CULTURAL COMPETENCE OF FACULTY OF BACCALAUREATE NURSING PROGRAMS

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By
Lorinda J. Sealey
B.S., University of Texas at Austin, 1972
M.S., Arizona State University, 1979
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ABSTRACT

The purpose of this study was to examine the level of cultural competence among faculty teaching in baccalaureate nursing programs in Louisiana and to identify associated factors. A survey was mailed to all 313 faculty members identified as actively involved in teaching in any baccalaureate nursing programs in Louisiana and 163 valid responses were obtained.

The Cultural Diversity Questionnaire for Nurse Educators, a researcher designed instrument intended to measure cultural competence, was the instrument used. It included Likert-type items organized into five subscales representing the components of cultural competence according to Campinha- Bacote's model of cultural competence (i.e., cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire), and a sixth subscale on the teaching of trancultural nursing concepts. An index was developed for the respondents overall cultural competence, and each cultural competence subscale as well as for the transcultural teaching behaviors subscale. The categories used to interpret the responses were five, ranging from least favorable (i.e., $\leq$1.5 = strongly disagree) to most favorable ($\geq$ 4.5 = strongly agree).

The participants' responses were in the "agree" response category for overall cultural competence, as well as for all subscale indexes, with the cultural awareness index being highest (4.14), and the cultural encounter index being lowest (3.56). Findings also indicated that the subscales cultural knowledge and cultural encounter explained 87% of the variance in overall cultural competence. The study results also indicated that a significant model does exist that enables the researcher to explain cultural competence on each subscale as well as overall cultural competence. The variable that had the highest positive correlation with each subscale index, as well as with the index of overall cultural competence, was continuing education in transcultural nursing within the previous five years. The nursing specialties women's health, childbearing

nursing and community health were also associated with increasing the indexes on selected subscales.

The researcher recommended faculty development programs on cultural competence and opportunities for cross cultural interaction as strategies for improving the overall cultural competence of nursing faculty. The researcher also encouraged further investigation of the differences in cultural competence among faculty in selected nursing specialties.

CHAPTER 1

INTRODUCTION

Overview of Cultural Competence

Recent changes in the ethnic composition of the population of the United States pose great challenges for health care institutions and health care providers. Salimbene (1999) points out that many health care providers serving formerly homogeneous populations are now expected to provide care for groups that are culturally and linguistically different and who have health beliefs and practices that are very different from those the providers are used to. According to Dossey, Keegan and Guzzetta (2000), culture not only accounts for differences in behaviors such as diet and exercise but it also determines what health conditions are considered worthy of attention and what behaviors the client engages in to restore health and to remain healthy. Salimbene contends that nurses and other health care providers must be prepared to understand the importance that culture will play in peoples' perceptions of their health needs and their responses to health care. She further asserts that the degree of patients' compliance with and response to treatment will be significantly affected by the degree of congruence between their expectations and the care they receive. The provision of culturally competent health care, that is, health care that takes into account issues related to the cultural context of individuals, their families and communities is therefore more imperative than ever. Smith (1998) and Leonard (2001) maintain that the provision of culturally competent health care results in client empowerment, decreased client anxiety, better utilization of health care services, improvement of the health status of the client population and an overall increase in client satisfaction.

Officials of the U.S. Department of Health and Human Services, Office of Minority Health (OMH) (Office of Minority Health, 2000), have also recognized the need for cultural

competence. They believe that it is necessary to move towards a national consensus regarding cultural and linguistic competence, in order to provide guidance for health care organizations and providers on how to respond to an increasingly culturally diverse clientele. They issued recommendations for 14 national standards for culturally and linguistically appropriate services (CLAS) in health care. According to OMH officials, the standards are directed primarily at health care organizations. However, they are also intended for individual providers and other groups as well. Educators from health care professions, training institutions or legal and social services professions are encouraged to incorporate the standards into their curricula (OMH, 2000).

According to an American Nurses Association (ANA) report, nurses comprise the largest segment of health care providers in this country (American Nurses Association, 2000). It is therefore essential that they be prepared to provide care that is culturally competent. But, are nurses ready to meet this challenge? More importantly, are those charged with the responsibility of preparing nurses to care for an increasingly diverse population in possession of the skills, knowledge and experience needed to fulfill this task? In an attempt to answer the latter question, this research study examined the level of cultural competence among faculty of baccalaureate nursing programs in Louisiana.

Population Changes

According to Day (1996), United States census data indicate that ethnic minorities who in 1995 made up approximately 26% of the nation's population are projected to increase to 36% of the total population by 2020. Diversity in the population is not new to the United States, given the historical existence of diverse cultural groups (e.g., African Americans, Appalachians, Navajos, Eskimos, Mexican Americans, etc.) in this country (Giger & Davidhizar, 1995). What

is new is the increasing proportion of ethnic minorities in relation to non-Hispanic Whites as indicated by the above percentages. In addition, the composition of the foreign born population living in the United States has changed. In a U.S. Census Bureau report, Smidley and Gibson (1999) noted that the number of immigrants from Europe has declined from 62% in 1970 to 16% in 1999. On the other hand, the proportion of immigrants from Asia has tripled (9% to 27%) and the proportion from Latin America has risen from 19% to 51%, with Mexicans making up two thirds of the total.

Another population change is the influx of recent immigrants to certain regions of the U.S. (e.g. the South) that have traditionally been very homogenous (Salimbene, 1999). For example, in Robeson County Georgia, it is estimated that most of the 10,000 Latinos living there arrived within the past five years (LeDuff, 2000). This shift in immigration patterns is also true in Louisiana where the Asian and Latino populations are projected to double by the year 2025 (Louisiana's population projections, n.d.). Many of these new immigrants speak little or no English and have different customs, values and beliefs about health and illness. Thus, these changes have contributed to greater population diversity in the Southern United States and have heightened the need for cultural competency among nurses practicing in this region (Salimbene, 1999).

Changes in Health Care Delivery

Spector (1996) pointed out that not only is the population changing but so is the way in which we deliver healthcare. More healthcare services today are provided in the home than in previous years. This practice calls for greater understanding of the cultural background of clients and their families. Meleis (1996) agrees that cultural competence is imperative when nurses provide care in the home since they become guests of their patients and must adhere to the

patients' rules about what behavior is proper. In hospital settings, patients are expected to abide by the rules of the agencies. However, care provided in the home must be within the context of the patients' values and lifestyle. Thus, there is a need for health care professionals who are qualified to provide culturally competent health care, both in the home as well as in health care institutions for a population that is projected to be more culturally diverse than ever.

Cultural Competence in Nursing

According to the 1992 Department of Health and Human Services survey cited by the ANA, registered nurses comprise the largest segment of workers in the health care industry, with close to two million actively employed (ANA, n.d.). People requiring health care services are therefore very likely to interact with nurses. Most nurses are Caucasians (90%), with African Americans (4%), Asian and Pacific Islanders (3.4%), Hispanics (1.4%), American Indians/Alaskan Natives (0.4%), and others making up the other 10% (ANA, n.d.). This current ethnic composition of nurses does not reflect the growing ethnic diversity of the U. S. population. It is in fact, similar to that of the creators of the U. S. health care system.

Salimbene (1999) believes that our health care system was created by a predominantly Caucasian population of Northern European descent and philosophy, and was tailored to suit the individualistic nature of American society. Thus, ideas held by the predominant number of nurses regarding how to care or demonstrate caring, and what is to be considered quality care is also based on what the creators of our health care system held as true. Today, these beliefs and values may not be compatible with those of the increasingly non-European population in America. Caring for this increasingly multiethnic and multicultural clientele will inevitably pose challenges for health care providers and requires sensitivity to the diversity of clients and the provision of care that is culturally competent.

The need for nurses to be sensitive to cultural variations in clients they care for is well established in the literature. Numerous works (Alpers & Zoucha, 1996; Andrews & Boyle, 1995; Giger & Davidhizar, 1995; Leininger, 1991; Salimbene, 1999; Spector, 1996) have been published on the importance of considering clients culture as an integral part of assessing their health care needs and planning culturally appropriate nursing care to meet these needs. For example, Leininger (1991), a leading transcultural nursing specialist, has long contended that "cultural beliefs, values, norms, and patterns of caring had a powerful influence on human survival, growth, illness states, health, and well being" (p. 36). She further stated that if professional nursing care was not compatible with the beliefs and values held by the recipients of care, "culture conflicts, noncompliance behaviors, cultural stresses, imposition practices…" (p.37), would result. In her book, Cultural Diversity in Health and Illness, now in its fourth edition, Spector (1996) explored health care providers' understanding of their own perception of health and illness, issues affecting consumers' acceptance of health care, and health beliefs and practices of selected populations. Giger and Davidhizar (1991) developed a model for assessing the health care needs of individuals, which includes factors that must be considered in planning culturally appropriate care. Andrews and Boyle (1995) are yet another example of nursing authors addressing the importance of cultural competence in nursing. They developed a nursing assessment guide with categories of information that they consider essential for nurses to know in order to plan care that is appropriate.

Cultural Competence and Nursing Care.

In 1980, ANA published its Social Policy Statement in which nursing was defined as "...the diagnosis and treatment of human responses to actual or potential health problems." (Carpenito, 1989, p.4). These human responses to health and illness are based on beliefs, values,

and practices that are deeply rooted in the individual's culture. Nurse's ability to interpret these culturally based responses or to plan culturally acceptable interventions undoubtedly affect the care they provide. Alpers and Zoucka (1996) reported that there is evidence that without cultural competence, nurses tend to subject clients of cultures different from their own, to ethnocentric attitudes and practices and they tend to impose their beliefs. Salimbene (1999) gave the example of patients who avoid eye contact with their health care provider and as a result are suspected of not being truthful when in reality, they are adhering to their cultural practice of showing respect for persons in authority and therefore not looking them directly in the eye. Such a situation can result in inadequate nursing care with unintended adverse results. Andrews and Boyle (1999) stated that without culturally competent health care providers, patients are sometimes misdiagnosed, with unfavorable consequences. They cited the misunderstanding of child-rearing practices and subsequent arrests of parents following accusations of abuse as an example of an unfavorable outcome.

Misunderstandings about cultural expressions of pain have also led to inadequate pain relief in many ailing patients. According to Giger and Davidhizar (1999), this is true of Japanese Americans who expect nurses to know best and therefore will not make requests (e.g., for pain medication) but instead will expect the nurses to meet their needs. Yet another example of the consequence of not providing care within the context of the patient's culture is the Korean mother who blames her child's illness on the nurse who affectionately patted her boy on the head. In Korean culture, (as in many other Asian cultures), touching someone's head is interpreted as trying to "steal his or her soul" (Salimbene, 1999).

Cultural Competence in Nursing Practice and Education

Tanner (1996) maintains that in recent years, most policy statements on nursing education indicate that nursing educators have recognized the need to increase the cultural competence of the nursing workforce. Nursing faculty across the country have over the past two decades, modified nursing curricula by either adding separate courses on cultural diversity or by integrating cultural diversity concepts into existing courses throughout the curricula (Chrisman, 1998). Several nursing organizations endorsed the need for cultural competence in nursing: The Transcultural Nursing Society, The American Nurses Association Council on Diversity in Nursing Practice, and the American Academy of Nursing Expert Panel on Cultural Diversity (Baldonado et. al., 1998). Data on the recruitment and retention of faculty and students from ethnic backgrounds designated as minorities are required by organizations that accredit nursing educational programs (Andrews, 1995). However, several studies that examined the nursing care abilities of baccalaureate nursing students, as well as professional nurses, reported low cultural competence levels. (Alpers & Zoucha, 1996; Baldonado et al., 1998; Bernal & Froman, 1987; Kulwicki & Bolonik, 1996 & Napholz, 1999). Thus, despite the efforts to prepare a more culturally competent nursing workforce in the formal educational setting, there are reports that not all students in nursing programs receive adequate content in transcultural nursing and that the content is inconsistent (Baldonado, et al, 1998). There have also been questions raised about nursing faculty readiness to prepare culturally competent graduates.

