic and environmental variables and personal lifestyle on health choices or nonchoices, are everyday contextual realities. CHNs confront these realities when they attempt to engage population aggregates in fashioning health-promoting and illness prevention initiatives. Using cultural institutions and resources to address human, group, and community problems form the basis of culture-competence for CHNs (DeSantis, 1994, 1997; Green, 1982). CHNs have long taken the concepts of cultural diversity and sensitivity/awareness to the applied practice level (Jossens & Ferjancsik, 1996; Ruffing-Rahal, 1991). It is a philosophy and a state of mind that has not yet been achieved by the majority of nurses in acute care or other institutional settings where the institution (a) is the culture, (b) sets standards for client and staff behavior and activities, (c) determines what clients need to know and often does not much care what the clients or their families do think or know, and (d) considers clients' knowledge, beliefs, and practices that differ from those of biomedicine or nursing to be knowledge deficits in need of correction (DeSantis, 1994, 1997; Geissler, 1991; Leininger, 1990). The conversion of acute care–oriented and institutionally situated nurses to the ideology and worldview of population-based CHN was the task given to faculty in NUR 420 for the RN-BSN transition track.

OVERVIEW OF THE RN-BSN TRANSITION TRACK

The RN-BSN transition track requires a total of 120 credits for the BSN degree. Thirty credits in nursing must be taken at the School of Nursing (see Table 1). Another 30 nursing credits are granted if passing scores are attained on the Regents College Examinations (adult nursing, maternal and child nursing, and psychiatric/mental health nursing). The remaining 60 credits are transfer credits reflecting mainly required prerequisite and general education courses.

NUR 420 is a five-credit course with three credits allocated for lecture and two for clinical, totaling 3 contact (clock) hours for class and 6 contact hours for clinical weekly

TABLE 1
Required Course Work for the RN-BSN Transition Track

Time Period	Credits
Semester 1	
NUR 302: Professional Concepts	2
NUR 314: Health Assessment	3
NUR 316: Application of Professional Concepts	5
Total	10
Semester 2	
NUR 402: Issues in Clinical Nursing	2
NUR 300: Introduction to Nursing Theory and Research	3
NUR 420: Community Health Nursing	5
Total	10
Semester 3	
NUR 404: Nursing Management and Leadership	3
NUR 426: Professional Role Synthesis	5
NUR xxx: Nursing Elective	2
Total	10

SOURCE: Adapted from *The University of Miami Undergraduate Studies* (1998), p. 446.

over a 14-week semester. Moving the course to a weekend format meant that students would meet for classes and practicums seven times or every other week. An eighth class occurs during the 15th or examination week. The weekend format also meant that practicums occurred when virtually none of the traditional public health or other population-based agencies were functioning with other than an on-call or emergency staff basis. Use of primary care or home health agencies on the weekend was not an option because (a) NUR 420 was to be a population-based, CHN course and (b) the prerequisite course, NUR 316, Application of Professional Concepts, was designed to provide multiple and varied CBN and primary care nursing experiences with individuals and families across the life span. Clinical placements for NUR 316 included University of Miami School of Nursing Centers, Immigration and Naturalization Service detention centers, homeless shelters, school health clinics, respite care, migrant camps, rape counseling facilities, church/parish health facilities, senior citizens centers, hospice, shelters for abused women and children, juvenile detention centers, prisons, and a variety of other primary care activities. The extensive CBN and primary care experiences in NUR 316 allowed faculty and the RN-BSN students in NUR 420 to concentrate on population-based CHN.

THE EXPERIMENT

The lack of availability of traditional population-based and public health agencies for practicums on the weekend required NUR 420 faculty to develop alternative types of CHN experiences. The faculty explored the possibility of providing an immersion experience over a concentrated period of time in another cultural setting, such as the rural health nursing experience developed by Erkel, Nivens, and Kennedy

(1995), the field school experience used by Kavanagh (1995, 1998) with the Lakota Indians, or the international health model used by Ailinger and Carty (1996) and Geissler (1995) to teach CHN in Nicaragua and the Dominican Republic, respectively. Such experiences have effectively engaged students in actively learning about and participating in other cultures and heightening their sensitivity to multiple and contrasting realities. An immersion experience was not possible in the RN-BSN transition track curricular plan due to class scheduling and student employment commitments.

CHN faculty also desired to avoid the common "day-tripper" model of CHN for the RN-BSN transition track. In the day-tripper model, students have clinical experience once weekly and often go to a variety of settings during the semester for short-term exposures to faculty-selected, arranged, and managed experiences.

Removing Structure-Promoting Serendipity

To bring about the health-culture reorientation in the weekend curricular format, the faculty decided to promote the serendipitous learning opportunities that are inherent in CHN (Geissler, 1995, p. 4) by removing much of the traditional structure and rigidity of preplanned clinical experiences. The entire clinical experience was to be centered on the process of community assessment. Students were divided into self-selected groups of four to five members and given five concise guidelines.

1. Select a geographically bounded community in the south Florida region. The assessment was deliberately limited to a geographically bounded community rather than to some other type of aggregate or institution where sociodemographic and health status indicators are less readily available.
2. Assess the community using Anderson and McFarlane's (1996, 2000) community-as-partner model.[2] The model was the only real structure given the students. It was selected because (a) it is a systems-oriented community assessment device, (b) it incorporates the underlying philosophy of primary health care as delineated by the World Health Organization ([WHO], 1978)[3], and (c) faculty wanted the RN-BSN students to view primary care as part of primary health care and to approach the concept of interdisciplinary collaboration from the multisectoral perspective. The pervasive view of interdisciplinary collaboration among the RN-BSN students was generally in the form of referrals and consultations with other health care providers. Requiring a systems-type of community assessment literally forced students to see that the health care system was but one factor in a complicated and intricate equation of political, socioeconomic, cultural, biological, physical, and other contextual and situational factors that contribute to health, illness, and policy making (Baer et al., 1997; Basch, 1999; Farmer, 1999; Fee & Brown, 2000; Freund & McGuire, 1995; Hahn, 1999; Kim, Millen, Irwin, & Gershman, 2000; Turnock, 1997; Young, 1998).
3. Use the nursing process to identify the health needs and problems that emerged from the community assessment and deter-

mine appropriate nursing diagnoses for the community or aggregates within the community.[4] The RN-BSN students were accustomed to using the nursing process, and faculty felt it would be a familiar way of organizing, condensing, and analyzing the large amount of assessment data they accrued.
4. Select one nursing diagnosis that could be addressed by a community-based intervention capable of being completed by the end of the course. The diagnosis/problem selected was thereafter referred to as the clinical project.
5. Develop, implement, and evaluate the clinical project. If the project included a formal presentation, demonstration, teaching session, or some similar activity, a faculty member was to be present as it was carried out.

Giving only five broad guidelines placed the students in a discovery mode, much as ethnographers experience when doing ethnography. Faculty believed that the students' experiences to date as registered nurses would give them the maturity and confidence needed to sustain them through (a) the early and crucial stage of what would soon become the unraveling of their known culture of acute care and institution-based nursing and (b) the construction of and experience in the yet unknown culture of population-based CHN.

The first class session discussed the concepts of community-as-partner and community-as-client and demonstrated rapid assessment procedures (RAPs) (Scrimshaw & Hurtado, 1987; WHO, 1999). RAPs are a method of rapid information gathering about values, beliefs, and cultural perspectives that helps identify and define health problems and assists in developing effective and valid clinical projects and criteria by which to evaluate these problems (Harris, Jerome, & Fawcett, 1997). Gaining skill in the use of RAPs was essential due to the dearth of health-culture data specific to aggregates in the communities assessed (DeSantis, 1999).

The students' assignment for the second class, 2 weeks hence, was to conduct a windshield survey[5] of their communities. Students immediately dubbed this as doing their "drive-bys." Based on the windshield survey, they identified areas where additional information was needed and proposed methods of gathering it. For example, one group noted the large growth in the adolescent population in a section of Miami-Dade County, which had limited health facilities and programs for that age group. They became interested in learning about adolescent health needs from the perspective of the adolescents. They gathered information by surveying 10th-grade students at the area high school and interviewed parents, school officials, and school health personnel. Another group wished to explore the health needs of commercial shrimp fisherman in the Florida Keys. They spoke with retired shrimpers, public health officials, shrimpers from boats docked for refueling, personnel from the shrimpers' union and health insurance companies, state marine officials, and hospital and clinic personnel from whom shrimpers received medical care.

Depowering the Empowered

Removing most of the structure from the traditional, pre-planned nursing clinical experience placed the RN-BSN students in a position of lacking power to enforce their ideas of reality and truth, that is, what should be and how it should be done according to them. The community-as-partner model essentially empowers the community. Empowerment is the "process of cultivating the power in others through the sharing of knowledge, expertise, and resources" (Funnell et al., 1990 as cited in Miewald, 1997, p. 357). Viewed from this perspective, community empowerment requires CHNs to be resources for the community, which remains in control of actions and interventions designed to improve the lives and health of its members. Putting the control of health in the hands of the community means examining the causes of ill health rather than promoting lifestyle changes in individual members, which has been the usual mode of operation of nurses in acute care and other institutional settings. Focusing on individuals or the micro-level of nursing decontextualizes them from the macro-level or community in which the vast majority of the root causes or risk factors for most of the leading causes of morbidity and mortality reside (Baer et al., 1997; Fee & Brown, 2000; Freund & McGuire, 1995; Hahn, 1999; Kim et al., 2000; Mullan, 2000; Young, 1998).

Focusing the RN-BSN students at the community level and making them dependent on the community for health information prevented them from entering the field with an agenda already in place and required them to re-evaluate who was in charge. It forced them to look at alternative realities or health cultures that defined what health and illness were, how they were caused, and what should and, most important, could be done about them. It helped the students to reconceptualize their traditional mindset of nurses as planners, managers, and evaluators to that of nurses as resource persons (DeSantis, 1998). It also aided in preventing cultural determinism and enhancing reflexivity on the part of the students. Through the process of community assessment, faculty hoped that the students would become empowered by the community to learn the health culture of CHN and to use the power of their new health culture to assist the community with a health problem or need.

Increasing Reflexivity

Faculty also desired that the students critically analyze the concept that they were culturally neutral and increase their reflexivity. RN-BSN students and the majority of other health care professionals depend overwhelmingly on formalistic knowledge to determine interventions. They thrive on data like universal norms for human growth and development, behavior, and life stages. Differences in norms become things to change so that they fit into the biomedical or nursing health care models. This is usually manifested by the response that once you find out what patients know and do not know about their condition or health care situation, you can do health teaching, that is, teach them what they need to know based on the tenets of biomedical-based health care. Such formalistic knowledge largely subverts the whole idea of diversity of views and reflexivity to mechanistic thinking. Faculty believed that the mere reproduction of knowledge devoid of context would devalue the experiences of the RN-BSN students and their clients and subvert critical thinking to formalistic action (DeSantis, 1998; Wozniak, 1998).

Placing the RN-BSN students in the position of dependent learners was a deliberate attempt to help them realize that their perspective was but one of a multitude of perspectives or multiple realities (DeSantis, 1994) that coexist in a community. Faculty hoped that through experiencing that they were but one of many and assuming the outsider role, the students would come to understand what collaboration and partnership really meant in population-based CHN. The outsider role would assist them to learn to think critically and, as Wozniak (1998) stated, "integrate diverse and changing constructs of community, gender, age, social class, needs, and acts of contestation into an understanding of . . . [other peoples] . . . and embed that understanding within the larger socio-cultural context" (p. 7). The students would learn to consciously practice reflexivity about what they knew, how they came to know it, and how they intended to use such knowledge.