"How culturally competent are we as faculty?" was one question posed by Tanner (1996) in an editorial in the Journal of Nursing Education. She believes that the development of cultural competence among nursing educators is essential. But she also stated that, " Too often, faculty is presumed to be competent in the very skills they are attempting to develop in their students, and

cultural competence is no exception" (p. 291). Leininger (1995) also discussed faculty qualifications to teach transcultural nursing as one of the critical issues in adapting nursing curricula to meet the challenges posed by the diversification of our society**.** She contends that many faculty who teach transcultural nursing have no graduate training in transcultural nursing, and teach from a common sense approach. Fewer than 20% are prepared in transcultural nursing. Some faculty report teaching transcultural nursing but teach no theory and do not provide appropriate clinical experiences to implement knowledge learned in the classroom. She stated that faculty need to educate themselves in the field of transcultural nursing, so that they can serve graduate as well as undergraduate students responsibly and "…be effective teachers, mentors and role models." (Leininger, 1995, p.11)

There are several approaches cited in the literature, for increasing the diversity and cultural competence of nursing faculty. For example, Ryan, Twibell, Miller and Brigham (1996) reported on a project whereby faculty members sought to increase their skill in teaching transcultural nursing by regional networking. In another project, seminars, print media and videos were used to educate nursing instructors to "teach and model cultural competence" (Chrisman, 1998, p.45). Short-term cultural immersion and a nurse exchange between Mexico City and Dallas, Texas were the approaches taken in another project aimed at increasing the cultural competence of the workforce and nursing faculty (Jones, Bond & Mancini, 1998).

There were however, only three studies cited in the literature concerning the examination of nursing faculty's knowledge of and/ or readiness to teach transcultural nursing. Yoder (1996) studied faculty responses to students of diverse ethnic backgrounds and found that faculty had varying degrees of cultural awareness. In another study, deans and directors of Florida nursing programs were surveyed regarding their approach to promoting and integrating cultural diversity

in their programs (Grossman, et. al., 1998). The respondents believed that the lack of "cultural knowledge, sensitivity and awareness' was one of the most critical issues they faced. Kelly (1991) surveyed a national sample of nursing faculty regarding among other things, their educational preparation in transcultural nursing. Forty-four percent (n=26) of the responding universities reported having faculty with transcultural nursing preparation and 71% (n=19) of these had taken academic courses in transcultural nursing, while 19.2% (n=5) held certifications in that field of nursing. These findings also indicate that 56% of all the universities and colleges surveyed had no faculty with transcultural nursing preparation. There is therefore a need for further study on faculty preparedness to teach transcultural nursing. Whether or not current nursing faculty possess the awareness, knowledge, skills and professional and personal commitment to prepare culturally competent nurses are questions that will be addressed.

Study Purpose and Objectives

The primary purpose of this study was to examine the level of cultural competence among faculty teaching in baccalaureate nursing programs in Louisiana and to identify factors associated with the levels of cultural competence of the respondents. The faculty of baccalaureate nursing programs was the focus of this study because these programs prepare over a third of all registered nurses (RN's) nationwide and most RN's in the state of Louisiana.

The educational programs responsible for preparing individuals eligible to take the RN licensing exam are of varying lengths and outcomes. According to the Occupational Handbook (United States Department of Labor, 2002), approximately half of the 1700 programs preparing RN's in the year 2000 were of two to three years in duration, leading to an associate degree in nursing (A.D.N.). More than a third of RN programs were offered by universities or colleges and granted a Bachelor of Science degree (BSN) after four to five years of study. The others were

programs administered by hospitals, which granted diplomas in nursing after two to three years of study. The Occupational Handbook also indicated that many graduates of A.D.N. and diploma programs often return to bachelor's programs for additional education preparing them for a "broader scope in nursing practice" (United States Department of Labor, 2002, para. 16), after which they are eligible for graduate nursing study and jobs in administration, advanced practice roles and positions as nursing educators. As a result, university based nursing education programs (i.e., BSN also known as baccalaureate nursing programs) not only provide the basic nursing education for over a third of RN's nationwide, but also for those nurses seeking greater opportunities in nursing practice. In Louisiana, of the 22 programs approved to provide nursing education, one is a diploma program, eight are associate degree programs and 13 are baccalaureate programs (Louisiana State Board of Nursing, 2002).

The specific objectives of this study were:

1. To describe the nursing faculty of baccalaureate nursing programs in Louisiana regarding the following variables: Age, sex, ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certifications held, and ethnic background of students taught, and the preparation in transcultural nursing (formal or informal).
2. To describe the extent to which the respondents include transcultural nursing concepts in the courses they teach.
3. To determine the cultural competence of faculty in baccalaureate nursing programs in Louisiana as measured by the scales of the "Cultural Diversity Questionnaire for Nurse Educators." This instrument includes an overall measure of cultural competence and six sub-scale scores including cultural awareness, cultural knowledge, cultural skills, cultural encounters, cultural desire, and cultural teaching behaviors.

4. To determine if a relationship exists between each of the sub-scales and the overall scale of cultural competence.

5. To determine if a model exists that explains a significant portion of the variance in each of the scales of cultural competence as measured by the "Cultural Diversity Questionnaire for Nurse Educators" from the following selected demographic and professional characteristics: Age, sex, ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certification held, ethnic background of students taught and preparation in transcultural nursing.

Definitions of Terms

The following definitions apply to this study:

1. Culture: The sum of beliefs, practices, habits, likes dislikes, norms, customs rituals that are learned in families during years of socialization and are passed on through generations (Spector, 1996).

2. Transcultural Nursing: ...that field of nursing focused on the comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior, nursing care, and health-illness values, beliefs, and patterns of behavior with the goal of developing a scientific and humanistic body of knowledge in order to provide culture specific and culture universal nursing care practices (Leininger, 1978, p.8)

3. Cultural competence: A process, not an endpoint, in which the nurse continuously strives to achieve the ability to effectively work within the cultural context of an individual, family or community from a diverse cultural background (Campinha -Bacote, 1994). The components of cultural competence are cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire (Campinha- Bacote, 1999).

CHAPTER 2

REVIEW OF LITERATURE

In recent years, there has been an explosion of information in the literature and in the print as well as the electronic media, concerning the increasing cultural diversity in America and the consequences of living in a multicultural society such as ours. One such consequence, the need for cultural competence in health care delivery, was the focus of this literature review. It includes a historical perspective of transcultural nursing, which Leininger (1999) identified as the area of study, research and practice in nursing focused on providing culturally competent nursing care. Literature on cultural competence in health care in general, and in nursing in particular was also examined with particular attention to the definition of cultural competence, its essential components and examples of cultural differences affecting health care. Finally, research studies that examined the status of cultural competence in nursing practice and nursing education were reviewed.

Historical Perspective of Transcultural Nursing

Transcultural nursing is the field of nursing focused on developing a body of knowledge through comparative study of health-illness values, beliefs and behaviors of people of different cultures, to be used as a basis for providing culturally competent nursing care. This field of nursing had its origins in the 1950's when Leininger, then a child psychiatric nurse, realized that many of the differences she identified in the children's behaviors (i.e., the way they played, ate, slept and expressed their needs) were culturally determined (Leininger, 1991). She subsequently studied anthropology and blended anthropological concepts of culture with nursing concepts of caring and eventually developed her theory of culture care diversity and universality, with the assumption that there are culture care differences and similarities between care-givers and

clients. She theorized that if nurses had knowledge of different cultures, they would be able to provide care that was consistent with people's beliefs and lifeways. This she referred to as culturally congruent care.

Leininger (1991) contends that every human being is born, lives and dies within a cultural frame of reference which consists of specific cultural values, worldviews, social structure, language uses, ethnohistory, environments and health care systems. Furthermore, each culture has its own lay-care system, which reflects its cultural frame of reference (emic). Professional nurses, on the other hand, represent the values (etic) of the professional health care system. When the two values meet and are not in conflict the care provided the client is congruent and satisfying. However, when the client and professional nurse meet and their values are in conflict, there can be culture conflicts, stress, non-compliance and imposition of etic values. Leininger further theorized that the congruence of emic and etic values are essential to help people function, remain well and survive.

Three modalities were conceptualized by Leininger (1991) to guide nursing judgments. These are 1) culture care preservation and /or maintenance where there is no conflict between emic and etic, 2) culture accommodation/ negotiation where the client may demand accommodation to meet his or her needs, and 3) culture care repatterning and restructuring where the nurse may need to work sensitively with a client to repattern a lifeway that is known to be harmful or bring about unintended effects. Leininger believes that nurses must be knowledgeable about cultural beliefs and practices of clients in order to use either of these modalities well.

Since the founding of transcultural nursing, there has been an expansion of knowledge about worldwide cultures resulting from research studies and scholarly discussions among the leaders in the field (Andrews & Boyle, 1995). The Transcultural Nursing Society (TCNS) was founded in 1974 and its current mission is "…to ensure that the culture care needs of the people of the world will be met by nurses prepared in transcultural nursing." (Transcultural Nursing Society, 2002, Mission statement, para. 1). Through the Journal of Transcultural Nursing, the official journal of TCNS, published for the first time in 1988 with Leininger as its editor, research findings concerning the relationship between culture and the delivery of nursing care has been disseminated worldwide. The goal to develop nurses who can deliver nursing care that was culturally congruent (i.e., nurses with cultural competence) is now well accepted. In fact, in a monograph published in 1995, the American Academy of Nursing (AAN) issued priorities and recommendations concerning diversity, marginalization, and culturally competent health care (Meleis, 1995).

The AAN recommended that individuals as well as institutions make a commitment to culturally competent care, and that nurse scholars, clinicians and educators maintain expertise in this field of nursing (Meleis, 1995). Similarly, the AAN recommended that ways be established to teach nursing faculty as well as nursing students to provide culturally competent nursing care. They further recommended that content reflecting cultural diversity in nursing school curricula be regulated with specific attention to continuing education and State Board examinations.

Cultural Competence

Definition of Cultural Competence

Definitions of cultural competence abound in the literature. Professionals in a variety of health related areas (e.g., clinical psychology, social work, mental health, medicine, nursing)

have defined cultural competence in relation to providers, organizations or health care delivery systems. For example, in 1988, Terry Cross, M.S.W, and then director of the Northwest Indian Child Welfare Institute defined cultural competence as "…a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional to work effectively in cross-cultural situations" (Cross, 1988, p. 1). Cross views cultural competence as a process. In his definition, the term culture refers to the human behaviors of a racial or ethnic group comprised of thought, actions, communication, customs, beliefs, and values. Competence implies having the capacity to function effectively.

Mason, Cross, Rider and Friesen (1988), stated that cultural competence is "… a developmental process for each worker. It is not something that happens because one reads a book, attends a workshop or happens to be a member of a minority group." (p. 4). According to Cross, cultural competence is a developmental process moving along a continuum of six positions, ranging from least competent to most competent (Cross, 1988). He described the least competent end of the continuum as cultural destructiveness, which is represented by attitudes and policies that are destructive to individuals within the culture. These attitudes reflect feelings of superiority and further dominance and control of one group over another.

The second position along the continuum is cultural incapacity. Agencies and individuals in this position are not intentionally destructive, but they lack the resolve to help minority clients or communities. They support segregation and communicate subtly to minorities that they are not welcome. The third position, which is close to the midpoint of the developmental process, is cultural blindness. The individuals and agencies in this position have the philosophy of being unbiased but they unfortunately fail to acknowledge that culture does

make a difference. They serve all of their clients equally, using a traditional yet ethnocentric approach and fail to see that these approaches may not be acceptable to all groups.

According to Cross (1988), as individuals and agencies continue to develop, they reach cultural pre-competence, basic cultural competence and finally, advanced cultural competence. Those in the position of cultural pre-competence realize their weaknesses in serving culturally diverse populations and make attempts to improve. They may train their employees to become more culturally sensitive, they may hire minority staff, or they may do needs assessments regarding their minority clients. Unfortunately, they tend to believe that the accomplishment of one of the above tasks is enough, either because they lack information about what is possible or about how to proceed. Nevertheless, this position includes those who have truly begun the process of becoming culturally competent. Both basic and advanced culturally competent agencies and individuals are characterized by acceptance and respect for differences, ongoing self-assessment, knowledge expansion and modification of their service models to meet the needs of their minority populations. The advanced culturally competent however, are distinguished by seeking to expand the knowledge base of cultural competent practice through research. This is the most culturally proficient point along the continuum. Mason (1994) stated that because culture is ever changing, "… arriving at this end of the continuum is an ideal state requiring a lifelong commitment." (p.6).

Purnell and Paulanka (1998) believe that to provide culturally competent care, health care providers must develop awareness of self, knowledge and understanding of the client's culture, acceptance and respect of cultural differences and adapt care to be congruent with the client's culture. Similarly, Mason (1994) stated that the five principles underlying the cultural competence model are valuing diversity, conducting a self-assessment, understanding the

dynamics of difference, and adapting to diversity. Mason further stated that adapting to diversity involves making appropriate adjustments to attitudes (i.e., thoughts, beliefs, etc.), practices (e.g., assessment skills, treatments), policies, and structure (e.g., decision making bodies), and the physical plant (e.g., office décor and artwork).

In an article in the journal School Psychologist, Dana defined cultural competence as "…a blend of ethno-relativistic attitudes and culture-specific skills, knowledge and behaviors that contribute to credible and acceptable professional services to children/adolescents from visible racial/ethnic groups in school settings" (Dana, 1995a, p.87). He believes that cultural competence is required in assessing children's needs and in providing mental health services that are individualized and thus more desired and effective. Dana (1996) further contends that if needs-assessments for health and mental health services are to be "acceptable, credible, beneficial and ethical" (p.473), they must be culturally competent. He also reported that the 1992 American Psychological Association (APA) Code of Ethics (Dana, 1995b) mandates culturally competent assessment practice.

As cited in Leonard (2001), the American College of Obstetricians and Gynecologists (ACOG) described a culturally competent health care system as one that "…values diversity, has the capacity for cultural self assessment, is conscious of the dynamics inherent in any multicultural encounter, and has developed the necessary adaptations to service delivery that reflect an understanding and appreciation of cultural diversity" (Leonard, 2001, p.8).

The American Academy of Nursing (AAN) expert panel on Cultural Competence defined culturally competent care as "care that takes into account issues related to diversity, marginalization, and vulnerability due to race, gender and sexual orientation...It is also care that is provided within the historical and 'dailiness' context of clients" (Meleis, 1995, p.4).

Leininger (1999) used the term cultural competence interchangeably with culturally congruent care, which she defined as "care that is meaningful and fits with cultural beliefs and lifeways" (p. 9). Leininger further stated that culturally congruent care involves the use of knowledge of local cultural lifeways and professional knowledge to design care that is fitting and helpful to specific cultures.

Meleis, a transcultural nurse specialist, describes culturally competent care as "care that is sensitive to the differences individuals may have in their experiences and responses due to their heritage, sexual orientation, socioeconomic situation, ethnicity, and cultural background " (Meleis, 1999, p.12). She further maintains that the culturally competent person is able to recognize how those differences may marginalize people and affect their responses. Also, a culturally competent person avoids stereotyping by recognizing variations of differences. Meleis believes that to provide culturally competent care one must be guided by a theoretical knowledge base (Meleis 1996). Another transcultural nurse specialist, Campinha-Bacote, views cultural competence as a process. Her definition of cultural competence is: "A process, not an endpoint, in which the nurse continuously strives to achieve the ability to effectively work within the cultural context of an individual, family or community from a diverse cultural background (Campinha –Bacote, 1994).

In summary, cultural competence was described as certain behaviors, attitudes, policies, abilities and skills (Campinha-Bacote, 1994; Cross, 1988; Dana, 1995a). Culturally competent services and care were described as those that were sensitive, fitting or congruent with or provided within the context of the recipients' culture (Campinha-Bacote, 1994; Cross, 1988; Leininger, 1999; Leonard, 2001; Meleis, 1995; Meleis, 1999). These services and care were also said to reflect acknowledgement, understanding and appreciation of differences in the recipients'

culture (Leonard, 2001; Meleis, 1995; Meleis, 1999). Culturally competent services and care were also described as effective, credible, meaningful and acceptable to the clients (Campinha-Bacote, 1994; Cross, 1988; Dana, 1995a; Leininger, 1999). Finally, Meleis believes that to provide culturally competent care requires a theoretical knowledge base.

Both Campinha-Bacote (1994) and Cross (1988), contend that cultural competence is a process and not an endpoint. Mason, Cross, Rider and Friesen (1988) view cultural competence as an ongoing process, developing along a continuum from least competent to most competent, with the most competent end of the continuum being a goal or an ideal, not an end point. The degree to which individuals and/or organizations possess certain essential components determines their progression along the continuum of cultural competence.

Components of Cultural Competence

Even though most authors described the elements of cultural competence somewhat differently, this literature review revealed that several concepts were repeatedly included as essential components of cultural competence. Mason, Cross, Rider and Friesen (1988) for example, believe that the five key components for becoming a culturally competent professional are 1) awareness and acceptance of differences, 2) awareness or the recognition of the influence of one's own culture on how one thinks and acts, 3) the dynamics of the differences during cross cultural interactions, 4) the development of knowledge about the client's culture and 5) the adaptation of skills to meet the clients' cultural needs.

Campinha-Bacote's (1999) model of culturally competent nursing care includes similar components as Mason, Cross, Rider and Friesen's (1988). These are cultural awareness (i.e., sensitivity), cultural knowledge, cultural skill (cultural assessment), the cultural encounter or

exposure, and cultural desire (Campinha-Bacote, Yahle & Langencamp, 1996; Campinha-Bacote, 1998). Meleis (1999) agrees that acknowledging differences, valuing diversity and knowledge are required elements for providing care that is culturally competent. In addition, she believes that, awareness of the effects of cultural differences (e.g., marginalization), advocating for the marginalized and intolerance of stereotypes are also required properties for cultural competence. The following section of this review includes a discussion of the components of cultural competence most prominent in the literature.

Acceptance And Acknowledgement Of Differences. Awareness and acceptance of differences is the first component listed in the model for cultural competence described by Mason, Cross, Rider and Friesen (1988). This involves acknowledging that differences exist in the way that clients from different cultures may behave, communicate and define health and illness, and that these differences may affect the client provider interaction. Salimbene (1999) agrees that the culturally competent nurse must understand how culture plays a role in forming his or her client's health beliefs and illness prevention practices. Meleis (1999) points out that to provide culturally competent care, one must value diversity and Purnell and (1998) maintain that accepting and respecting cultural differences improve the likelihood that health care practitioners will provide culturally competent care. Leonard (2001) also agrees that diversity must be valued and states that client - provider relationships are likely to improve once clients realize that there is interest in their culture and that they are respected.

Cultural Awareness. Campinha-Bacote (1994) includes cultural awareness as the first component in her model of cultural competence. She believes that cultural awareness is a process whereby health care providers become aware and learn to appreciate the "values, beliefs, lifeways, practices and problem solving strategies of a client's culture" (Campinha-

Bacote, 1998, p. 10). She holds that this awareness involves self-examination and exploration by providers of their own culture and its influence on their way of thinking and behaving. This process, she believes, is essential if providers are to avoid imposing their own values on their client's.

According to Purnell and Paulanka (1998), the process of becoming culturally aware is viewed on a continuum ranging from unconscious incompetence (i.e., lack of awareness of cultural differences between providers and their clients) to unconsciously competent (i.e., the ability to automatically provide culturally congruent care). Intermediate steps along the continuum include conscious incompetence, or awareness that knowledge concerning cultural differences is missing, and conscious competence. In this case the provider consciously seeks knowledge about the client's culture and makes an effort to apply the principles learned but is not yet comfortable with caring for culturally diverse clients.

Awareness or the recognition of the influence of one's own culture on how one thinks and acts is the second component in Mason, Cross, Rider and Friesen's model for cultural competence (Mason, Cross, Rider & Friesen, 1988). They suggest that providers examine the influences of their culture (i.e., the effects of family, peers, social institutions, etc.) on themselves, to better understand the impact of culture on client provider-interactions. Leonard (2001) states that this awareness begins with the recognition that health care has its own deeply rooted beliefs and practices which, unless challenged, may remain unconscious and yet affect the interactions between clients and providers. She also maintains that in order to achieve the knowledge, skill and respect for differences required to provide culturally competent care, nurses must engage in honest review of their values, beliefs and prejudices against other cultures.

Cultural Knowledge. Leininger (1991) believes that knowledge about diverse cultures is necessary to provide care that fits the client. Her theory of culture care diversity universality refers to the differences as well as commonalities in meanings, values, lifeways or symbols of care among different cultures. In order to care for persons from a particular culture, Leininger maintains that nurses need to know about kinship, social, political, religious, economic, educational, and technological factors that interact and influence individuals from that culture. In fact, one of the basic premises of her theory of "culture care diversity and universality" is that "Culturally congruent nursing care can only occur when culture care values, expressions, or patterns are known and used appropriately and meaningfully by the nurse with individuals or groups" (Reynolds & Leininger, 1993, p. 16). Therefore, she believes that it is important for nurses to conduct studies that yield cultural knowledge.

Salimbene (1999) holds that cultural knowledge helps providers anticipate barriers to access or problems with compliance and it helps them to avoid violating cultural taboos. Mason, Cross, Rider and Friesen (1988) also consider the development of knowledge about the client's culture a critical component in the process of becoming culturally competent.