Having to restructure their concept of nursing and health outside of their native acute care or institutional culture was one way of increasing the RN-BSN students' reflexivity, thereby sensitizing them to the diversity of views and incorporating those views into a community-provider plan of action. By having to relearn their culture of nursing, they became the client struggling to be heard and trying to be considered relevant by the community they were trying to learn about and assist. Examples of students' clinical projects are listed in Table 2. None of the groups developed clinical projects that extended into true primary health care à la Alma Ata. However, the students did emerge with a newfound appreciation for the concept of environmental justice, the politics of health care, and what was meant when poverty was described as a risk factor.

PROBLEMS, POTENTIAL PROBLEMS, AND RECOMMENDATIONS

Several anticipated and unanticipated problems that occurred with the clinical portion of NUR 420 are briefly presented. Contingency plans are now in place for other potential problems that could occur.

Inability to Complete the Actual Project

A very real problem that has not occurred is the failure to actually complete a clinical project within the semester enrolled. Close faculty supervision was required to prevent students from taking on more than they could realistically hope to complete in a semester and to promote economy of

TABLE 2
Examples of Student Clinical Projects

Project	Description
1	Improving contraceptive use and distribution and education about HIV/AIDS and other sexually transmitted diseases for commercial shrimpers in the Florida Keys.
2	Making a health teaching film for migrant farm workers on diabetic diets. The film centered on ordering food in cafeterias and engaging cafeteria workers as grassroots health educators.
3	Certifying home health visitors in a migrant camp in cardiopulmonary resuscitation. The health visitors were the first on the scene when emergencies arose with infants, children, and other family members.
4	Conducting a health fair on alcoholism in the Florida Keys.
5	Teaching basic nutrition to kindergarten students on a Florida Seminole reservation.
6	Teaching infant first aid to adolescent mothers at a Miami-Dade County school for pregnant teenagers.
7	Being part of a health fair on parenting in Homestead, Florida.
8	Setting up blood pressure screening clinics in recreational centers for the elderly in African American and Puerto Rican communities.
9	Conducting classes on nutrition and eating disorders for all 10th-grade students in a Miami-Dade County high school.
10	Doing a series of HIV/AIDS outreach and educational sessions on South Beach (Miami Beach) at established health clinics, storefront clinics, and sidewalk health kiosks.

NOTE: This list does not adequately reflect the great amount of work and effort students expended, the application of what they learned, or their evolving health-culture reorientation from acute care nursing to population-based community health nursing.

time and effort. Requiring the windshield survey to be done by the second class helped keep students on track, aided in constructing a project time line, and prevented procrastination. This requirement led automatically into a discussion and analysis of their initial impressions of the community and potential or actual problems/needs to be investigated between classes.

Division of labor among group members was encouraged to stress principles of collaboration and to prevent duplication of effort. The students tended to be rather communal, going as a group to gather statistics, do interviews, make needed observations for RAPs, or approach gatekeepers (e.g., clinic personnel, school administrators, and public officials) for access to information or population groups. Biweekly progress logs were very helpful in limiting student projects to realistic endeavors and in detecting potential problems not yet apparent to the students. Also essential was meeting with each group after class for a progress/summary report, group problem solving or brainstorming, and establishing goals for the next 2 weeks.

Faculty Coverage

Because the entire clinical portion of the course was a work in progress, it was essential that the students develop measurable objectives for evaluating their success. Project objectives became the basis for evaluating the project and arriving at the clinical grade. They also became the basis by which other faculty who were needed to cover for course faculty could assist in judging, as fairly as possible, the effectiveness and success of the clinical portion of the course. For example, although the actual class met on the weekend, most of the projects were done on weekdays. NUR 420 faculty taught other courses during the week so that faculty coverage of clinical projects could have become a problem. Conversely, one project had to be scheduled on a Saturday, which, as luck might have it, was the class day. By prior agreement with the students, a noncourse faculty member attended their Saturday project presentation. In anticipation of her coming, the group fully appraised her of their project objectives and related activities. She and the NUR 420 faculty member jointly determined the clinical grade, relying greatly on the clinical objectives submitted by the group.

Extra Expenses

As a grassroots experience in fund-raising and resource procurement, faculty encouraged students to approach school and university officials and community sources for assistance when attempting to secure needed equipment, teaching materials, or mementos to give as a "thank you" to individuals for their cooperation and assistance. However, sometimes an occasional extra expense was unavoidable. It was the philosophy of the faculty that neither students nor course faculty should sustain extra costs to meet course requirements. After the initial NUR 420 weekend course, a modest budget of up to $500 was allotted by administration for discretionary use by faculty in meeting unanticipated project expenses.

Group Friction/Dissension

The inability of individuals in some groups to work together was a problem at times. Faculty made it quite clear to the students that they were adults and professionals who have been very capable of handling conflict in their work settings, in their own families, and in other aspects of their lives. Faculty also took several steps to prevent group friction from becoming a factor by limiting groups to five students who self-selected their membership. Those living in the same geographic region were encouraged to become members of the same group and to select a community within their area to decrease travel time and enhance working together between class sessions. This was not always possible because the weekend program attracted students from all parts of Florida. Students commuting from long distances compensated by (a) participating in group planning via e-mail and phone, (b) using the time after class to determine assignments they were to complete by the next class, (c) assisting with the community assessment via the library or web to gather health and census data, and (d) taking overall responsibility for organizing and editing the written portion of the project. A fair divi-

sion of labor was generally achieved based on the limitations presented by each member's work, family, personal responsibilities, and geographic location. For most students, NUR 420 was a very practical lesson in sharing responsibility, capitalizing on each other's differing talents and knowledge, and putting the nurturing and holistic aspects of nursing into practice.

Time

Students initially felt that the clinical portion of the course necessitated more time in actual hours than would have been required if they had had the usual individualized, preplanned, clinical experiences scheduled in predetermined blocks of time. This complaint was short-lived once faculty explained that each student was to have 84 contact hours of clinical experience over the course of the semester. With five students per group, each group had the equivalent of 420 hours to accomplish their community assessment and specialized clinical project. Groups did not raise this complaint vigorously if they had devised a suitable division of labor and a time line for developing and implementing their clinical projects.

Support of Administration and Faculty

Such a relatively unstructured course could not have succeeded without the support of administration and faculty colleagues who gave course faculty the leeway to experiment and remove the structure of formal, preplanned clinical experiences. The dean and associate dean came to hear the students present their community assessments and clinical projects, giving the students an extra special sense of pride in their accomplishments. Several projects were featured for accreditation site visitors and in the president's annual state of the university letter as examples of how the university was meeting its community service commitment.

Support of the Community

The critical imperative for the success of the course was the support of the south Florida community. Especially important were the people, the general citizenry, who had a thirst for health knowledge, a desire to improve the health and status of their community, and a willingness to teach and learn from those that they perceived respected and cared for their communities. Also important was the south Florida health care community. Like health care providers and agencies everywhere, this community was inundated with daily change and upheaval under the guise of health care reform. At the same time, it was inundated by a large number of students learning the principles of community-based care at the ground level, requiring a considerable amount of the individual provider's time in the form of mentoring and facilitating.

Staff at public and private community service agencies were unyielding in their support, providing information on transportation, crime statistics, health care facilities, popula-

tion demographics, and other community assessment information the students sought as they went about identifying problems they could address in a short period of time. Not to exhaust the good will of individual communities, faculty were insistent that students not choose the same communities each semester for their assessments and clinical projects. Faculty were equally insistent that students notify them of whom to call or write to thank for special arrangements or assistance. Faculty also received multiple thank you letters from the agencies in advance of their project follow-up letters.

Some students became personally invested in their projects as citizens and nurses. Many were residents of the communities they assessed or had jobs in health care institutions serving those communities. As such, they knew many gatekeepers who could help them access needed information and/or assist in getting projects underway. They, thus, became invested in selecting projects that improved the quality of life of their family, neighbors, and fellow citizens. Many have gone back independently as volunteers to help extend their projects, initiate new ones, or do health teaching.

CONCLUSION

Faculty have been pleased by the results of the "invention due to necessity." Course evaluations, exit interviews with graduating students, and students' self-evaluations revealed that the majority did experience a health-culture reorientation from the micro-level of individual/family in an agency-controlled setting to the macro-level of aggregate/population in a relatively unstructured setting of the community. Many students experienced the dichotomy of being an outsider and insider at the same time. Others experienced the effects of being an outsider trying to gain entrance into a relatively new and strange world of health care that was largely foreign to them. The majority felt the depowering effects of loss of control by going from teacher-doer-director to learner-receiver-collaborator/partner.

Although few engaged in primary health care from a multisectoral perspective of WHO, they certainly saw health care from a different vantage point and experienced what health promotion, illness prevention, and health maintenance meant from a population-based perspective. They learned the essence of ethnography: (a) listening and hearing, (b) observing and seeing, (c) asking questions that permitted respondents to actually answer what and how they felt, (d) participating while reflecting on their own responses and feelings, and (e) translating from the nurse-etic (outsider perspective) to the community-emic (insider perspective) for faculty, the health care community, and public and private officials. They learned to speak in the language of CHN. Most important, they learned that CHN is a philosophy and worldview and not simply an out-of-hospital experience or the transferring of acute care nursing to a community-based setting.

NOTES

1. The Quad Council of Public Health Nursing Organizations comprises the following organizations: (a) the American Nurses Association Council for Community, Primary, and Long-Term Care Nursing Practice; (b) the American Public Health Association Public Health Nursing Association; (c) the Association of Community Health Nursing Educators; and (d) the Association of State and Territorial Directors of Nursing. A complete definition of the tenets, scope, and standards of public health as defined by the Quad Council can be found in the American Nurses Association document "Scope and Standards of Public Health Nursing Practice" (Quad Council, 1999).

2. In the community-as-partner model, the community is the core surrounded by eight interacting subsystems: communication, economics, education, health and social services, physical environment, politics and government, recreation, and safety and transportation. The core represents the demographics of the community; its values, beliefs, and practices; and its history. The core and its subsystems are in constant interaction and reach a level of equilibrium or health represented by effective coping skills and problem-solving abilities, achievement of common public health indices, and favorable developmental indicators such as high employment, high levels of education, and good housing. The system utilizes its internal strengths (health) as mechanisms to provide lines of resistance to stress and tension and to cope with and defend against internal and external stressors. Stressors may cause tension and disequilibrium in the system, resulting in a decline in public health indices and developmental indicators like rising unemployment and declining public services. Changes in the ability of the community system to react to tensions and stressors provide the basis for community diagnoses and subsequent interventions by the community in partnership with the community health nurses (CHNs). For further discussion of the Neuman model and the community-as-partner model see Anderson and McFarlane (2000), Lowry and Martin (2000), and Neuman (1972).

3. Based on the Declaration of Alma Ata (World Health Organization [WHO], 1978), primary health care is defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (p. 3).

Primary health care

1. reflects and develops from the political, social, cultural, and economic characteristics of the country and its communities;
2. addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;
3. involves, in addition to the heath sector, all related sectors and aspects of national and community development . . . and demands the coordinated efforts of all those sectors;
4. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care, making the fullest use of local, national, and other available resources and, to this end, develops through appropriate education the ability of communities to participate;
5. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; and
6. relies, at the local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed. (WHO, 1978, pp. 4-5)

4. Students were encouraged to use Muecke's three-part format for stating community diagnoses: (a) *Risk of* refers to the specific community problem or risk, (b) *among* is the population the CHNs work with in relation to the problem/risk, and (c) *related to* describes the community and environmental characteristics identified in the database gathered during the assessment phase (Muecke, 1984).