Campinha-Bacote (1998) describes cultural knowledge as the process of obtaining information about the worldviews of different cultural groups. Reynolds and Leininger (1993) explains that a cultural group's world-view is their perspective on life events, which in turn shapes their values about themselves and the world around them. Health care providers should understand that a group's world-view also explains how they interpret their illnesses and what causes they attribute them to (Campinha-Bacote, 1998). According to Murdock, as cited in Campinha-Bacote (1998), a cultural group may attribute the etiology of their illness to one of four phenomena: 1) Natural causes or a physiologic consequence of a natural event is one

possible etiology (e.g., heat, cold, wind, etc.; 2) Mystical causation such as fate, or mystical retribution; 3) Animistic causation or the intervention of a supernatural being such as a ghost or God; and, 4) Magical causation or magical means used by a human being with the intent to cause harm (e.g., sorcery). It is also important to gain knowledge about the different interacting styles within groups that are culturally diverse (Campinha-Bacote, (1998). A person may be acculturated or consciously rejecting cultural practices of his cultural group or, he may be culturally immersed and accept only the values of his own cultural group. He may also not disclose which culture he accepts or rejects, or he may be bi-cultural and be quite comfortable in the mainstream culture as well as in his own.

Dana (1996) uses the term cultural orientation to describe the above phenomenon. He believes that by determining clients' cultural orientation, providers can determine if clients: 1) have retained the language and culture of their country of origin (i.e., are traditional); 2) are exhibiting a mixture of behaviors from both original and dominant society but are not fitting comfortably with either (i.e., are marginal); 3) are exhibiting familiarity with both original and acquired cultures (i.e., bicultural); or, 4) have adopted the values, beliefs and behaviors of the dominant society (i.e., assimilated). Dana believes that knowledge about a person's cultural orientation is mandatory since it informs providers of the appropriateness of using assessment and intervention methodologies that were designed for the predominant Anglo-American society, on clients that are racially and ethnically different. Furthermore, knowledge of cultural orientation alerts providers to "within-group differences" (p. 483) and can prevent the use of a single assessment and intervention strategy for all clients within a cultural group (Dana, 1996).

Campinha-Bacote (1998) maintains that cultural knowledge is important in preventing mis-diagnoses of mental illness in culturally diverse populations. Individuals of different cultures

express mental illness differently, in ways that are said to be "culture bound". Examples of culture-bound illnesses described by Campinha-Bacote are "falling out" and "Susto". "Falling out" occurs among African American and Black Caribbean cultures and may be manifested by a collapse and a perceived loss of speech and sight by the individual even though his or her speech and hearing remain objectively unaffected. "Susto" on the other hand is seen in some Hispanic cultures. It consists of a frightening experience, which the victim believes robs him of his soul and includes symptoms such as anorexia, listlessness and withdrawal.

Knowledge of biological variations among cultural groups is also required if culturally competent care is to be provided. Purnell and Paulanka (1998) refer to this area as “biocultural ecology” and state that it identifies skin color and biologic variations, diseases and health conditions and variations in drug metabolism. They point out that health care providers must be aware of differences in manifestation of certain conditions in people of different color skin. A provider knowledgeable about these variations would be aware that when assessing Asians for jaundice, looking at the sclera of the eyes rather than the skin might yield more accurate information.

Campinha-Bacote (1998) believes that providers should be knowledgeable of the diseases endemic to certain cultural groups (e.g., hypertension in African-Americans) and Purnell and Paulanka (1998) state that in the case of newer immigrants, they should be examined for diseases common in their country of origin. Knowledge of disease to which certain cultural groups are susceptible enables health care providers to conduct appropriate screening and early treatment for these conditions.

Providers should also be aware of the variations in drug metabolism among specific ethnic groups, which may be caused by environmental, genetic cultural or structural reasons

(Campinha-Bacote, 1998). For example, Kudzma (1999) reports that patients of some ethnic groups (e.g., Chinese and Japanese) metabolize certain drugs (e.g., valium) more slowly than others. This may place them at greater risk for experiencing adverse effects. Kudzma also reports that some drugs (e.g., labetelol) used to treat hypertension in Blacks are more consistently effective than other drugs (e.g., propanalol and its derivatives). Other factors influencing patient compliance and response to medications are less physiologic and relate to what side effects patients report to their health care providers. Kudzma indicates that in Japan for example it is not considered polite to discuss gastrointestinal symptoms, therefore patients experiencing these are much less likely to report them and more likely to discontinue taking the medications prescribed. Also, some patients may combine herbal and homeopathic remedies with their medications, which may result in altered responses to certain drugs. In either case, patients from the affected cultural groups may not derive the intended benefits from their drug regimens, if health care providers are not knowledgeable in this area (Kudzma, 1999). Kudzma contends that the traditional "one-size-fits-all" (p. 49) approach to prescribing medications commonly used in this country can no longer be continued, given the increasing ethnic and cultural diversity of recent years.

Cultural Skill. Campinha Bacote's model for cultural competence includes cultural skill as an essential component of cultural competence. She defines cultural skill as "the ability to collect relevant data regarding the client's health history and presenting problem as well as accurately performing a physical assessment" (Campinha-Bacote, 1998, p. 26). Cultural skill also refers to the provider's ability to conduct a cultural assessment, which should include information about the individual's cultural beliefs, practices and values and this information should assist the provider to intervene within the cultural context of the individual.

Numerous guides for conducting cultural assessments can be found in the literature. Leininger's (1991) Acculturation Health Care Assessment Enabler Guide looks at traditional and non-traditional lifeways of clients in an attempt to determine their degree of acculturation. Specific factors (i.e., the clients' use of language, environment, clothing, world view, values, beliefs, daily activities, religion, educational values, dietary patterns, health care patterns, views on illness prevention, etc.) are rated on a five point Likert scale from one (mainly traditional) to five (mainly nontraditional).

One approach to assessing the patient and /or family's perception of their health problem is to pose certain specific questions such as: What do you think caused your problems? Why do you think it started when it did? What do you think your sickness does to you? How does it work? Or, How long do you expect it to last? (Tripp Reimer, Brink & Saunders, 1984). Such questions shed light on patients' perspective of what they are experiencing. Andrews and Boyle (1995) described Bloch's assessment guide for ethnic/cultural variations, in which, cultural, sociological, psychological and bio/physiological data categories are identified and each category has an accompanying questionnaire with instructions for obtaining the appropriate information. (e.g., education, family support). In yet another cultural assessment guide Andrews and Boyle (1995) include thirteen categories of information (e.g., cultural affiliations, values orientation, cultural sanctions and restrictions, communication, nutrition etc.) to be investigated in order to plan culturally appropriate nursing care.

The cultural assessment model by Giger and Davidhizar (1995) is based on the premise that each individual is culturally unique and is a product of past experiences, social and cultural factors (i.e., values, beliefs, cultural norms). According to this model, six factors must be taken into account for all individuals. These are communication, space, social organization, time,

environmental control and biological variations. The corresponding assessment guide provides specific topics and questions related to each of these factors that the nurse should address. This guide was intended as a more practical assessment tool that could be used in the clinical setting.

Purnell and Paulanka (1998) believe that there are 12 interconnecting cultural domains that are common to all cultures. Armed with knowledge about these domains, he contends that health care providers can adapt their treatment regimens to suit clients' needs and improve their health. The domains in Purnell's model are: Overview, inhabited localities and topography, communication, family roles and organization; workforce issues, biocultural ecology, high risk health behaviors, nutrition, pregnancy and childbearing practice, death rituals, spirituality; health care practices, and health care practitioners.

Another skill important in providing culturally competent care is communication. This includes using what Dana terms the appropriate service delivery style**.** The style of service delivery in the dominant Anglo American society is a business like, somewhat impersonal approach that discourages familiarity between provider and client (Dana, 1996). According to Dana, this approach may be uncomfortable and alienating to individuals with traditional or marginal cultural orientations. For example, he reports that Hispanics prefer a more personalized, leisurely pace (i.e., personalismo), whereas African Americans initially appear aloof but are sizing up the provider prior to personalizing the relationship. Dana concludes that providers who are sensitive to these preferred styles of their clients are more likely to obtain accurate assessment data. In addition, he maintains that it is most important to use clients' first language when conducting assessments.

The recommended standards for culturally and linguistically (CLAS) appropriate services in health care of the Office of Minority Health, Department of Health and Human Services

address the issue of language (OMH, 2000). Specifically, standard number six states that:

> Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer) (OMH, 2000, para. 52).

This standard recognizes the importance of using clients' language of preference to ensure accuracy of communication and to avoid errors caused by misunderstandings and inaccurate information. Such mis-communication could lead to incorrect diagnoses and treatments, as well as poor compliance.

Cultural Encounters. Campinha-Bacote defines cultural encounters as "the process which encourages health care providers to directly engage with clients from diverse cultural backgrounds" (Campinha-Bacote, 1998, p. 39). She states that these interactions are intended to increase the providers' repertoire of responses, both verbal and non-verbal, in cross-cultural situations. In addition, cultural encounters increase the providers' accuracy in communicating (i.e., sending and interpreting messages) with clients of diverse cultures. Providers learn that their usual non-verbal communication (e.g., thumbs up signs) may be misinterpreted or may even be offensive to individuals of different cultures for whom they have totally different meanings. Cross-cultural encounters also allow the participants to validate, clarify, modify and sometimes negate notions about other cultures, which have been obtained from academic sources. With cross-cultural encounters, there is direct interaction with other cultural groups and intra-ethnic variation in values, beliefs and practices can be appreciated. This in turn decreases the likelihood of stereotype formation.

The importance of these encounters is also recognized by Mason, Cross, Rider & Friesen (1988). They maintain that "dynamics of difference" (Mason, Cross, Rider, and Friesen, 1988, p. 4) occur whenever cross-cultural interactions take place. That is, providers as well as clients

bring their history, communication patterns, etiquette, and problem solving styles, stereotypes and feelings about working with someone who is different to the experience. The result is often misunderstanding and misjudgment. Mason, Cross, Rider and Friesen believe that when providers understand these "dynamics of difference", the likelihood of intervening successfully with clients will increase.

Cross-cultural encounters may range from local cross-cultural interactions to international immersion programs. Jones, Bond and Mancinni (1998) reported on a language and cultural immersion project where American health care professionals spent one week in Cuernavaca, Mexico learning Spanish and living with Mexican families. This language and cultural immersion was one strategy aimed at increasing the cultural competence of health care providers to better meet the needs of a growing Hispanic population. The authors believed that language and cultural immersion such as this, facilitates the development of cross-cultural communication skills and increases self- awareness and knowledge about another culture.

Chrisman (1998) also reported on the use of cross-cultural encounters to increase faculty cultural competence. Specifically, faculty were required to spend four to six hours consistently with a group from a culture different from their own. According to Chrisman, faculty who participated in these cultural encounters were more able to relate to feelings of loneliness and of being outsiders, such as to those experienced by culturally diverse patients during hospitalization.

Ryan, Twibell, Brigham and Bennett (2000), believe that one of the barriers to developing more culturally focused nursing curricula, is the lack of actual experience with diverse cultures. The authors conducted a research study to identify the effects of cultural immersion on the personal lives and nursing practice of the study group. The participants in the

study were nine graduates of a nursing program with a required cultural immersion experience in their senior year, intended to broaden their world-view and to promote personal insight. In particular, the authors sought to explore the students' perception of the immersion experience, how they adapted to the experience, and what about the experience specifically affected them professionally and personally. They also sought to formulate concepts regarding social interactions that took place during the immersion experiences. Data was gathered from the participants' written responses to a question concerning the effect of the experience on their practice and from two focus group discussions.