5. A windshield survey is the observations made of multiple dimensions of an area while driving or riding through it—for example, community topography and geographic boundaries, activities the populace engages in and when they occur, gathering places, availability of public services, quality of housing, and number, type, and location of institutions such as schools, hospitals, and businesses. It is usually the initial step in a more comprehensive community analysis format such as the community-as-partner model (Anderson & McFarlane, 2000; Lowry & Martin, 2000).

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The Bridging Approach: Effective Strategies for Teaching Ethnically Diverse Nursing Students

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This article describes one of the five patterns of teaching, the bridging pattern, which was identified by the author in a previous qualitative study that investigated the processes by which nurse educators teach ethnically diverse nursing students. An overview of the original study is presented, followed by a discussion of the findings regarding the bridging pattern. Data were obtained through in-depth interviews with 26 nurse educators and 17 nurses representing three population groups: Asian Americans, African Americans, and Mexican Americans. In the bridging pattern, educators encourage students to maintain their ethnic identity, and teaching-learning strategies are modified to meet the cultural needs of students. The conditions, actions and consequences involved in the bridging approach to teaching are described and examples that emerged from the data are presented as illustrations. Examination of the actions of the bridging faculty may assist educators to analyze their own approach to teaching ethnically diverse students.

Two critical issues confronting the nursing profession are the shortage of nurses and the increased numbers of linguistically and culturally diverse clients. Diversity among clients is now the norm, and encountering clients who speak limited or no English is commonplace (Stewart, 1998). Racial and ethnic groups are underrepresented among registered nurses, and nursing is still considered a profession that represents the dominant majority (Coffman & Spetz, 1999; Eliason, 1998; Trossman, 1998). Educators must address the challenge of increasing the success of students from diverse populations in nursing programs. Teachers need to develop strategies to teach and retain diverse students who will provide culturally relevant care (Campbell & Davis, 1996; Crow, 1993). Some projections indicate that by the year 2026, 70% of American students will be from Hispanic or non-White population groups (Garcia, 1995). This major demographic shift necessitates a major change in how educators view teaching and learning (Latham, 1997, p. 88). Bintz (1995) asserted that educators who teach in multicultural settings should base education on a diversity model, which recognizes that diverse students operate from deeply embedded and culturally defined systems of values, beliefs, and meanings about the world. Meaningful learning is grounded in a model of education based on a theory of difference rather than consensus. When educators attend to the subtle differences between the norms of a college culture and the expectations, values, behavioral norms, and assumptions about education that students bring to a college, they are more successful in addressing the needs of students from diverse populations (Sheckley & Keeton, 1995).

Theoretical models and paradigms discussed in educational multicultural reform literature are applicable to nursing education. This reform movement strives to restructure overarching policies and to change educational institutions in ways that give all students an equal opportunity to learn without barriers (Banks, 1995; Grant, 1995; Grant & Gomez, 1996; Sleeter & Grant, 1993). Multicultural education research describes models teachers can use to empower students and suggests strategies to assist diverse students to express their views. Banks's (1995) research identified five dimensions of multicultural education: (a) content integration, (b) the knowledge construction process, (c) prejudice reduction, (d) an equity pedagogy, and (e) an empowering school culture and social structure. Sleeter and Grant's (1993) approach labeled as "education that is multicultural and social reconstructionist" is designed to promote structural equality and cultural pluralism in the classroom and educational system. Culley (1996) critiqued the discourse on multiculturalism in the nursing literature suggesting that the "ethnic sensitivity" model of race and health fails to analyze the institutionalized racism within the health care system and society in general.

There is a significant body of nursing literature that focuses on an international perspective, transcultural or cross-cultural nursing care issues, and the integration of cultural content into the curricula. Nursing literature includes discussions of student diversity issues such as the status of minorities in nursing education (Davis, 1995), assessing culturally diverse students (Davidhizar, Dowd, & Giger, 1998), and teaching English as a second language (ESL) students (Abriam-Yago, Yoder, & Kataoka-Yahira, 1999; Malu & Figlear, 1998). Other studies have investigated barriers influencing success (Merrill, 1998), mentoring programs (Gonzalez, 1994; Rew, 1996), and recruitment and retention issues (Campbell & Davis, 1996; Dowell, 1996; Hesser, Pond, Lewis, & Abbott, 1996; Jeffreys, 1998; Omeri & Ahern, 1999). The predominant model in the nursing literature focuses on teaching the culturally different student. The aim of this model is to assimilate ethnic/racial minorities into the mainstream so the students will acquire the knowledge and values of the dominant culture (Sims & Baldwin, 1995).

There have been very few studies conducted to explore nurse educators' approaches to teaching ethnically diverse students. One study conducted by Dickerson & Neary (1999) found that faculty have a strong academic worldview and that maintenance of professional standards in the tradition of Western medicine overrides efforts to provide culturally relevant individualized programs. Their research suggested a common theme regarding the pedagogy of nursing faculty. The traditional nursing approach to teaching/learning has limited flexibility for change to accommodate alternative methods that encourage multicultural dialogue. In their study of faculty teaching Native American students, they found that faculty need to examine how to negotiate the gaps between the academic culture and the student's traditional culture. Some faculty recognized the need to bridge the gap, whereas others were not as sensitive to this need. There is little research reported that has investigated the opinions of ethnically diverse nurses or students regarding the issues they face or the strategies that serve their educational needs. The majority of the research regarding students is focused on African American students (Jordan, 1996; Kirkland, 1998; Langston-Moss, 1997). There is a need to explore the teaching methods nurse educators and nursing students or graduates perceive to be effective.

PURPOSE

This article presents a part of a previous large qualitative study, conducted by the author, which examined the processes by which nurse educators teach ethnically diverse nursing students. The details of design and methodology of the original investigation and other aspects of the study were reported elsewhere (Yoder, 1996, 1997). This discussion will briefly present an overview of the original study and will then focus on one of the five patterns that was identified in this research, the bridging pattern.

In the original study, data were obtained by in-depth interviews with two groups of informants: 26 nurse educators teaching in California nursing programs and 17 nurses who graduated from California nursing programs. The nurses represented three population groups, Asian Americans, African Americans, and Mexican Americans. The nurse informants reflected on their perceptions of their experiences as students. A grounded theory method was used for data analysis and theory development.

Data analysis revealed that educators manage teaching by an interactive process of responding that has three components: (a) sending cues, (b) interpreting cues, and (c) acting/interacting based on cues. A significant condition identified as influencing the process was the cultural awareness of the educator. Broad structural issues, as well as conditions influencing the individual, bear on the cultural awareness. At the individual level, the principal conditions identified as influencing cultural awareness were the lived experience of the educators, their participation in sensitivity sessions, their experience interacting with diverse students, and their level of commitment to equity. Differing levels of cultural awareness resulted in varying levels of responding in culturally sensitive ways. The educators' responses ranged from no accommodation for the needs of ethnically diverse students to a high adjustment of teaching strategies to meet the needs of students.

PATTERNS OF TEACHING

Five patterns of teaching emerged from the data and were identified by the investigator as: (a) the generic pattern, (b) the culturally nontolerant pattern, (c) the mainstreaming pattern, (d) the struggling pattern, and (e) the bridging pattern. In the generic pattern, educators did not consider ethnicity an important factor influencing the educational process. Educators adopting a culturally nontolerant pattern were unwilling tolerate cultural differences. In the mainstreaming pattern, strategies were directed toward repatterning student behaviors to meet the expectations of the dominant society. The struggling pattern was characterized by growing awareness of cultural differences and struggling to adapt strategies to respond to cultural needs. These educators identified the need to become more culturally competent in their interactions with diverse students. In the bridging pattern, educators encouraged students to maintain their ethnic identity and modified their strategies to meet cultural needs of students.

The identified teaching approaches resulted in different consequences for the nurse educators and the ethnic students. The generic, culturally nontolerant, and mainstreaming approaches, which provided very little accommodation of ethnic students, resulted in negative consequences. In con-

trast, consequences of the bridging pattern were positive for students.

The conditions influencing the educators and students, their actions, and consequences of the bridging teaching approach for faculty and students are described. Examples presented as illustrations are derived from the data. This study illustrates the unique characteristics of the bridging group of educators. By examining the teaching strategies of the bridging educators, the reader will gain an increased understanding of possible teaching approaches. This will be helpful as educators reflect on their own approaches to teaching in multicultural settings.

CULTURAL AWARENESS OF THE BRIDGING FACULTY

The educator's level of cultural awareness was the main condition explaining the variation found among the informants, which influenced their responses to ethnically diverse students. The individuals identified in the bridging group were all ethnic minority persons, and they demonstrated a high level of cultural awareness. The majority of the faculty adopting other teaching approaches were European American. The most significant conditions influencing the bridging educators' levels of awareness were their experiences as ethnic minority persons, their identification with students' experiences, the extent to which they valued diversity, and their formal educational preparation.

The bridgers retained a strong ethnic identification, which was an important factor affecting their responses to students. They had the capacity to identify with the experiences and feelings of ethnically diverse students. When describing her preparation for working with diverse students, one informant simply stated, "life." These life experiences provided informal education for interpreting the cues that the students sent. They valued diversity, appreciated the unique backgrounds of the students, and viewed working in a diverse setting as a rewarding experience. This valuing, communicated to the students, was used as a strategy to enhance the learning environment as one informant expressed:

> We have said we want minorities because we value that and the contribution that they make. . . . It is bringing up all those positive things. They see, "Oh, I have something of value . . . and I can contribute and make a difference when I go to see that patient."

Bridging educators identified with the experiences students described because many had faced issues similar to the problems the students encountered. Because of this firsthand experience, they were able to relate to students on a personal level. Life experience had provided an informal education for interpreting the cues that students sent.

In addition to informal preparation, many of the informants studied ethnic and cultural issues as a part of their graduate preparation. Their education included (a) classes in medical anthropology, anthropology of health, and history of illness; (b) research experience; and (c) participation in institutes providing intensive cultural training. All worked with diverse clients in their clinical practices. The educators in this group were better prepared to work with diverse students because of their educational background and life experiences.

FACULTY INTERACTIONS WITH DIVERSE STUDENTS

The process of interacting with diverse students involved assessing the cues the students sent, distinguishing cultural problems, and recognizing the barriers students faced. One informant described how she drew from her own life experiences to assess the students' cultural backgrounds and note cues:

> My family aspired middle class even though we were poor. . . . I think knowing about aspirations helps enormously. Many times I see students who say, "I'm the first one in the family. I've got to do well." . . . So they are not just going to school for themselves, they are going to school for the whole family sometimes.

This group of educators analyzed the students' cultural frames of reference and determined the effect of the students' cultural views on their understanding of nursing concepts. They also explored differences in perceptions and endeavored to build teaching strategies that were relevant to students. Based on their assessment of cultural cues, these educators identified differences in students' cultural frames of reference. The major cultural conflict issues that emerged in this study were (a) differing definitions of health, (b) alternative views of appropriate relationships with teachers, and (c) varied ideas about suitable learning approaches. Often ethnic students' assumptions about basic nursing concepts differed from the views of majority students. Nursing concepts are culturally based as one informant explained:

> I think that the perceptions are different, the definitions of health and illness are different. . . . The first thing I want to do is find out what that difference is. What do students understand by health? What do students understand by their own personal experience of illness, and what does that mean to them and their own family?