Ryan, Twibell, Brigham and Bennett (2000), found that the immersion experience provided a context for learning flexibility and adaptation. Strategies that the respondents reported using to adapt to the transcultural experience included preparation for the actual experience, dependence on the group and on the faculty for support, developing and using a variety of coping responses, learning new ways of communicating, adapting to unique living conditions, and learning to think differently. Major outcomes of the experience that were identified were learning to accept others and accepting differences, increased awareness of the need to understand different communication patterns, recognition of personal biases, increased awareness of the need for cultural competence, and the determination to provide culturally sensitive care. The authors highly recommend that cultural immersion experiences be included in nursing curricula as a vehicle for learning cultural competence. They believe that these experiences ensure exposure to a culture different from the students' own, and that they force them to evaluate cultural differences and to examine their own values and beliefs.

Cultural Desire. Campinha-Bacote defines cultural desire as "the motivation of health care providers to 'want to' engage in the process of cultural competence" (Campinha-Bacote, 1999, p.205). She maintains that for providers to be truly culturally competent, in addition to having had cultural encounters, and possessing cultural awareness, knowledge and skill, they must truly want to care for clients who are culturally diverse. In addition, they must believe that care that is culturally relevant is essential to good health care. She believes that understanding the concept of caring is essential to understanding cultural desire (Campinha-Bacote, 1998). Leininger (1991) defined caring as:

> …understanding and knowing human beings in as natural or human a way as possible, and …being with them in an assistive, helping, guiding or enabling way to help them achieve certain goals, improve, ameliorate, a human condition or lifeway, face disability, or assist with dying. (p.30)

Campinha-Bacote (1999) believes that providers' actions must be congruent with their feelings and that culturally diverse clients of providers who truly care know that they are valued. She further maintains that the culturally competent health care provider must truly believe and be personally committed to the importance and value of providing culturally competent health care services and not be motivated only by the desire to be politically correct. Mason, Cross, Rider and Friesen (1988) hold a similar viewpoint in that they assert that cultural competence is a process resulting from the desire to provide quality health care to all.

Meleis (1999) describes several properties that characterize culturally competent individuals. She maintains that they exhibit a sense of challenge by diversity and are not threatened by it. They never tire from trying to interpret the meanings of symbols their clients present. They are instead, energized by the variety before them and find teaching, researching and caring for people challenging.

Ryan, Twibell, Miller and Brigham (1996) reported on a roundtable discussion that was part of a project to increase the skills of faculty to teach transcultural concepts. Lack of faculty commitment to teach transcultural concepts, was found to be one of the barriers to attaining the project goals. Lack of knowledge about cross-cultural nursing theory and concepts, concerns about teaching stereotypes, and lack of time and energy were given as reasons for faculty's lack of commitment to implement new cross-cultural curricular content. Even though there was agreement that clinical experiences would be an excellent way for students to implement cross-cultural concepts, many faculty members were unable to arrange such experiences due to lack of contact with potential clients and health care providers of diverse cultures. Participants concluded that with increased faculty preparation in this new content area, there would be an increase in confidence, a decrease in hesitancy and greater commitment to teaching it.

Cultural Differences Affecting Health Care

The major racial and ethnic groups in the United States are European Americans, African Americans, Hispanics or Latino Americans, Asian Americans (e.g., Chinese, Japanese, Vietnamese, Cambodians, East Indians, etc.) and American Indians. Each of these groups has distinctive beliefs and practices that affect their definition of health and the actions they take to deal with health problems. Differences in their communication patterns also affect their interaction with health care providers. There are also many within-group differences among these groups based on their region or country of origin and socio-economic status. Following are some examples of the differences encountered in the literature and their effect on health care.

Biological Variations

Dossey, Keegan and Guzzetta (2000) define biological variations as those differences that are biologically determined and not merely adaptations due to lifestyle preferences or socio-

economic status. As examples of biological variations, they list: "…body size and structure, including variations in teeth, facial features and skin color; variation in metabolism and enzyme production that result in drug reactions, interactions and sensitivities; susceptibility to disease …and nutritional issues …and deficiencies such as lactose intolerance." (Dossey, Keegan & Guzzetta, 2000, p. 303).

Skin color among African Americans can range from white to very dark skin tones, almost black (Purnell & Paulanka, 1998; Giger & Davidhizar, 1999). These variations in skin color have definite implications for assessing conditions such as palor, jaundice or cyanosis. Good lighting is essential and unlike in European Americans, palor or cyanosis would be manifested in the conjunctiva of the eye or the mucous membranes on the inner lips rather than on the skin itself (Purnell & Paulanka, 1998 & Giger & Davidhizar, 1999). The sclera of the eyes, palms of the hands and soles of the feet would be appropriate areas to check for jaundice in African Americans. Mongolian spots are another biological variation found mostly among infants of African Americans (90%) and Asians, as well as American Indians (80%). These dark blue-green areas, usually on the lumbosacral region of the body, are remnants of melanocytes and are not to be confused with bruises (Giger & Davidhizar, 1999). Lack of knowledge and skill in assessing any of the above conditions could lead to delays in diagnosis and treatment or misdiagnosis and inadequate care.

Other examples of biological variations include the prevalence of sickle cell anemia and hypertension among African Americans, the prevalence of tuberculosis and hepatitis among the Hmong, and diabetes among American Indians ((Dossey, Keegan & Guzzetta, 2000). Variations in responsiveness to drugs are other examples of biological variations. Purnell and Paulanka

(1998) report that African Americans respond less to beta-blockers, and according to Campinha-Bacote (1998), Japanese have a lower therapeutic range for the drug Lithium.

Explanation Of Illness Causation

According to Dossey, Keegan and Guzzetta (2000), in the Hmong culture, illness is thought to be brought on by supernatural causes such as soul loss, spiritual disharmony, or sins of the ancestors. These authors also maintain that for many American Indians, the causes of illness include not living according to the code of life and evil spirits. Campinha-Bacote (1998) refers to these illnesses as culturally defined and cites the examples of "falling out" (p. 21) and voodoo illnesses, which are conditions, reported by some members of African American and Caribbean cultures. These conditions are believed to be brought on by a supernatural force via "witchcraft" or "rootwork" (P. 21). Other examples of culturally defined syndromes can be found among Hispanics or Latinos who may explain the cause of some illnesses as the result of 'evil eye', loss of respect, loss of the soul or an imbalance between hot and cold. The symptoms of these conditions may vary from gastrointestinal disorders to weakness, listlessness and withdrawal. These clients may seek care from traditional folk healers. According to Dossey, Keegan and Guzzetta (2000), if a client believes that the cause of his or her illness is a sin or a broken taboo, that client would probably not be receptive to following a regimen prescribed by a medical doctor and might only respond to some culturally defined ritual. Campinha-Bacote (1998) points out that oftentimes, culture bound illnesses are misdiagnosed as mental illnesses, and she maintains that knowledge about cultural diverse populations' perceptions about health and illness would prevent these misdiagnoses.

Perception Of Time

Giger and Davidhizar (1999) contend that nurses should appreciate cultural differences regarding time perception. They describe one aspect of time perception as temporal orientation, which refers to the fact that an individual's behavior will be related to the past, present or future, depending on the priority given to each of these by the cultural group he or she belongs to. For example, according to Purnell and Paulanka (1998), African Americans are generally more present than future or past oriented. However they also point out that certain subgroups of African Americans may have different temporal orientations, such as older members of this cultural group for whom the past plays and important role. Purnell and Paulanka also describe Mexican Americans as being present oriented, especially those of lower socio-economic status. For them it is more important to live in the present because of tomorrow's uncertainties.

According to Giger and Davidhizar (1999), these time orientations have implications for nurse client interactions. Present oriented persons may believe that the present is more important because it will never return and they may hesitate to move on to the next scheduled activity. They may not adhere to a time schedule and may be late for appointments. Present oriented individuals may also not take part in preventive health activities but will seek care when problems are present and real to them. Giger and Davidhizar caution against generalizing and point out that socio-economic status should be taken into account when assessing time orientation. For example, middle class Mexican Americans and African Americans may have adopted the value of punctuality held by the dominant culture.

Another cultural difference related to time is how it is measured. Giger and Davidhizar (1999) maintain that time has historically been measured in days and years. During the day, clocks are used to measure the hours, minutes and seconds. However they point out that in some

cultures, social time or social processes and patterns that order social life, take precedence over the clock as the primary source of orientation to time. Fadiman (1997) aptly described this phenomenon in her account of the conflicts between a Hmong refugee family with an epileptic child and health care providers at a small county hospital in Merced, California. Fadiman pointed to the difficulties she encountered in establishing the sequence of events when interviewing the family. Prior to coming to the United States, they identified the time of the year by lunar cycles according to their agricultural activities, instead of by the months of the calendar. Thus, they spoke of the cycle during which opium was harvested, or the cycle during which corn was planted, or the cycle during which opium was weeded, and so on. Now that the family lived in the United States and was not farming, they had difficulty remembering the sequence of events. Furthermore, when given a schedule for medicating their sick child (e.g., one tablet every four hours) the family had difficulty complying partly because, according to Fadiman, rather than using clock time, they were used to telling the time of the day by their former daily patterns such as "…'the first cock crow,' 'second cock crow,' 'time that the sun inclines,' 'time that shadows cover the valley,' 'pig feeding time' 'full darkness'"(Fadiman, 1997, p.100). The consequence to the child was poor medication levels and a worsening rather than improvement of her condition.

Communication

Geiger and Davidhizar (1999) believe that communication is the means through which humans interact and share information and that it is very important in the healing process. They further maintain that when nurses or other healthcare providers and their clients are from different cultures, communication may be impeded and this can result in many barriers to the healing process. These communication problems may not only be caused by the lack of common

language between the nurse and client, but also by the difference in communication styles and patterns. Thus, in addition to understanding the actual words used to communicate, health care providers must also be aware of the meaning of facial expressions, gestures and intonations used It is therefore essential that providers learn about the communication patterns of the cultural groups they work with (Giger & Davidhizar, 1999).

When communicating with African Americans, for example, the use body movements and a direct and expressive speech can be expected. Purnell and Paulanka (1998) state that the volume of their voices may be louder and should not be interpreted as reflecting anger. According to Giger and Davidhizar (1999), many African Americans also use "Black English" or a dialect that is noticeable different from Standard English and which should not be regarded as substandard or reflecting lesser intelligence. The health care provider must also identify the terms used by African Americans to signify certain medical conditions in place of standard medical terms. For example, sugar is often used in place of diabetes and low blood is used in place of anemia. Giger and Davidhizar also point to the large degree of intra-ethnic variation that exists among African Americans and suggest that health care providers treat members of this group (as well as members of any other ethnic group) on an individual basis.

Another example of a cultural variation that could affect provider-client communication is that Mexican Americans prefer to engage in small talk, prior to moving on to the health interview. This practice known as "personalismo" (Purnell & Paulanka, 1998, p. 400) requires that the provider inquire about family members and show caring and respect before asking direct questions related to the reasons for seeking health care. A nurse who is too direct during an initial encounter with a Mexican American client will be less successful than one who first allows time for the development of respect and trust.

Purnell and Paulanka (1998) believe that working with client of limited English ability is another situation in which the provider must act to safeguard the accuracy of communication. They state that providers who are non-native speakers must take care to select words that have clear meaning. Similarly, using the incorrect form of a verb could change the intended meaning of a sentence. Providers should ideally select interpreters who are in the health field and can use the appropriate dialect whenever possible. They should avoid using relatives since they may, for cultural reasons, not be able to communicate the information as intended. Children are also not considered appropriate to use as translators because of the sensitive nature of much of the topics to be discussed. Fadiman (1997) referred to the interpreters she used to communicate with the Hmong as cultural brokers, because they not only translated but they also taught her about their culture.