The bridgers believed that the students' perceptions of the role of a teacher were related to their cultural values. One interesting phenomenon was the cultural conflict about the role of the educator and the students' apprehensions about approaching teachers. A Vietnamese American described her perceptions:

Some of them, they were very afraid to approach a teacher because we are taught that an authoritative figure is not your friend. So you have to respect them. Respect means you do not bother them. . . . If you don't understand, that's your problem. So, it is hard to tell them to just come up to ask questions because sometimes they are just afraid. Sometimes they just don't want the teacher to know that they are stupid. . . . They just pretend that they know, but really, they don't know.

One educator who conducted individual conferences with each student explained how she explored views of collegial relationships:

I have lots of Asians. . . . They are always a little more formal. The teacher is respected, and they are usually quiet. We talk about that and the differences. . . . I tell them to call me [first name] but they still feel they have to call me Mrs. [last name]. I say, 'No, call me [first name].' But they carry that over. So I let them decide. [chuckle]

The bridgers claimed that the students' approaches to learning were grounded in their cultural system leading to conflicting values about learning approaches. In the dominant cultural system in which individualism and independence are highly valued, many educators stress the importance of independent learning and competition. An independent learning approach presented problems for some ethnic students who were enculturated in family systems in which interdependence was encouraged. One educator described the conflict between dependence and self-reliance she encountered:

Some of the students believed that the teacher was there to teach you. When you don't understand something, you go to the teacher, and the teacher should take your hand and walk you through learning a concept. . . . Some of the Anglo teachers believed that learning should be an independent thing. . . . The students thought that those Anglo teachers didn't want to spend the time with them.

Identifying Barriers Students Face

In contrast to the other groups of educators, bridging faculty identified many barriers students encountered in the university as well as in the clinical agencies. The majority believed that prejudice, discrimination, and racism present major problems for ethnic students. The following excerpt illustrates some of the concerns expressed:

At all levels, they face the barriers of racism, institutional racism. . . . In terms of the university, they face the barriers of stereotyping. I would say that occurs at all levels. . . . The level of expectation is low, and they are not expected to succeed at the university level. . . . The barriers are all based on the premise of racism.

Students faced social or interpersonal barriers such as unfavorable faculty attitudes, lack of faculty awareness of racial/ethnic issues, negative stereotyping, and unfavorable peer-group attitudes. In addition to confronting barriers, students were expected to adopt the professional nursing system grounded in the norms and values of America's dominant society, although they often held different health beliefs, assumptions, and theories.

The majority of faculty interviewed assumed that students' problems in agencies resulted from students' lack of competence. However, according to the bridging educators, the problems often arose from resistance within agencies. One commented, "When I go to White institutions, I can see the prejudice, and I can really feel it." Additional conflict occurred because many nursing concepts and theories are grounded in the norms and values of the dominant culture. Therefore, it was difficult for some ethnic students to relate to the concepts. One informant stated,

There are not many minority nursing theorists, and what is held up is White nurses who speak for nursing. As a minority student, there is a void in terms of these speaking for me.

There was a great difference that distinguished the bridgers from the other categories of educators in their perceptions of the amount of prejudice students encountered and the number of barriers they faced.

EFFECTIVE STRATEGIES OF THE BRIDGING EDUCATORS

The bridgers recognized the subtle needs and feelings of the ethnic students. They identified many of the same needs the student informants expressed. The close parallel between the students' feelings and the bridging educators' perceptions of student feelings was illustrated by many examples. Bridging faculty respected the cultural differences of students, and they developed actions that were culturally adaptive. They employed four major strategies: (a) incorporating the student's cultural knowledge, (b) preserving cultural or ethnic identity, (c) facilitating negotiation of barriers, and (d) advocating for system change.

Incorporating the Student's Cultural Knowledge

Incorporating students' cultural knowledge validated the students by asserting that they have a valuable contribution to make. According to the bridgers, the goal was not to encourage students to adopt majority cultural views but rather to enrich the knowledge system. One informant explained,

My strategy reflects my philosophy of teaching. Teaching isn't putting something into a person. It is taking something out of a person. . . . That is my generic teaching style, to draw on students' own experiences. Having culturally diverse students in the room makes it much richer and easier for me.

These educators attempted to relate the content to the cultural views of the ethnic students as well as the majority students.

Value conflicts resulted in difficult problems when students' cultural values about pain and child-rearing practices differed from dominant cultural values of clients and nurses. One teacher described her experience as follows:

> I had this Vietnamese student. She was working with a child who had an appendectomy. In her culture, you could be in a lot of pain, but you didn't say anything because that is not culturally acceptable. . . . She was expecting the child to behave, or she was expecting the mom to make the child to behave and not express this pain. . . . She was expecting the mom to calm the child.

By careful assessment of the student's conceptualization of the situation, bridging pattern educators discovered how the students' values impacted their clinical performance. When faculty clarified the cultural expectations of the dominant group, they were careful not to confer an inferior status to the values the students' expressed. Value conflict situations were not difficult for these educators to manage because accommodating different worldviews was a natural process. They drew from their repertoire of experiential knowledge to address cultural issues.

Preserving Cultural or Ethnic Identity

A second form of intervention focused on preserving the student's ethnic identity. The strategies educators used to facilitate this were enhancing the student's ethnic self-concept, providing successful role models, and encouraging students to function biculturally. Selecting experiences to provide a comfortable environment offered the opportunity for students to develop positive identities as ethnic persons. One informant described a favorable clinical experience. She stated,

> There is something about community health that we should emphasize earlier. . . . It should be brought up more [earlier in the program]. The students, who have different cultural backgrounds, they shine in community health. As they have gone through school, they haven't seen their culture as a very positive thing. They see it as a hindrance. Now [in community health], they get these clients that are of the same culture.

Bridging teachers drew on anecdotes and illustrations from their own diverse ethnic backgrounds. This created a safe environment that encouraged students to share their own ethnic beliefs. Educators did not view ethnic students as deficient and advocated that students retain their own cultural beliefs and behaviors as they develop proficiency to function in the dominant culture. One informant explained,

> The best thing you can do is be bicultural. OK, you look around and you are in a White world. You act like they do. When you are in a Black world you talk like this [switched to Black dialect]. When you are in a White world, you say, "Hey, I can deal with this too."

Providing Successful Ethnic Role Models

The educators fostered positive ethnic identity by linking students with ethnic role models in the clinical settings. One informant stated, "It seems to help when they see someone from their own culture making it." Another developed a mentor program with Black, Hispanic, and Asian nurses in the community and encouraged ethnic support groups for students. Connecting with ethnic professional nursing organizations is especially valuable. She explained,

> Students attend the ethnic minority nurses' professional association meetings. The impact of that was very potent. They said, "You know it was great to see a group of Black nurses."

Many of the teachers developed mentoring relationships with students. One explained, "I think I am a role model especially for culturally diverse students."

Facilitating Negotiation of Barriers

Bridging faculty considered prejudice, discrimination, and racism realities of ethnic students' experiences, and they assisted them to cope with the world they faced. First, the faculty permitted the expression of problems related to prejudice or discrimination and validated the reality of the student's experience. They then engaged in collaborative problem solving. One informant discussed her strategy as follows:

> I say, "This person is not going to go away, and we will have to deal with it.". . . I even role play the person, and the student tries to deal with it in an objective way. . . . When the student says something (to staff), it takes them by surprise. . . . They realize, "This is not somebody that I am going to be able to walk over."

In addition, they role-played to students how to handle racial or ethnic conflict situations. One informant described how she dealt with a class in which majority students were intolerant of ESL students:

> I decided I'm going to say something in class. . . . I talked about tolerance and mutual respect. . . . I made them aware of their behavior, that I am not going to tolerate their behavior, and if they want to stay in nursing, they will have to change their behavior.

The bridgers drew on their own experience facing barriers and their commitment to social change and invested their energy to assist the students in dealing with encounters with racism and prejudice.

Advocating for System Change

Bridging educators described many strategies they used to advocate for structural and policy changes. Faculty assisted students to form ethnic student support groups that identified and advocated necessary policy changes. They also developed liaisons with ethnic community groups and professional associations to provide additional support for students. Advocating required commitment, and facilitating change was a difficult process. An African American educator concluded,

> All persons are not committed in the same way. There are differences. I guess what I am saying is that we need dedicated persons, people that philosophically believe and therefore will work to bring changes. It isn't something that can be done in 5 years. It is a lifelong activity.

CONSEQUENCES OF THE BRIDGING PATTERN

The bridging approach resulted in many positive consequences for faculty and students. Educators believed that large numbers of ethnic students enhanced their teaching and provided positive reinforcement for them as one informant illustrated:

> It influences me in a positive way. I feel it is very mutual. I feel that the students of color are glad to see a faculty member of color, to identify with me, to relate to me. Also for me, it enhances my teaching because I can call on different groups to express their own experiences in health care and illness. I think it gives a broader range of the spectrum of what we are dealing with here.

Faculty indicated that they "learned from the students" and believed their teaching effectiveness increased. The faculty structured their teaching to incorporate the cultural knowledge of ethnic students. When they incorporated aspects of the worldviews of ethnic students and allowed expression of a broader range of viewpoints in the classroom, the awareness of all students increased. These educators also believed that their approach enhanced ethnic identity and self-esteem.

The consequences of the bridging pattern for students were overwhelmingly positive. When barriers were acknowledged, the students' perceptions were validated, and they believed that they were assisted in addressing racial issues. When students experienced the bridging approach to education, they felt their environment was comfortable, and their cultural perspectives were reinforced. Bridging educators provided an educational environment that enhanced students' self-confidence and identity as ethnic nurses. An African American student informant described the educational climate she experienced as follows:

> They wouldn't let go of me. When I failed, [name of faculty] called me up and said, "You better get back here or I am going to come after you." They were very facilitating. They said they knew I would do it.

Students believed their cultural perspectives were reinforced; cultural differences were viewed as an asset rather than a liability or deficiency. When clinical experiences were organized to utilize students' strengths, their self-esteem was raised, and the students' contributions were validated. One Mexican American described the impact of a warm reception on her career:

> She [the community health nurse] looked at me and told the rest of the people, "Well, here is a Hispanic nurse, I am going to convert her and get her out in the community." She was such a positive impact on my life to this day, and she is White, red headed, and blue eyed.

Students indicated that their unique strengths were recognized and contributions were valued. Their input was not suppressed but rather drawn on to provide valuable content for all students. They perceived that they were welcomed in the educational environment and were valued for the contributions they would offer to the profession of nursing.

DISCUSSION

This article explicated the findings of the author's (Yoder, 1996, 1997) previous study that identified the instructional responses to ethnically diverse nursing students and the consequences of varied approaches for students and education programs. In particular, it expanded on one of the five teaching patterns identified in the study, the bridging pattern. This teaching approach was viewed to have the most positive consequences for ethnically diverse nursing students. Faculty responding in the bridging pattern had a high level of cultural awareness and valued diversity. They identified more needs and problems of students particularly those related to barriers that originate in the learning environment and within the cultural system of the dominant society. For this group of educators, an increase in the number of minority students is a positive development. The bridgers utilized techniques to assist students to voice their own ideas and empowered them to view themselves as sources of knowledge rather than always adopting the views of the dominant group. Sharing unique cultural experiences and viewpoints enhanced the learning of all students in the classroom because it enabled students to gain from a variety of opinions. The bridging educators encouraged students to maintain their ethnic identity and to function biculturally. They attempted to bridge two cultural worlds—the culture of the student and the culture of the school or clinical setting.

There is a great need for the bridging approach in nursing education today. The majority of students interviewed did not experience a bridging pattern of teaching. Usually, informants discussed the bridging they believed they needed rather

than the bridging approaches they had experienced. The issues that were raised most frequently by students from all ethnic groups were the lack of ethnic role models and the need for ethnic faculty. It is critical to develop educational models that provide a climate in which all nursing students have an equal opportunity to learn. Educators in all settings should examine their instructional approaches and expand and refine their understanding of culturally responsive teaching.

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CLINICAL PRACTICE DEPARTMENT

Health Care Ethics: Cultural Relativity of Autonomy

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Park DuValle at Spencer County

Culture refers to the totality of learned and transmitted beliefs, values, and attitudes shaped and perpetuated by members of a social group (Leininger, 1991). Ethics has been described as the study of the rules of conduct recognized in regards to a particular class of human actions. Ethics serves as a branch of philosophy that defines a role guideline for desired actions relative to social mores (Dunn, 1998). Ahronheim, Moreno, and Zuckerman (1994) have defined clinical ethics as the systematic identification, analysis, and resolution of ethical problems associated with care of particular patients, goals of protecting the rights and interests of patients, assisting clinicians in ethical decision making, and encouraging cooperative relationships between patients, families, clinicians, and health care institutions. As a society's values culminate in the development of correlating morals, these morals are ultimately reflected in every aspect of life. In the context of health care, cultural heritage influences the perceptual framework of illness, wellness, and accepted treatment modalities (Berger, 1998; Orr, Marshall, & Osborn, 1995). In consideration of these concepts, it can be logically understood that health care ethics can be and generally is greatly influenced by the practicing society.

In Western philosophy, the four key principles that have emerged as guides to ethical health care decision making are autonomy, beneficence, nonmaleficence, and justice. Although the concept of autonomy has been interpreted various ways, it most commonly endorses the expectation that persons have the capacity to reason and make decisions concerning their own futures (Woodward, 1998). This fundamental principle can be directly related to the constitutionally described American cultural values of liberty, privacy, and individual rights (Gostin, 1995; Ip, Gilligan, Koenig, & Raffin, 1998; Oppenheim & Sprung, 1998). As a result, Western philosophy has evolved into a culture preoccupied with the self, focusing on the individual body and embodied personality (Cook, 1999). The purpose of this article is to discuss the cultural relativity of ethics as related to health care, specifically focusing on the dominant Western principle of autonomy.

The following case scenario will guide the discussion. Ms. Liang is a 45-year-old single woman with metastatic breast cancer. She immigrated to the United States 5 years ago from China, where she had worked as a seamstress in the garment industry until her disease prevented it. She now lives at home with her elderly parents and younger brother and sister. When asked about her reason for visiting the clinic, she did not use the word *cancer* but a more general term equivalent to *disease*. When asked about the future and whether she planned to limit therapy, Ms. Liang responded, "I hope I can recover soon. I will rest for a year and then go back to work. . . . Someday my disease will be cured, and I will recover completely, and I won't need any more treatment." When asked about resuscitation, she replied affirmatively that she would "take every chance" for recovery. Her brother shared a different interpretation that seemed to be centered on his role as a support person. He communicated that the family life had been disrupted because of his sister's illness. "At the beginning, when the doctor told me that she had cancer, I told my family not to tell her because I was worried that she would be too sad." He described changes over time, from his initial hope that her health would improve to a realization that her condition was

> getting worse and worse. We all know that she won't last long. You know, as a Chinese family, we care for each other whenever anyone has a problem. After she got sick, she could not make any decisions on her own; she needed the family to help her make those decisions.

The physicians working with Ms. Liang disagreed with her family's consensus to not tell her of her diagnosis and described her family as "controlling and abnormal in the way they dealt with the situation." It was also suggested that the patient may have psychiatric difficulties because "she was quiet and never spoke for herself" (Hern, Koenig, Moore, & Marshall, 1998). When patients and families fail to conform to expected behaviors or disagree with health care providers, it is a common occurrence to label them as dysfunctional

(Levine & Zuckerman, 1999). Ms. Liang is criticized for not making informed, independent, and strong decisions, whereas at the same time, the physician maintains full control of treatment options. The significant point here is that allowing other family members to decide may not be abnormal. This scenario describes a fundamental tension between patient and medical authority, influenced by cultural differences of the involved parties. More significant in this scenario is the lack of awareness and understanding that the parties have regarding the development of their own perceptions and attitudes as well as those of the other party involved.

CURRENT STATUS

In our pluralistic society, cross-cultural encounters between patients and providers have become commonplace. Within these interactions, ethnic minority groups, immigrants, or refugees may be represented as either patients or health care providers. A body of growing literature has focused recently on cultural diversity and ethical issues surrounding health care, exploring the issues of international application of research ethics, disclosure of medical information, informed consent, family role, limitations of treatment, and critical care (Orr et al., 1995).

Over the past 25 years, ethical and legal analysis of health care decision making in the United States has revolved around the idea of patient autonomy, which endorses the rights of individuals to make informed decisions about their medical care. Thus, this informational model stresses that patients should be told the truth about their diagnosis and prognosis and the risks and benefits of proposed treatments and that patients should be allowed to make choices based on this information. However, the person must be legally competent and understand the information provided, and he or she must make a voluntary choice free from undue influence or coercion (Blackhall, Murphy, Frank, Michel, & Azen, 1995). The elements of informed consent in Western health care may pose potential challenges in cross-cultural health care encounters. Full, truthful disclose may be at variance with cultural beliefs about hope, wellness, and thriving of persons; autonomous decision making may contradict family-centered values and the social meaning of competency; and uncoerced choices may counter cultural norms of obedience to the wishes of spouse or family members.

It has been suggested that American health care ethics (hereon referring specifically to the United States) considers its principles, reasoning, and perceptions to be objective, without bias, and reasonable to an extent that not only makes them socially and culturally neutral but also bestows them with a sense of universality. Conversely, American ethical principles have also been accused of being asocial, acultural, and lacking tools to comprehensively investigate the social and cultural realities that matter to diverse patient populations (Jecker, Carrese, & Pearlman, 1995). This perspective is consistent with a growing body of national and cross-national literature suggesting that moral values are culturally relative, that family and community decision making should be considered more seriously; and that autonomy must be balanced with other morally important concepts in the provider-patient relationship, including loyalty, integrity, solidarity, and compassion (Gostin, 1995).

MY POSITION

It is my position that the concept of autonomy is indeed culturally relative. Through ethnographic study of cultural groups, it is possible to gain insight and understanding of the values that guide health care decision making. It is important to understand the evolution of the Western principle of autonomy and its philosophical basis. Linguistically, *auto* (self) and *nomos* (law or rule) form the term *autonomy*. The concept was originally used to indicate the independence of Greek city-states from outside control. During the sovereignty-of-the-state periods, the liberal philosophical works of Mill and Kant stressed that individuals are moral agents entitled to respect. During these eras, the self-determination espoused through autonomy began to be considered good in itself because it manifested itself through the expression of an individual personality. It served as a means to an end because it identified the individual's best interests, incorporating the values of that person into the decision (Ahronheim et al., 1994; Childress, 1989). Over the centuries, political, social, and cultural exchanges resulted in the Anglo-Saxons of England taking on this individualist philosophy, largely influencing the Puritan movement (Goodwin, 1995). When colonists from England came to North America in the 1600s, so came Western thought. Through extensive ethnographic study, American culture has been characterized as youth oriented, individualistic, self-reliant, high achieving, and optimistic, focusing on equality and freedom. Within American culture, the individual is generally expected to perfect his own human qualities and capabilities through not only other people but also his own efforts and desires through personal responsibility (Leininger, 1994; Spangler, 1991).

Chinese culture has seen several major schools of philosophy, including Taoism, Buddhism, and Confucianism. Although these worldviews largely emphasize harmony, interpersonal relationships, and the importance of the community or group over the individual, there are some unique characteristics, especially in the perceptions of death and dying. In traditional Chinese society, largely based on Confucianism, life should be preserved at all costs and providers should do their best to save lives. Herein lies the basis for Ms. Liang's perspective regarding treatment and resuscitation. Culturally, there is less emphasis on individual rights, self-expression, and self-determination. Within the highly emphasized community and family relationships, function and responsibility are stressed. The individual is viewed pri-

marily in terms of their relationships to others. (Leininger, 1991). Understandably, the family plays an important role in health care decisions. When a family member is sick, that person is viewed as vulnerable and in need of protection, and the family assumes responsibility for ensuring that the patient receives proper care. Furthermore, it is a common belief that speaking about death can bring bad omens, and many families or individuals may avoid such conversations. It is often considered callous and inconsiderate to give all the information regarding grave decisions directly and openly to the patient because it is considered unnecessary and inappropriate to burden the family member by further discussing the reality of the disease. The patient does not require full knowledge because the family will make the necessary decision. Usually, the situation is discussed with the family, and only the information family deems necessary is disclosed to the patient (Berger, 1998; Ip et al., 1998; Oppenheim & Sprung, 1998; Zhaojiang, 1995).

These brief ethnographic descriptions provide a theoretical foundation supporting the existing various ethical perspectives related to the Western concept of autonomy. Empirical research has validated these cultural contexts. In Blackhall et al.'s (1995) study focusing on ethnicity and attitudes toward patient autonomy, the authors found that relative to European Americans, Korean Americans and Mexican Americans were less likely to favor telling the truth about diagnosis and prognosis and to choose the patient as the primary decision maker. Within the Korean American and Mexican American groups, older participants and those with lower socioeconomic status tended to be opposed to truth telling and patient decision making even more strongly than were their younger, wealthier, and more highly educated counterparts. These variances associated with age, education, and socioeconomic status can be highly correlated with the level of acculturation to American norms. In this study, the decision-making style of most Mexican American and Korean American participants was described as family centered. Mitchell (1998) referred to the results of a 1994 study that found that for Chinese and Mexican American patients with advanced stage malignancies, family interdependence and filial obligations were considered more important than were patient autonomy and knowledge of the condition. Significance of family decision making in deference to individual autonomy has also been found through studies in Spain, France, Japan, and Eastern Europe (Berger, 1998; Blackhall et al., 1995). Although the patient autonomy model does not exclude family involvement, in the family-centered model, it is the sole responsibility of the family to hear bad news about a patient's diagnosis and prognosis and to make decisions regarding care and treatment and what or whether the patient should be told. It was found that autonomy is generally viewed not as empowering within these cultural groups but as isolating and burdensome to patients who are too sick to make meaningful decisions.

The Western concept of autonomy is stressed as a part of basic human respect. Within the dominant worldview of American culture, however, respect is associated with individualism. The fact that autonomous decision making usually demands full information does not mean that disclosure is universally respectful of patients. Deep respect for individuals is demonstrated not by faithful observance of what practitioners believe is best for the person but by consideration of what the patient requests and his or her perceptions of care (Gostin, 1996; Katims, 1995).