Social Organization

According to Giger and Davidhizar (1999), social organization refers to how cultural groups are structured. These structures may be based on "… family, religious, ethnic, racial, tribal, kinship, clan, and other special interest groups" (Giger & Davidhizar, 1999, p.69). For each cultural group, these units that form the basis of their social organization have different importance and have different effects on the clients' decisions regarding their health care. For Mexican Americans, their foundation is the nuclear family even though the family network usually includes in-laws grandparents and many other relatives. Within the family, the father is considered the head and must be consulted about decisions concerning other family members. Hospitalized Mexican American patients often have family members visiting and providers can usually count on them to help with the patient's care.

Giger and Davidhizar (1999) maintain that in African American families the wife or mother is often the one responsible for making decisions regarding health care. This role must be recognized and respected by the provider. There are also often wide networks of support for the patient. The role of the family is also paramount among Japanese Americans. Here, the father makes family decisions and authority flows from the top down with the sacrifice of individual needs for the good of the family being a central theme. Discussion of personal problems and expression of emotion are not encouraged. For the nurse, this implies that a family member would most likely be present at the bedside to provide assistance to the patient, especially with personal care, so that the nurse need not be bothered.

Among Vietnamese, the immediate family consists of not only the nuclear family (i.e., parents and unmarried children), but also the husband's parents, and the sons with their wives and children. Obedience and honor to parents are of utmost value, as well as sharing of material goods. If the parents are elderly, it is the responsibility of the eldest son to take over for the parents and make decisions. When caring for a member of this cultural group, the provider should include the family in planning the care of the client and should be aware of the appropriate family member to approach for decision-making.

Research on Cultural Competence in Nursing Practice

The results of research studies on levels of cultural competency of nursing students as well as professional nurses have not been encouraging. Several researchers used the Cultural Self-efficacy Assessment Scale (CSES), developed by Bernal and Froman, to measure confidence in cultural competence. (Alpers & Zoucha, 1996; Bernal & Froman, 1987; Kulwicki & Bolonik, 1996; Napholz, 1999). As reported by Bernal and Froman, self-efficacy is as a way of connecting or predicting how people will actually perform a task as a result of how they feel

about the task. (Bernal & Froman, 1987). Performance of the task, vicarious experiences, verbal persuasion or praise, and emotional or physiological factors such as pain are all sources of information that individuals use to form opinions about self-efficacy regarding specific tasks. The researchers developed a Likert-type scale of 30 statements derived from anthropological and transcultural nursing literature and representing important aspects of transcultural nursing knowledge and skills. The statements on the scale are grouped into sections dealing with: a) knowledge of cultural concept, b) cultural patterns, and c) cultural assessment skills.

Bernal and Froman (1987) first used the CSES scale to examine the reported confidence of community health nurses caring for black, Southeast Asian and Puerto Rican clients. Specifically, they looked at the degree of self-efficacy of the participating nurses in caring for the designated clients and they tried to determine if there were differences in self-efficacy for caring for any of the three groups. The highest confidence level was reported for caring for blacks then Puerto Ricans and then Southeast Asians. However, the highest rating did not even reach a moderate level of confidence. The authors concluded that regardless of years of study, age, specialty or educational preparation, the nurses in the study had little confidence in their transcultural nursing abilities.

More recently Kulwicki and Bolonik (1996) looked at 71 graduating baccalaureate nursing students and their degree of confidence in providing culturally appropriate care for African American, Hispanic, Arab American, Asians/ Pacific Islanders and Native American maternal- child clients. The CSES was used to measure cultural competence/confidence. Seventy-one students participated in the survey and very little confidence in caring for these clients was expressed. Alpers and Zoucha (1996) compared cultural competence /confidence among nursing students, at a private southern University, who had a course in transcultural

nursing and those who did not. Those students who had the course in transcultural nursing reported having more confidence in understanding and providing care for African American and Hispanic clients, whereas the students who had not taken the course reported significantly more confidence in understanding and providing care for Asian clients. Upon further investigation this latter group was found to have difficulty understanding transcultural nursing concepts, were unable to apply the concepts in group activities and had very little experience with Asian clients. Furthermore what was reported, as confidence may have been more arrogance on their part.

Napholz (1999) used the Ethnic Competency Skills Assessment Inventory (ECSA) to compare self-reported cultural competency skills of two groups of junior nursing students. The ECSA was administered before and after the instructional approaches were implemented. The first group received the traditional instructional approach to teaching cultural diversity. That is, their assignments included cultural self-assessment exercises, incorporating socio-cultural objectives into weekly anecdotal notes, and clinical papers and nursing care plans documenting understanding and incorporation of culturally sensitive nursing care. Treatment group two had the on-site assistance of an expert in transcultural nursing in addition to the traditional instructional approach. The consultant openly discussed ethnic and racial differences with the students and assisted them in formulating culturally relevant nursing care plans. Postest results were significantly higher than pretest results for both groups. However, prior to the treatments pretest results of treatment group one were significantly higher than treatment group 2. After the treatment there was no significant difference between the groups. These results suggest that non-traditional approach to teaching transcultural nursing was effective in removing the difference in cultural competency skills between the groups. The significant difference between

the groups at the outset was however a threat to the internal validity of this study which the authors recognized.

CHAPTER 3

METHODOLOGY

The purpose of this chapter is to describe the procedures that were used to answer the research questions posed above regarding cultural competence of faculty of baccalaureate nursing education programs. The subjects studied are described and the methodology used in selecting them is explained. Also included in this chapter is a detailed description of the instrument and procedures used in data collection, and data analysis.

Subjects

Population and Sample

The population of interest in this study was defined as the faculty of baccalaureate nursing education programs in the Southern portion of the United States. The accessible population for this study was nursing faculty of baccalaureate nursing programs in the State of Louisiana. All identified faculty members (i.e., 100% of the defined accessible population) actively involved in teaching in these programs were included in the study sample.

Sampling Procedures

A list of the 13 nursing education programs in Louisiana offering a Bachelor of Science degree in nursing (BSN), was obtained from the Louisiana State Board of Nursing, the official regulatory agency for nursing education and practice in the State of Louisiana. The names of faculty members of each of these programs were obtained from published directories available from the official website of their respective universities. All but four of the program websites included faculty directories. The names of the faculty members of those programs were obtained directly from the Deans/Director of these programs or from other published sources. The published directories available on the official websites of two nursing programs did not indicate

whether the faculty members taught at the undergraduate or graduate level. This information was obtained directly from the directors of those programs. A total of 313 nursing faculty of baccalaureate nursing programs were included in the study sample.

Instrument

The instrument used in this study was the Cultural Diversity Questionnaire for Nurse Educators, a researcher-designed instrument based on the preceding review of the literature, and it included items developed by the researcher as well as items adapted from research by Campinha- Bacote (1998), Goode (2000), Mason (1995) and Ward (2001). The basic organizing framework for the instrument was Campinha- Bacote's (1998) model for cultural competency. Namely, the instrument was organized according to the concepts: cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire as defined by Campinha-Bacote. According to her model, these concepts are the components of cultural competence. For the purposes of this instrument, the concept of acceptance and acknowledgement of differences as defined by Mason, Cross, Rider & Friesen (1988) were included as part of the concept cultural awareness.

Description of Study Instrument

The instrument consisted of two sections. The first section was a Likert-type scale consisting of a total of 55 items intended to measure the respondents' level of each of the components of cultural competence. The second section of the instrument included 17 questions on demographic characteristics, teaching experience and areas of specialization of the respondents. See Appendix A for a copy of the research instrument, Cultural Diversity Questionnaire for Nurse Educators.

The 55 questionnaire items in the first section were organized into five subscales according to the component of cultural competence they were intended to address: A cultural awareness subscale with12 items; a cultural knowledge subscale, including 14 items; a cultural skills subscale with 12 items; a cultural encounters subscale with six items; and, a cultural desire subscale with 11 items. Of these 55 items, 11 were specifically related to the respondents' behaviors and practices with students in the classroom as well as in the clinical practice area. These items formed the transcultural teaching behaviors (i.e., sixth) subscale.

The respondents were asked to indicate, for each statement on the questionnaire, if they strongly agreed, agreed, were undecided, disagreed or strongly disagreed. A numerical value of 5,4,3,2, or 1, was be assigned to each response with strongly agree equaling 5, agree equaling 4, undecided equaling 3, disagree equaling 2 and strongly disagree equaling 1. In order to prevent the respondents from establishing a response pattern, several of the items are written negatively, so that to strongly agree with these items was the least desirable response. These item were coded in reverse so that strongly agree was assigned a value of 1, agree equaled 2, undecided was coded as 3, disagree was coded as 4 and strongly disagree was given a value of 5. The items that were reverse-coded were items number 1, 4, 5, 8, 9, 11, 15, 31, 34, 38, 45, and 49. Appendix B presents the individual questionnaire items in each subscale.

Development of the Study Instrument

Each item on the first section of the research instrument was a statement concerning the respondents' perceptions, attitudes or behaviors regarding cultural competence. The items addressed the major concepts or content areas identified in the literature as significant factors for the components of cultural competence. For example, the concepts of diversity of groups, beliefs and practices and biological variations were recurrent themes encountered in the

literature regarding cultural awareness, knowledge, skills and encounters (Campinha-Bacote, 1998; Giger and Davidhizar, 1995; Kudzma, 1999; Leininger, 1991; Mason, Cross, Rider and Friesen, 1988; Purnell & Paulanka, 1998;). Similarly, knowledge of disease incidence among diverse populations was identified as an important factor in cultural competence (Campinha-Bacote, 1998). A major concept in the literature on cultural awareness was that of self-awareness or self-examination and knowledge of one's personal values (Campinha-Bacote, 1998). Another concept in the literature that the items on the research instrument addressed was the importance of appropriate verbal as well as non-verbal communication skills in conducting cultural assessments (Dana, 1996; Giger and Davidhizar, 1995, Purnell & Paulanka, 1998). There were also items addressing the concepts of motivation and commitment to cultural diversity as measures of the respondents' desire for cultural competence. Appendix C presents the blueprint used in designing the research instrument.

Prior to the data collection phase of the study, a preliminary instrument consisting of 60 items was field tested with nursing faculty not currently teaching in BSN programs, to determine the clarity of the instructions for completing the questionnaire, the clarity of the items and the existence of inconsistencies in interpreting the meaning of individual items on the questionnaire. In addition, the comfort of the respondents with the items and the length of time it took to complete the questionnaire, were examined. Of the 26 field test respondents, two were former BSN faculty members currently practicing as nurse practitioners and two were faculty members in Diploma nursing programs. The other participants were faculty members of an Associate Degree nursing program who were asked by their director to participate in the field test of the research instrument at the beginning of a faculty meeting. Of the 23 present, 22 completed the questionnaire. The researcher was present during all field tests of the study instrument to answer

questions and clarify the meaning of items whenever necessary. The instrument was then revised based on the field test results as well as on the basis of a blueprint developed by the researcher to ensure that the items on the questionnaire addressed the content areas necessary to measure each component of cultural competence.