COUNTERPOINT

The legal focus on autonomy in Western health care evolved as a result of the perceived and somewhat actual threat of paternalistic choices on patients' lives. A historical view of the patient-physician relationship assumed that it was the role of the physician, acting in the best interests of the patient, to direct care and to make decisions about treatment. The primary moral principle to be pursued was beneficence, and the patient's role was to comply with the physician's orders (Levinsky, 1996). This paternalistic approach assumed that patients and providers had the same goals, that providers could accurately judge patient preferences, that only the physician had the expertise necessary to determine what should be done, and that it was appropriate to spare patients the worry of decision making or even "to deceive them in order to engender faith, reassurance and hope" (Deber, 1994, p. 171). In consideration of this, it is understandable that autonomy developed as a result of good intentions in recognizing the individual's choice. However, it is essential to recognize that the individualism associated with American culture is a minority paradigm in relation to the world's population and cultural frameworks. The impact of the cultural imposition of Western principles is evident not only in global relationships but also within the common diverse cultural context of American society.

In a study involving poor Black women in the United States, it was found that those coached by a health educator in a question-asking protocol asked more questions and kept more appointments. However, their interactions with physicians were characterized by more anger and anxiety and less satisfaction than were those of the control group. When the women were trained to ask more questions, it satisfied the wishes of the health care personnel, but, at the same time, caused the women greater personal distress (Deber, 1994).

In "Patient Preferences About Autonomy: The Empirical Evidence," Schneider (1998) provided results from numerous studies assessing patients' preference for decision making and desire for information. These studies occurred in a variety of health care environments with various findings. Some patients wanted less information, some were satisfied with the amount of information they received, and yet others wished for more information. One trend that did emerge was

that regardless of amount of information given, patients overall had less desire to make decisions regarding the condition. The studies found that the patients would want the physicians involved to make the decisions.

These findings bring different points into our discussion. First, we know that studies have shown that desire for information can be largely culturally related. The common factors analyzed in the studies referred to above included age, education, occupation, marital status, and gender. Cultural background of the participants was not a consideration. Second, the studies do not provide information regarding the options that the patients were given for possible decision makers. In reading the results, the only options communicated for decision making were patient or physician. It is apparent that these numerous empirical studies did not consider the possible decision-making role of the family, which is not identified as a common construct of American individualist culture.

Schneider (1998) recommended that patients who prefer to not practice autonomy do so because they have never been permitted to have medical authority and that if they were, would "learn to realize and relish its benefits" (p. 47). At the core of autonomy is the idea that all people want to make decisions that shape their lives. Few decisions are more consequential than those related to an individual's health. Therefore, patients must want to make their own medical decisions. Norris (1996) suggested that providers should not comply with familial requests to exclude the patient from the informational and decision-making process simply because of cultural and religious beliefs for two reasons, specifically. First, cultural or religious membership does not imply individual acceptance of all beliefs of the group. Second, human beings are constituitively free; to practice autonomy properly, one must have the appropriate information to make medical decisions. Although Norris does share a credible point, his opinion necessitates a thoughtful exploration of the concept of autonomy. It is important to distinguish between the often misleading phrases "principle of autonomy" and "principle of respect for autonomy." Through more profound linguistic and philosophic consideration, it can be concluded that a person may practice autonomy but not make direct decisions regarding their health care. The person is indeed autonomous in that he or she has chosen to cede desire for information and decision making to another party, whether it be family or provider (Childress, 1997; Schoene-Seifert, 1997).

CONCLUSION

Literature and studies have demonstrated that values serve as a basis for moral decision making and do indeed vary with cultural beliefs. As the study of moral guidelines, it is logical that ethics is greatly influenced by the cultural framework in which it is practiced. Anecdotal and empirical evidence have suggested that the Western principle of autonomy, which has greatly guided health care decision making, is indeed culturally relative. It is not my position that one ethical system is better than another. To the contrary, each serves its own function within the cultural context with which it is associated. I am not suggesting that providers of any cultural background should deny their own values, as that would be cultural imposition in itself.

It seems that many guidelines related to cross-cultural communication have focused somewhat on an outline format, addressing family, religion, education, and so on. Whereas these characteristics may contribute to a cultural profile, one cannot assume that the cultural significance of these areas exists in all scenarios. Although it is helpful to have an understanding of various cultural groups, generalizations and stereotyping may easily occur, spurred by the practical desire to resolve the situation. Realistically speaking, cross-cultural communication will only begin to improve when health care professionals recognize the significance of their own individual attitudes. By increasing self-awareness, a greater understanding of others can develop. It would be helpful to utilize the concept of ethnohistory as a standard guideline in this process of self-awareness. As a result, this pattern of learning can be practiced consistently to appreciate the perceptions and attitudes of others, regardless of cultural background or the health care issue at hand. Upon reaching a true, greater understanding of one's own cultural framework, ethical decision making in cross-cultural encounters should be guided by (a) the ability to communicate appropriately and effectively with patients and their families, (b) sufficient understanding and appreciation of the patient's cultural framework while remaining aware of potential individual variances, (c) mutual identification of goals and culturally relevant value conflicts, and (d) willingness to pursue discussion until a compromise is reached or resolution is achieved (Jecker et al., 1995; Orr et al., 1995; Taylor, 1993).

The concept of autonomy is probably the most defining characteristic guiding medical decision making in Western society. By investigating the existence and perception of this largely Western concept on a global basis, greater understanding could develop in relation to not only health care but also other areas of human society. Areas to be studied regarding the concept of autonomy may include world religions (as well as locations where the religion is practiced by the majority/minority), subcultures within a larger geographic area, and influences of emigration and acculturation on the concept of autonomy. In our growing global community, it is essential for more cross-national investigation regarding the cultural relativity of ethics. As health care providers practicing in a diverse society largely guided by Western ethical principles, exploring the cultural concepts of autonomy is not only recommended but also necessary.

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INFORMATIONAL RESOURCES DEPARTMENT

Book Review

Culture and Subjective Well-Being edited by Ed Diener
and Eunkook M. Suh. Massachusetts Institute of
Technology, 2000, 355 pages, ISBN 0-262-04182-0,
$45.00

The book is a nonfiction text and part of the *Well-Being and Quality of Life Series—A Bradford Book*. The book is separated into four sections (Introduction, Cultural Differences in the Definition and Causes of Well-being, Societal Conditions, and Individual Differences) with different contributing authors for each of the 12 chapters. The authors represent many of the leaders in the area of culture and subjective well-being (SWB) on various topics and from a diversity of disciplines. Chapters include, but are not limited to, SWB compared with the quality of life of cultures; cultural syndromes and SWB; individual psychological culture and SWB; the pursuit of happiness and the realization of sympathy; cultural patterns of self, social relations, and well-being; genes, culture, democracy, and happiness; and age and sex differences in SWB across cultures. The authors are comprehensive in their review of the data and are sensitive to cultural perspectives, methodological considerations, statistical shortcomings, and future research plans that will shape the field's future.

Many researchers have begun to explore SWB and have been postulating what constitutes the construct. Although they have not reached a consensus, this text reviews many aspects (e.g., genetics, age, gender, self-acceptance, positive relations with others, autonomy, goals, personal life, personal growth) as underlying properties. Their writings support the consideration of a biopsychosocial model of SWB that reflects vital aspects of the human condition—biology, psychology, and social circumstances that are interwoven with a person's culture. Others have hypothesized a developmental approach to understanding culture and SWB, stating that SWB is not static but rather a dynamic concept that changes over time. Irrespective of the theoretical model, researchers from around the world have been investigating the complexities that constitute culture and SWB.

How the complexities of SWB interact with and are influenced/created by culture are well illuminated within the text. The authors address general concepts that underlie Western and Eastern cultures (e.g., complexity–simplicity, tightness–looseness, individualism–collectivism) and the ways in which these concepts influence SWB. Findings have been mixed but have lead investigators to ponder ecological models that incorporate the person's environment (gross national product, politics, social equality), culture (war, floods, horizontal/vertical, individualism–collectivism, family), and the individual (health, education, stress, social support), just to name a few. These as well as other variables in the text are examined in an attempt to better understand the interrelationships between various aspects of culture and SWB.

In general, the authors have presented their ideas in a clear, concise, and comprehensive manner. Each chapter focuses on a different aspect of culture and SWB and typically includes theoretical discussions, concept definition, supporting data, a critical review of the data, discussions, conclusions, and future directions. This structure helps the reader to negotiate the diverse aspects of the text and allows the reader to easily reference areas of particular interest.

Culture and Subjective Well-Being is an excellent graduate level and/or reference book for individuals interested in or actively investigating culture and SWB. Overall, the investigation of culture and SWB is in its adolescence. The text does an excellent job of raising the field's awareness about culture and SWB, posing many questions and forging future directions. In that, the text completes its duty of educating the reader, presenting data from cross-sectional and longitudinal data, responding critically to the findings, hypothesizing future directions, and creating a template for future research. *Culture and Subjective Well-Being* is a thorough review of the current theories, questions, advances, challenges, state-of-the-art methodologies, findings, and future research directions by a rigorous group of investigators from various disciplines. This compilation of theoretically thoughtful and empirically tested constructs of culture and SWB will be an asset to any investigator interested in shifting their focus from a model of psychopathological outcomes toward life, health, and resilience.

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TRANSCULTURAL NURSING SOCIETY DEPARTMENT

President's Message

RICK ZOUCHA, APRN, DNSc, CTN
President, Transcultural Nursing Society

In keeping to true form, I will continue with the theme of the year—cultural competence. But rest assured, the year 2002 will bring a new and exciting theme. Until then, let me begin with the consistent and comfortable discussion of cultural competence.

As 2001 draws to a close, I must take a moment to reflect on my 1st year as president of the worldwide Transcultural Nursing Society. I am truly a very lucky person to have the pleasure of serving in this capacity. I have had the opportunity to meet people from all over the world and to share a common goal of seeking to understand the cultural care needs of people regarding their health and well-being. It is inspiring to meet with members of the Transcultural Nursing Society and discuss and dream about the future. A future that is grounded in a distinguished past filled with vision and hope. This vision is brought to reality through the work and commitment of our members and the rich cultural lives of those we serve. As president of the Society, I had the pleasure of attending the dedication of the worldwide Transcultural Nursing Society office at Madonna University in Detroit, Michigan on May 8, 2001. Before, during, and after the dedication, I could not help but relate the dedication to the process of cultural competence. The generosity of Madonna University to the Society is overwhelming, and the spirit of partnership was evident. Sr. M. Francilene Van de Vyver, president of the university, and Dr. Mary Wawrzynski, dean of nursing and health, continue to prove that a commitment to promoting the cultural care needs of people around the world is alive and well. At the dedication, I spoke briefly about the Society searching for a home, and now not only have we found a home but also we are home. The worldwide *TCN* office would not have been possible without the untiring work of our founder Dr. Leininger. She and the small committee formed to work on this project deserve much credit for continuing the vision, mission, and goals of the Society. I offer appreciation in the name of the membership, the BOT, and the people we serve to all who contributed to the worldwide office and supporting the work of the Transcultural Nursing Society.

So now we have a home, and with a home comes responsibility. To continue the work of those who have toiled before us, we must make a commitment to keep the home running and in order. The worldwide office is the office of all the membership and to be used for the needs of the membership. We also have formed a lifelong partnership with Madonna University, and together we can accomplish great things. The BOT is open and encouraging of suggestions from the membership regarding usage and purpose of the worldwide office. If you are ever in Detroit, please stop by and visit the worldwide office and feel at home as I did in May.