To further ensure its content validity, the revised instrument and blueprint were then submitted for review to a panel of four experts: A nurse practitioner and former nurse educator with a masters degree in nursing with a focus on cultural diversity; An education professor whose specialty area includes cultural diversity in the classroom; a retired nurse educator with research experience in higher education administration and minority retention; and, an anthropologist with research experience in the area of cultural competence and currently active in institutional research at a major university. All items were deemed appropriate to the content they were intended to address according to the blueprint. Those items identified as repetitive were eliminated and other items were re-worded and re-ordered to improve their clarity and the overall flow of the questionnaire. This final revision resulted in the study instrument of 72 items.

Procedures for Data Collection

The data for this research study was collected between March and May in spring of 2003. A packet was addressed to 313 study participants and mailed to their place of employment (i.e., school of nursing). Each packet included a cover letter, a copy of the questionnaire and a postage-paid, pre-addressed envelope in which to return the completed questionnaire. Each questionnaire was coded. The cover letter explained the purpose and rationale for the study as well as the value of the study to the respondents and the importance of their participation. The estimated time for completing the survey was also included in the cover letter along with instructions for completing and returning of the survey. The respondents were assured that the

purpose of the code on the questionnaire was to help the researcher keep track of non-respondents and that it would at no time be used to associate their responses with them individually. They were also assured that their participation in the research study was strictly voluntary and that they were free to withdraw from the study at any time. The respondents were urged to complete and return the questionnaire immediately. Finally, an address and telephone number were provided for the respondents to contact the researcher if they had questions concerning the study. See Appendix D for a copy of the cover letter.

Approximately two weeks following the initial mailing of the packet, a follow up postcard was sent to all non-respondents. They were reminded of the questionnaire that was sent earlier and the importance of their responses to the study was reiterated. They were once again urged to complete and return the questionnaires immediately. The postcard also included a note of thanks to those respondents who had already returned the questionnaire. See Appendix E for a copy of the follow-up postcard. One month following the mailing of the original packet, a second follow-up letter was sent to all non-respondents (as determined by the codes on the completed questionnaires) and at this time a second copy of the questionnaire along with the original cover letter and a postage paid pre-addressed envelope was included and the respondents were again urged to complete and mail the questionnaire immediately.

The overall response rate was 55 percent. Of the 313 surveys mailed, 172 were returned completed. Of these, nine were not included in the data analysis because they indicated that they taught only at the graduate level. A total of 163 completed surveys were included in the data analysis. The researcher was unable to determine any particular non-response patterns except that doctorally prepared members of the sample had a higher response rate (76%, n = 51) than non-doctorally prepared members (49%, n = 121).

Data Analysis

Following is a description of the procedures that were used to analyze the data collected for this study.

Objective 1

This first objective involved describing the nursing faculty of baccalaureate nursing programs in Louisiana according to a number of demographic and professional variables, which are mostly categorical in nature. Descriptive statistics such as frequencies and percentages were used to analyze these data. Some data collected were interval in nature (e.g., years in nursing education, age, number of Continuing Education Hours or CEH's in transcultural nursing) and were described using means, and standards deviations.

Objective 2

The extent to which the respondents include transcultural nursing concepts in the courses they teach was measured by their responses to the items included in the transcultural teaching behaviors subscale of the questionnaire. This sub-scale consists of 11 statements on the questionnaire that specifically describe the teaching behaviors exhibited by the respondents that relate to transcultural issues. These responses were measured using a 5-point Likert-type scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Descriptive statistics including frequencies, percentages, means and standard deviations were used to analyze these data.

Objective 3

The third objective was to determine the cultural competence of the respondents as measured by their responses to the items on each of the five subscales of the Cultural Diversity Questionnaire for Nurse Educators: 1) The Cultural Awareness subscale consisted of 12 statements on the questionnaire that relate to the respondents' awareness and appreciation of

cultural diversity; 2) The Cultural Knowledge subscale consisted of 14 statements about world views of diverse cultures and concepts and facts about cultural diversity; 3) the Cultural Skills subscale consisted of 12 statements regarding assessment of culturally diverse clients; 4) The Cultural Encounter subscale was made up of six statements regarding the respondents' interactions with culturally diverse groups; and, 5) the Cultural Desire subscale, which included 11 statements regarding the respondents' motivation and desire to be culturally competent and to care for culturally diverse clients.

The responses were measured using a 5-point Likert-type scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). An index was created for each subscale by computing the mean of the respondents' scores on the items in that subscale. This index represents the respondents' level of that component of cultural competence (i.e., cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire) measured by the corresponding subscale. Prior to computing the index, each subscale was analyzed separately to determine its internal reliability as indicated by Cronbach's Alpha and a factor analysis was conducted to examine appropriateness of the variables used to measure the constructs in each subscale. The variables in each subscale that best fit the factor model were retained to compute the index for that subscale. The overall cultural competence score was then calculated by computing the mean index or the mean of the respondents' scores on each of the subscales. Frequencies, percentages, means and standard deviations were used to analyze the resulting indexes and overall cultural competence scores.

Objective 4

The relationship between each of the subscales and the overall scale of cultural competence, as measured by the Cultural Diversity Questionnaire for Nurse Educators, was

analyzed using a multiple regression analysis. For the purpose of this analysis, the overall cultural competence score was the dependent variable and the scores on the cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire subscales were the predictor variables.

Objective 5

To determine if a model exists that explains a significant portion of the variance in each of the sub-scales of cultural competence, as measured by the Cultural Diversity Questionnaire for Nurse Educators, seven multiple regression models were analyzed. The seven dependent variables were each subscale score and the overall cultural competence score. The predictor variables were the following respondents' characteristics: Age, ethnic background, years in nursing education, other language spoken, specialty area, certification held, ethnic background of students taught, and continuing education in transcultural nursing.

CHAPTER 4

FINDINGS

Objective 1

The first objective was to describe the study sample onto the following characteristics: Age, sex, race or ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certifications held, ethnic background of students taught, and preparation in transcultural nursing. Following is a description of these demographic as well as professional characteristics of the respondents who are nursing faculty of baccalaureate nursing programs in Louisiana.

Demographic Characteristics

As expected, most (n = 157, 96.3%) of the respondents were female. Their ages ranged from 28 to 70 with a mean age of 50. The largest number of respondents were between the ages of 41 and 50 (n = 61), whereas, the age group with the smallest number of respondents was 30 and under (n = 4). The study sample was predominantly Caucasian (n = 122, 74%), and African Americans comprised the second largest ethnic group (n = 18, 11%). Even though most (n = 155, 95.1 1%) of the respondents were born in the United States, almost a third (n = 50, 30.7%) reported that they speak another language. French (n = 30, 60%) and Spanish (n = 27, 54%) were the languages (other than English) most frequently cited as spoken by the respondents. See Table 1 for selected demographic characteristics of the respondents

The respondents were asked to estimate the percentages of students in their nursing programs, from selected races and/or ethnic backgrounds. Based on their responses, the mean

Table 1

Selected Demographic Characteristics of Study Participants

Characteristics	n[a]	%
Age[b]		
< 30	4	2.4
31-40	21	12.9
41-50	61	37.4
51-60	59	36.1
≥ 61	12	7.3
Missing	6	3.9
Sex		
Male	6	3.7
Female	157	96.3
Race/Ethnicity		
Caucasian	122	74.8
African American	18	11.0
Creole	1	0.6
Hispanic	3	1.8
American Indian	1	0.6
Asian	3	1.8
Missing	15	9.2
Country of Origin		
United States	155	96.3
India	2	1.2
Zambia	1	0.6
Costa Rica	1	0.6
England	1	0.6
El Salvador	1	0.6
Missing	2	1.2
Speaks Another Language		
Yes	50	30.7
No	93	55.2
Missing	23	14.1

[a]N = 163 [b]Mean = 49.4, SD = 8.25

estimated percentage of Whites was 72.7 percent (SD = 28.7), and African Americans (SD = 28.8) were estimated to comprise the second largest group of students (mean = 22.8 %). Table 2 describes the mean estimated percentages given by the respondents for selected racial/ethnic groups in their program.

Table 2

Mean Estimated Percentages of Students From Selected Racial/Ethnic Groups In Nursing Programs Where Respondents Taught

Race/Ethnicity of Students	Mean Estimated %	SD
Whites	72.7	28.7
African Americans	22.8	28.8
Asians	1.8	3.0
Black Hispanics	0.5	3.0
White Hispanics	1.2	2.2

Professional Characteristics

The amount of experience teaching nursing reported by the respondents ranged from six months to 31 years, with a mean of 13.7 years (SD = 9.19). Close to 24 percent (n = 39) of the respondents reported having more than 20 years experience in nursing education and 19% (n = 31) reported teaching nursing for less than five years. Six (3.7%) respondents reported a bachelor's degree as their highest degree earned. All others reported having master's (68.1 %) or doctoral (28.2) degrees. About half (n = 83, 50.9%) of the respondents reported that they had attended or completed a continuing education program (s) in transcultural nursing in the past five years.

Table 3

Selected Professional Characteristics of the Study Participants

Characteristic	n	%
Years in Nursing Education[a]		
≤ 5	31	19.0
6-10	32	19.6
11-15	29	16.6
16-20	23	14.1
21-25	20	12.3
26-30	17	10.4
≥ 31	2	1.2
Missing	11	6.7
Continuing Education[b]		
Yes	83	50.9
No	76	46.6
Missing	4	2.5
Highest Degree Held		
Bachelors	6	3.7
Masters	111	68.1
Doctorate	46	28.2
Holds Certification[c]		
Yes	75	46.0
No	80	49.1
Missing	8	4.9
Nursing Specialty Areas[d]		
Adult Health	77	52.8
Community Health	31	19.0
Child Health/Illness	28	17.2
Psych-Mental Health	24	14.7
Childbearing	18	11.0
Women's Health	15	9.2
Gerontology	15	9.2

(table cont'd)

Administration	11	6.7
Transcultural Nursing	5	3.0

(N = 163) [a]M = 13.7, SD = 9.19
[b]Continuing education in transcultural nursing [c] Certification in nursing specialty area
[d]Respondents listed more than one specialty area therefore percentages add up to more than 100. Includes transcultural nursing and specialty areas listed by more than five respondents

Many respondents reported having more than one specialty area, however Adult Health, Child Health and Illness, and Community Nursing were the most frequently listed specialty areas. Close to half (46%) of the participants are certified in at least one of their specialty areas. Only five respondents (3%) listed transcultural nursing as a specialty area and none of these reported being certified in that area. See Table 3 for selected professional characteristics of the respondents.

Objective 2

Transcultural Teaching Behaviors.

Objective 2 was to describe the extent to which the respondents include transcultural nursing concepts in the courses they teach. This was determined by the respondents' level of agreement with 11 statements concerning their inclusion of these concepts in the classroom, as well as in the clinical practice area. The responses were rated as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = Undecided, 4 = Agree, and 5 = Strongly Agree). For most items, a rating of "1" was the least favorable response (i.e., strongly disagree) and a rating of "5" was the most favorable response (i.e., strongly agree). However, for selected items on the study instrument, strong disagreement was considered to be the most favorable response and strong agreement was considered the least favorable response. Therefore, the ratings of these selected items were reversed when they were used in computing the index of a subscale, such that Strongly Disagree = 5, Disagree = 4, Undecided = 3, Agree = 2, and Strongly Agree = 1. Table 4

describes the mean ratings and standard deviations for the responses to the statements regarding transcultural teaching behaviors. The following response categories established by the researcher were used to interpret the responses: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); > 4.50 = Strongly Agree (SA).