So you might ask, where is the cultural competence connection that we have become so accustomed to in the past year? The cultural competence connection is in the relationships made in the past year. In welcoming old and new members to the society, in the dedication of our worldwide TCN office, and in celebrating at the annual conference, we participate in the process of cultural competence with one another and the people we serve. I invite us all to appreciate the diversity and wealth of cultural knowledge we all bring to the Society. I invite us all to appreciate who we are as a group and the significant and important contributions we make to nursing through our commitment to cultural care. In our everyday professional and personal lives, we operationalize the process of cultural competence. Through our openness and willingness to change our worldview, we are the models of cultural competence. Who we are as members of the Society and the manner in which we practice nursing and health care should show the world that we live the process of cultural competence. With this in mind, I caution us as a group and as individual members to keep committed to the process of cultural competence for we are really never expert or completely culturally competent. For the sake of those we serve, we must remain humble and always be the learner to promote culturally competent care.

I bid you all well with this last message of 2001. In keeping to true form, I will discuss and promote a different theme starting with my first president's message of 2002, so stay tuned! Until next time or until we meet again!

Founder's Focus: Types of Sciences and Transcultural Nursing Knowledge

Madeleine Leininger, PhD, LHD, CTN, RN, FAAN, FRCNA

It is interesting how disciplines get hooked on what constitutes "science" and scientific methods, often using science without critically questioning its meanings and uses. From a transcultural and anthropological perspective, however, cultures are creative with their traditional and unique ways of knowing truths as science over time. But still, today, many nurses continue to rely on medicine's use of the 19th century scientific method, with experimental designs and the testing of *a priori* variables tightly controlled and manipulated for statistical and empirical data. Currently, the linguistic dictum and goal is to rely on "evidence-based" knowledge for research, teaching, and clinical practice and for current federal funding. This trend, with an empiricist focus, is often devoid of important cultural and care data about the human values, beliefs, and life ways of people because they are viewed as impossible for measurement or reducible statistical or directly observable physical evidence, and hence are viewed as nonscientific. Such narrow and limited thinking of what constitutes science must be critically reexamined and changed.

Since beginning the development of transcultural nursing knowledge in the late 1950s, I realized that cultures have different ways of knowing what constitutes "truths" as science, for they know science as *truths that are known, believed in, and tested over time in their cultures*. As a transcultural theorist and researcher and after studying and using both qualitative and quantitative paradigmatic research methods, I discovered that different qualitative methods—approximately 25—have been enormously valuable to discover comparative cultural care and health truths as science. Accordingly, use of more than 400 scientific transcultural nursing studies are providing in-depth and valuable new information. This science included observations, abstractions, and embedded data with interpretative, explanatory meanings and credible truths. These scientific research findings are the significant, unique, and major breakthroughs of transcultural nursing science slowly coming into practice and transforming health care.

Such realities make it imperative to rethink and redefine past, sacred definitions of science. I have defined science as a rigorous, systemic, and open discovery process to obtain and know largely unknown, embedded, or vaguely known truths that provide significant explanatory or interpretive meanings and facts about new or reaffirmed phenomena under study. This science definition is by a transcultural nurse and anthropologist who has had nearly 50 years of research, direct experience, and critical appraisal of studying people and covert truths. Indeed, science goes beyond empirical or measurable outcomes to different ways of discovering subtle, meaningful and objective truths of people.

I have also identified that there are four major types of science that need to be considered by those seeking scientific truths. They are philosophical science, which is largely based on logical and inferential reasoning to arrive at truths as knowledge, including love, goodness, beauty, caring and other human knowledge areas; empirical science (still largely Western), which is based on quantitative measurable statistical, objective data from *a priori* hypotheses and selected variables experimentally controlled and tested; theological moral-ethical science, which is based on discovery truths from theological religious beliefs, faith, dogma, scriptures, God (or a supernatural being), morals and ethics, human rights, cultural justices, and other related truths known to people over time; and holistic, integrated, and synthesized science, which is based on truths from multiple life experiences or ways of knowing that are synthesized for holistic meanings such as holistic cultural values, beliefs, experiences, artistic expressions (art and music), illnesses, suffering, chronic disabilities, caring, healing or dying experiences, or other human and nonhuman conditions and life experiences known as meaningful truths.

The above four types of science discoveries need to be considered to discover, know, explain, or interpret transcultural and comparative phenomena as truths. These four types of science go beyond empirical science and the traditional scientific method to arrive at epistemic, ontological, and other many ways of knowing or establishing truths as science. Expanding and rethinking science is crucial today for global knowledge of human beings. These types of science can help us order and fully discover transcultural nursing and other health care knowledge as substantial truths to be fully used and valued worldwide in serving people.

"That the cultural care needs of people in the world will be met by nurses prepared in transcultural nursing."
- Leininger

27TH ANNUAL CONFERENCE OF THE TRANSCULTURAL NURSING SOCIETY

Marriott City Center Hotel Pittsburgh, Pennsylvania October 10-13, 2001

Preconference

TRANSCULTURAL NURSING THEORIES MODELS AND APPROACHES: A DISCOURSE INTO THE FUTURE
October 10, 2001
Panel discussions by TCN theorist and authors:
Andrews, Boyle, Campinha-Bacote, Davidhizar, Leininger, Purnell and Spector with critique by expert panel.

Conference

CULTURAL COMPETENT CARE IN HEALTH CARE ORGANIZATIONS
October 11-13, 2001
Keynote Speakers:
David Satcher, MD, PhD, Surgeon General of the USA and
Madeleine Leininger, PhD, LHD, RN, FAAN, CTN, Founder Transcultural Nursing

Registration Fees

Early Bird Full Registration (Deadline: September 10, 2001)
TCNS Members = $250
Non-Member = $350
Students = $150 (ID required)

Full Registration

Includes conference registration (10/11-13), reception (10/10), continental breakfast (10/11-12), gala banquet (10/11), full breakfast with Circle of Presidents and Leininger (10/1), daily beverage breaks, conference materials/book of abstracts, continuing education credits, and participant roster.

Accommodations

Room rates: $95 per night for single or double occupancy
Special rates for attendees available up to September 18, 2001
Call for reservations telephone number: 1-888-456-6600

For full conference brochure, registration, and membership application, visit our Web site at *www.tcns.org* or Duquesne University's Web site at *www.duq.edu*. For any questions, contact either of the following:

Conference Coordinator, Shirley Smith, MSN, RN	Program Chair, Dr. Dula Pacquiao
Phone: (412) 396-6535	Phone: (908) 527-3147
Fax: (412) 396-6346	Fax: (908) 362-6427
E-mail: smith1@duq.edu	E-mail: dulafp@aol.com

TRANSCULTURAL NURSING SOCIETY

RESEARCH AWARDS
CALL FOR PROPOSALS

The Transcultural Nursing Society has established two $1,000 annual awards to provide assistance to nurse researchers conducting investigations on phenomena related to transcultural nursing. The awards may be used for the following purposes:

- Conduct a pilot study that has the potential for expansion to a larger project.
- Analyze existing data and make recommendations related to a promotion of culture-specific nursing care and/or development of transcultural nursing knowledge.
- Assist with any phase of a research project related to transcultural nursing

RESEARCH AWARD CATEGORIES

CAREER DEVELOPMENT AWARD:

For investigations in clinical or academic settings by professional nurses (excluding research being conducted for master's or doctoral degree requirements)

GRADUATE RESEARCH AWARD:

For research conducted by professional nurses in partial fulfillment of a master's or doctoral degree

RESEARCH AWARD GUIDELINES

- Submit completed applications by **November 15, 2001**.
- Submit abstract and budget to the Transcultural Nursing Society Research Chair at the end of the project.
- Limit proposal to five typed, double-spaced pages.
- Use the *Publication Manual of the American Psychological Association* (APA), Fourth Edition.
- Include a cover sheet that lists the title of the proposal, name of the investigator(s), mailing address, telephone, fax, e-mail address, and award category (career development or graduate research award category).
- Include title of proposal on page one of proposal but do not put name of investigator on proposal.
- Attach a brief curriculum vitae for each investigator (including background related to research).
- Submit instruments (if appropriate), a brief bibliography, and consent form (if needed) as attachments. These are not included in the five-page limit. Be sure to remove the investigator's name from all attachments.
- If the investigator receives the award, he or she agrees to personally present a brief report of the research at the annual Transcultural Nursing Society Conference following the completion of the study.
- Please include the following sections:

Purpose (identify specific aims)

Significance (include brief literature review and significance to nursing practice, education, or other disciplines)

Domains of Inquiry or Research Questions (include definitions of terms if used in a unique manner for this study)

Method (describe study design, populations or informants, how population access is obtained, researcher's qualifications, mentor involvement (if appropriate), data collection process, evaluation criteria, and human subject assurances. Indicate expected time for project completion).

Data Analysis (describe analysis process).

Budget Proposal (include other funding sources and show how this award will supplement the primary budget or how this money will be used).

- Recipients will be notified in late January 2002.
- Submit five copies of the proposal and all of the above components to:

  Rick Zoucha, DNSc, RN, CS, CTN
  Duquesne University School of Nursing
  629 College Hall
  Pittsburgh, PA 15282

Transcultural Nursing Society Scholarship Award

The Transcultural Nursing Society is offering a $1,000 scholarship for a graduate student (master's or doctoral) in a program focusing on transcultural nursing.

The Scholarship Award
- Offers support for graduate nursing education worldwide.
- Supports a graduate nursing student who is already enrolled in a course of study (part-time or full-time).
- Is nonrenewable.

Criteria
- Applicant must be a member of the Transcultural Nursing Society
- Applicant must have a focus, major, or minor in either transcultural, cross cultural, or international nursing.

Applicants must submit one copy of
- An official transcript of graduate work
- Verification of current student status (advisor letter or copy of student identification is acceptable)

- One letter of recommendation from an advisor or faculty member who teaches in the transcultural program or course

Applicants must submit three copies of
- A brief description of graduate courses to be completed that are relevant to transcultural nursing
- A statement indicating why the applicant is pursuing a focus in transcultural nursing
- A statement indicating career goals

Please submit the required materials by May 1, 2002 to:

Rick Zoucha, DNSc, RN, CS, CTN
Duquesne University School of Nursing
629 College Hall
Pittsburgh, PA 15282
Phone: (412) 396-6545
Fax: (412) 396-6346
E-mail: zoucha@duq3.cc.duq.edu

Certification Committee News

Members of the Transcultural Nursing Society Certification and Re-certification Committee, Doctors Marge Andrews, Anita Berry, Patti Ludwig-Beymer, Rauda Gelazia, and Chair Jeanne Hoffer have continued to work hard on standards, policies, and procedures, as well as updating the certification examination. The work will be completed by October 2001.

The next certification examination will be held in Pittsburgh, Pennsylvania. The examination will be given the day before the opening reception. There will be approximately eight candidates sitting for the examination. Are you ready to be certified? Join us!

For information on the certification and recertification process, contact:

Dr. Jeanne Hoffer, Chair
Certification and Re-certification Committee
P.O. Box 26
Cleveland, TN 37364
Fax: (423) 614-3114
E-mail: ajhoffer@earthlink.net

Certification fees:
Application: U.S. $150.00
Examination (written and oral): U.S. $100.00
Recertification application: U.S. $100.00
Acceptance fee: U.S. $50.00
FEES ARE NOT REFUNDABLE

TRANSCULTURAL NURSING SOCIETY
MEMBERSHIP FORM

BENEFITS OF MEMBERSHIP

- Free subscription to 4 issues annually of the Journal of Transcultural Nursing
- Two free issues of Newsletter annually
- Reduced registration fees to Annual Conferences, Pre-conferences and Regional Conferences
- Eligibility for Research Awards (two $1,000 awards annually) and Scholarship Award (one $1,000 award annually)
- Eligibility for Leininger Awards (two $500 awards annually)
- Eligibility for Certification in Transcultural Nursing (CTN)
- Networking/collaboration and opportunity to meet scholars/experts in transcultural nursing from around the world

Directions: Complete the following application form as a new member or for renewal of membership. Mail completed application and appropriate fee to:

Transcultural Nursing Society
Madonna University
College of Nursing and Health
36600 Schoolcraft Road
Livonia, MI 48150-1173
Telephone: 1-888-432-5470
Fax: 734-432-5463
Email: Barnes@smtp.munet.edu

Membership Year: (January 1 to December 31st)_____

Name:_____

Title/Highest Degree/Certification:_____

Current Position(s):_____

Work Address:_____

Home Address:_____

Telephone: **Work:**_____**Home:**_____
              Fax: Work:_____**Home:**_____
              Email: Work:_____**Home:**_____

Expertise (include special areas you possess advance knowledge, skills and abilities)

If you are a **new member**, who referred/recruited you to the Transcultural Nursing Society?

_____

How did you learn about the Transcultral Nursing Society?

_____

Check appropriate boxes:

Are you getting the Journal of Transcultural Nursing Society? ❑ Yes ❑ No

I prefer to receive my mail at: ❑ home ❑ work

The following information about me can be shared with other members (check all that apply):

❑ Name	❑ Title/degree	❑ Positions	❑ Expertise
❑ Work address	❑ Home address		
❑ Work phone	❑ Home phone	❑ Fax	❑ Email

In addition to my name being printed in the newsletter (new members only), the above information may be shared with other members through (check all that apply):

❑ Membership Directory   ❑ Journal   ❑ Newsletter
❑ Dissemination by Member-at-Large to regional members

I would like to become a member of these standing committees (check all that apply):

❑ Membership	❑ Publicity	❑ Program	❑ Nominations
❑ Promotional	❑ Regional Liaison	❑ Research Awards	❑ Scholarship Award

Other activities (specify, e.g. abstract review for programs only):

_____

Indicate category of membership:

❑ Regular Membership (includes Journal subscription)   = $70.00
❑ Associate Membership (includes Journal subscription) = $45.00
        ❑ Student (full-time; submit copy of student ID)
        ❑ Retired

Indicate method of payment:

❑ I am enclosing a check or money order (in US dollars, payable to the Transcultural Nursing Society)

❑ I am paying by credit card: ❑ Visa   ❑ Master Card

        Account Number_____ Expiration Date_____
        Amount in US dollars_____

        Signature:_____ Date_____

Leininger Awards:
Call for Nominees

The Leininger Transcultural Nursing Award was established in 1983 to recognize outstanding and creative leaders in transcultural nursing. A second annual award was added in 1997. The two awards, $500 each, are offered each year to qualified applicants. Funding for these awards is provided by Dr. Madeleine Leininger, founder of the transcultural nursing field. International candidates are encouraged to apply. Presentation of the awards is made at the annual Transcultural Nursing Society conferences. The awardees are expected to be present to receive the award and to give a brief response, which includes a 250 word statement of the meaningfulness of this award to him or her in relation to transcultural nursing.

The following are the current selection criteria and guidelines, revised in 1998.

Awardees of the Leininger Transcultural Nursing Leadership Award will give evidence of:

1. Outstanding leadership contributions in two selected areas of transcultural nursing expertise, for example, teaching, published research, theory development, clinical community practice, administration (academic or service), or in transcultural nursing consultation.
2. Creative and unique leadership to advance transcultural nursing knowledge and to support culturally competent care practices.
3. Local, regional, national, or global leadership efforts to make transcultural nursing publicly and professionally known and valued to improve people care among diverse and similar cultures.
4. Being an active leader and member of the global Transcultural Nursing Society by promoting the general goals and mission of the Society.

APPLICANT GUIDELINES

1. The applicant either can be nominated by another person or self-nominated.
2. Each applicant submits to the chairperson of the Award Committee the following:

   a. Documentation for declared two areas of expertise (see Criterion 1), showing supportive evidence for each area of outstanding leadership.
   b. Submission of at least two letters of support from nursing colleagues (preferably from transcultural nurses) who can attest to the nominee's leadership contributions related to the criteria.
   c. Evidence of being an active member of the Transcultural Nursing Society for at least 2 years or showing a history of membership.
   d. Submission of any other documents the applicant feels are important to substantiate leadership activities related to the criteria, such as leadership for transcultural workshops; initiating transcultural nursing research projects, courses, or programs; presenting papers at transcultural nursing or other nursing conferences; establishing clinical field experiences; providing transcultural nursing consultation; publishing transcultural nursing articles, facilitating public awareness of transcultural nursing, and/or supporting transcultural interdisciplinary endeavors.

Applicants for the year 2001 awards must send five (5) copies of all documents together as a mini portfolio to the to the chair of the award committee by July 15, 2002. Mail to:

Dr. Marilyn McFarland
601 North Wenona Avenue
Bay City, MI 48706 USA

Transcultural Nursing Society
2001 Board of Directors and Other Contacts

Manuscript Submission Information for Authors

The *Journal of Transcultural Nursing* is the official journal of the Transcultural Nursing Society. It is a peer-reviewed, multidisciplinary journal that is intended to provide a forum for the discussion of the relationship between culture and health care. Research reports, analysis and discussion articles, reviews of the literature, theoretical articles, clinical applications, and analytical case studies are desired.

Style and Format. Manuscripts should be prepared in accordance with the guidelines set forth in the *Publication Manual of the American Psychological Association,* 4th edition. Manuscripts, including abstracts and references, should be double-spaced using 12 font type, left-justified margins, 1-inch margins on all sides, and should be printed on a letter-quality printer. All identifying information about the author(s) should be on the title page only. A short heading and page number should be typed on each page. Manuscripts should not exceed 20 pages, excluding references, tables, and figures. Each table, figure, graph, and so on should have its relative placement noted within the text. Tables should be typed one to a page, with any notes or legends typed on the same page. Tables should be numbered, titled, typed double-spaced, tab delineated, and without use of lines. Figures should be submitted as black-and-white glossy prints in camera-ready form. Label each figure on the back with its number and author name. Graphs and line drawings should be submitted as prints on matte-finished, heavyweight paper. Graphs and figures should *not* use gray-scaling or shading but, rather, should use hatch markings to demonstrate differences. A photocopy of each figure, graph, or drawing should be on a single page with its number, title, and legend or caption typed on the same page. (Do not imbed the number, title, or legend into the photographed print.) All tables, figures, graphs, and drawings should follow the reference list and should *not* be placed within the text.

Departments. Submission of manuscripts to one of the following departments is encouraged:

Theory: Manuscripts concerning theory design, construction, development, utilization, application, and critique will be presented in this department. Theories related to transcultural nursing; relationships between culture and health care, including ethnopharmacology or ethnonutrition, anthropological or cross-cultural patterning of health care beliefs and practices; intercultural and intracultural communication; or transcultural ethics are of interest. In addition, manuscripts discussing organizational, technological, political, or economic theories that influence health care delivery to specific cultural groups also are encouraged. Articles discussing the application of nursing theories to transcultural nursing are also suitable for submission.

Research: Research studies that expand the body of knowledge of transcultural nursing and health care as a human science will be included in this department. Studies will be considered that use such qualitative methodologies as ethnography, ethnonursing, grounded theory, phenomenology, oral/life histories, critical theory, focus group methods, hermeneutics, participant observation, case-study analysis, pattern recognition, or other innovative methods that relate the dynamics of culture to health care. In addition, studies that use a variety of quantitative methodologies to investigate transcultural nursing and health care phenomena also are welcomed. Discussion and/or analytical articles on such topics as instrument development, or themes related to the conduction of research on these phenomena, are likewise encouraged.

Education: Manuscripts included in this department aim to promote the understanding of the sociocultural context of the nursing educational structure, processes, and outcomes. Topics may focus on the organizational culture of schools, teacher-student-client relationships, teaching methods, learning and cognitive styles, curricular designs, evaluation strategies, and academic outcomes. In addition, content focusing on extracurricular strategies such as recruitment, advisement, peer support, financial aid, and mentoring are invited. Topics relevant to teacher training and development also are solicited. Subject content may pertain to any aspect of the educational experience in the undergraduate or graduate levels or in any setting, including clinical practice, that emphasizes the linkage between culture and education.

Clinical Practice: The focus of this department is to explicate the sociocultural context and universal and variant patterns influencing the delivery of nursing and health care. Topics may deal with culturally defined health beliefs and values, folk and professional models of health care delivery,

practitioner/client interactions, family and community roles, or health care outcomes. Specific topics may include cultural variations in symptom management, birth or death rituals, use of home remedies, dietary considerations, cultural assessment tools, cultural conflict resolution, use of interpreters in the clinical setting, organizational culture of health care settings, ethical-legal conflicts, or other practice-related subjects. Case studies must include the following: statement and significance of the problem, a brief review of the literature, presentation of the case study, discussion and analysis of the case study within the cultural context, conclusions, recommendations for practice, and references.

International: This department will highlight themes and examples of international collaborative practice, education, research, and consultation. This department will serve as an international forum for nurses and other health care disciplines to share expertise, knowledge, opinions, and experience with nurses and health care professionals throughout the world.

Informational Resources: Methods of accessing information concerning transcultural nursing or health care will be the major emphasis of this department. Articles regarding library searches, web page listings, Internet resources, computer software, packages and topics on informatics related to the journal's subject matter are encouraged. In addition, book reviews, critiques of videotapes or educational materials, annotated bibliographies, and similar brief reports are welcomed.

Abstracts. All manuscripts except Letters to the Editor or Commentaries should be accompanied by an abstract of no more than 125 words. Abstract headings for research articles are the following: purpose (include background and significance); design (include population, sample, setting); method (include measures, intervention if applicable); findings/results; discussion and conclusions; and implications for practice.

Title Page. A title page should accompany all manuscripts. Include the following for *all* authors: title, names of authors in the order to be listed, complete credentials, position titles, affiliations, and contact information (address, phone, fax, e-mail). Indicate the corresponding author with an asterisk (*). Author names should appear only on title page and should not appear on any other page headings. A secondary title page listing only the title must also be included.

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Cover Letter. A cover letter, stating that the material has not been published elsewhere and that it is not under consideration at any other journal, must accompany all manuscripts.

Review and Action. Letters of inquiry are not required. Authors are notified when the manuscripts are received. Manuscripts are examined by the editorial staff and are peer reviewed by at least two reviewers drawn from our editorial board and panel of peer reviewers. Decisions for publication are made primarily on the basis of reviewers, usually within 3 to 4 months of submission. Authors are sent the comments from the reviewers, but the manuscripts are not returned to the authors. The journal reserves the right to edit all manuscripts to its style and space requirements.

Submission. Submit the cover letter, five copies of the complete manuscript and accompanying materials, and a diskette with IBM-compatible software, preferably in Microsoft Word for Windows format.

Mail to:

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Do *not* send materials by means of mail services that require a signature. For example, if you are sending the manuscript via such services as FedEx or U.S. Express mail, please waive the signature requirement as this will prevent the delay of the receipt of the manuscript.

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