Of the 11 statements concerning teaching cultural competence, the respondents disagreed most with " It is more important for my students to conduct cultural assessments on culturally diverse clients than on other clients" (M = 2.49). According to the literature, strongly disagreeing with this statement would be the most favorable of the responses. As a result, the rating for this item was reversed in computing the cultural teaching index below. In this case, strongly disagree was rated as 5 and strongly agree was rated as 1. The only item respondents were undecided about was "I screen books movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in courses or sharing them with clients cared for by me or my students" (M = 3.28). The respondents agreed with all other items concerning teaching, but they did not "Strongly Agree" with any of the items. In summary, none of the items were rated as "Strongly Agree". One item received a rating of "Disagree", one item was rated as "Undecided' and the other nine received ratings in the "Agree" category. See Table 4.

A factor analysis was conducted to determine how well the items on this subscale fit together in measuring a single construct. A principal component analysis was employed with the number of factors to be extracted specified as one. Items with a loading on that factor of less than 0.3 were deleted from the subscale.

Table 4

Cultural Competence Teaching Subscale: Level of Agreement With Statements Regarding The Inclusion Of Transcultural Nursing Concepts In the Classroom And Clinical Practice Setting

Item	[a]M	SD	[b]Response Category
I am personally and professionally committed to teaching how to provide nursing care that is culturally competent	4.33	0.49	A
I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural, racial and ethnic groups	4.24	0.52	A
I teach my students that the client's culture is a determining factor in the clients' perception of health and illness and in his or her adherence to prescribed treatment regimen	4.18	0.67	A
I teach my students that when working with clients who are culturally, racially and ethnically different they should become familiar with indigenous beliefs and practices	4.09	0.48	A
I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse	4.00	0.75	A
My students are required to seek information on acceptable behaviors, courtesies, customs and expectations, that are unique to the culturally, racially, and ethnically diverse groups served by our program	3.98	0.83	A
I require that students be knowledgeable about diseases that have a high incidence among clients in our service area, from diverse cultural, racial, and ethnic groups	3.98	0.65	A

(table cont'd)

I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially and ethnically diverse.	3.83	0.75	A
My students are expected to demonstrate knowledge of their clients' worldviews, beliefs, and practices by incorporating this knowledge in their plan of care	3.81	0.70	A
It is more important for my students to conduct cultural assessments on ethnically diverse Clients than on other clients	2.49[c]	1.00	D
I screen books, movies, and other media sources for for negative cultural, racial, or ethnic stereotypes before using then in my courses or sharing them with clients cared for by me and my students	3.28	1.05	U

[a]Mean values based on the response scale 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, 5 = strongly agree
[b]Response categories based on the following scale were established by the researcher: : <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).
[c]Response scale for this item would be reversed for calculating subscale index so that 1 = strongly agree, 2 = agree, 3 = undecided, 4 = disagree, 5 = strongly disagree

Table 5 describes the items in the transcultural teaching behaviors subscale and their respective factor loadings. The factor loadings of the items retained in the subscale scale ranged from .50 to .70 and the one factor solution accounted for 32.49% of the variance in the subscale. These remaining items were used to compute a transcultural teaching behaviors index, which indicated that the respondents agree that they include content on transcultural nursing in the classroom as well as in the clinical practice setting (M = 3.97). The refined transcultural teaching behaviors subscale (i.e., subscale without deleted items) was checked for reliability using Cronbach's Alpha internal consistency coefficient resulting in Alpha = 0.79.

Table 5

Factor Analysis of the Teaching Subscale: Factor Analysis of the Teaching Subscale of the Cultural Competence Scale of Nursing Faculty of Baccalaureate Nursing Programs in Louisiana

Item	Factor Loading	% Variance Explained
I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially and ethnically diverse	.70	32.49%
I am personally and professionally committed to teaching how to provide nursing care that is culturally competent	.65	
I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using then in my courses or sharing them with clients care for by me or my students	.64	
I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse	.63	
I teach my students that the client's culture is a determining factor in the clients' perception of health and illness and in his or her adherence to prescribed treatment regimen	.62	
I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural, racial and ethnic groups	.61	
My students are expected to demonstrate knowledge of their clients' worldviews, beliefs, and practices by incorporating this knowledge in their plan of care	.57	
I require that students be knowledgeable about diseases that have a high incidence among clients in our service area, from diverse cultural, racial, and ethnic groups	.52	
My students are required to seek information on acceptable behaviors, courtesies, customs and	.50	

(table cont'd)

expectations, that are unique to the culturally, racially, and ethnically diverse groups served by our program	
I teach my students that when working with clients who are culturally, racially and ethnically different they should become familiar with indigenous beliefs and practices	.50
It is more important for students to conduct cultural assessments on ethnically diverse clients than on other clients	-.17 [a]

[a] Item deleted from subscale

Objective 3

The third objective of this research study was to determine the cultural competence of the study participants as measured by their responses to the items on each of the five subscales of the Cultural Diversity Questionnaire for Nurse Educators. Each subscale was designed to measure a component of cultural competence. These were: 1) The Cultural Awareness Subscale; 2) The Cultural Knowledge Subscale; 3) the Cultural Skills Subscale; 4) The Cultural Encounters Subscale; and, 5) the Cultural Desire Subscale. The respondents expressed their level of agreement with the statements on each component subscale, and as with the transcultural teaching behaviors subscale, their responses were rated as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = Undecided, 4 = Agree, and 5 = Strongly Agree. For most items, a rating of "1" was considered the least favorable response (i.e., strongly disagree) and a rating of "5" was considered the most favorable response (i.e., strongly agree). However, for selected items on the study instrument, strong disagreement was considered to be the most favorable response and strong agreement was considered the least favorable response. Therefore, the ratings of these selected items were reversed when they were used in computing the index of a subscale, such that Strongly Disagree = 5, Disagree = 4, Undecided = 3, Agree = 2, and Strongly Agree = 1.

The following response categories established by the researcher were used to interpret the responses: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).

The items on each of the subscales intended to measure the components of cultural competence were developed by the researcher following a review of the literature or adapted from existing instruments in the literature (See Appendix B). These items had not been previously utilized together on a single instrument. Therefore, in order to determine their appropriateness in measuring a single concept and their usefulness in future similar research, a factor analysis was conducted for each of the subscales (i.e., cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire). Principal components analysis was the procedure utilized with one as the number of factors extracted. As with the transcultural teaching behaviors subscale described above, a factor loading of 0.3 or greater was the criterion used to retain items on their respective subscales. The items that met this criterion were retained and an index was then computed for each subscale based on the respondents' ratings of those items. The responses of the participants on each of the subscales and the index of each subscale, as well as the overall level of cultural competence are described below.

Cultural Awareness

The items intended to measure Cultural Awareness included statements related to the respondents' awareness and appreciation of cultural diversity. Table 6 presents the responses to these items. There was no strong agreement with any of the 12 items on the study instrument intended to measure cultural awareness and the respondents disagreed with each of the following statements: "Individuals of different cultural/racial/ethnic groups have perceptions of health, illness, and preventive health that are no different from my own" (M = 2.07); "What I believe

about health, illness and preventive health is strictly based on science" (M = 2.29); and, "The same approach should be followed when caring for all patients regardless of culture, race, ethnic or religious background or worldview" (M = 1.92). According to the literature, disagreement with each of these items should be considered favorable responses, indicating awareness and appreciation of cultural diversity. These items would require reverse coding if retained to compute the cultural awareness index. The participants agreed with the remaining items measuring cultural awareness.

Table 6

Cultural Competence Awareness Subscale: Level of Agreement With Statements Regarding Awareness and Appreciation of Cultural Diversity

Item	M[a]	SD	Response[b] Category
I accept that male-female roles may vary significantly Among different cultures and ethnic groups	4.35	0.59	A
I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural, racial and ethnic groups	4.24	0.52	A
When I care for a client, I consider how the difference between our perceptions of health, illness and preventive health could affect the outcome of my care	4.20	0.16	A
I teach my students that the client's culture is a determining factor in the clients' perception of health and illness and in his or her adherence to prescribed treatment regimen	4.18	.66	A
I teach my students that when working with clients who are culturally, racially and ethnically different they should become familiar with indigenous beliefs and practices	4.09	0.48	A

(table cont'd)

What I believe about health, illness and preventive health is influenced by my culture	4.06	0.81	A
I am aware of some of the stereotyping attitudes and preconceived notions and feelings that I have towards members of other cultural, racial, and ethnic groups	4.01	0.62	A
I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients	4.00	0.82	A
I am aware that biological variations exist in different cultural, racial, and ethnic groups	3.99	0.83	A
What I believe about health, illness and preventive health is strictly based on science	2.29 [c]	1.07	D
Individuals of different cultural/racial/ethnic groups have perceptions of health, illness, and preventive health that are no different form my own	2.07 [c]	0.91	D
The same approach should be followed when caring for all patient, regardless of culture, race, ethnic, or religious background or worldview	1.92 [c]	1.02	D

[a]Mean values based on the response scale 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, 5 = strongly agree
[b]Response categories based on the following scale established by the researcher: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).
[c]Response scale for this item would be reversed for calculating subscale index so that 1 = strongly agree, 2 = agree, 3 = undecided, 4 = disagree, 5 = strongly disagree

Table 7 presents the factor loadings of the items in the cultural awareness subscale as a result of the single component factor analytical procedure. Four items had factor loadings below .3 and were deleted from the subscale. Three of these were among those items worded such that they would have been reverse coded if they had been used in calculating the subscale index. The

factor loadings of the items retained ranged from .36 to .67 and the one factor extraction explained 21.89 % of the variance in the subscale. The eight items meeting the criteria for

Table 7

Factor Analysis of the Awareness Subscale: Factor Analysis of the Awareness Subscale of The Cultural Competence Scale of Nursing Faculty of Baccalaureate Nursing Programs in Louisiana

Item	Factor Loading	% Variance Explained
I accept that male-female roles may vary significantly among different cultures and ethnic groups	.67	21.29
I teach my students that the client's culture is a determining factor in the clients' perception of health and illness and in his or her adherence to prescribed treatment regimen	.66	
I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural, racial and ethnic groups	.62	
When I care for a client, I consider how the difference between our perceptions of health, illness and preventive health could affect the outcome of my care	.58	
I teach my students that when working with clients who are culturally, racially and ethnically different they should become familiar with indigenous beliefs and practices	.50	
I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients	.44	
What I believe about health, illness and preventive health is influenced by my culture	.38	
I am aware that biological variations exist in different cultural, racial, and ethnic groups	.36	

(table cont'd)

I am aware of some of the stereotyping attitudes and preconceived notions and feelings that I have towards members of other cultural, racial, and ethnic groups	.29 [b]
The same approach should be followed when caring for all patient, regardless of culture, race, ethnic, or religious background or worldview [a]	.29 [b]
Individuals of different cultural/racial/ethnic groups have perceptions of health, illness, and preventive health that are no different from my own [a]	.19 [b]
What I believe about health, illness and preventive health is strictly based on science [a]	.12 [b]

[a] Reverse coded item [b] Item deleted from subscale

retention were used to compute the cultural awareness index. According to this index (4.14), the respondents agreed that they had an awareness and appreciation for cultural diversity. The cultural awareness subscale that resulted after deleting the items with factor loadings below .3, was checked for reliability using Cronbach's Alpha internal consistency coefficient resulting in Alpha = 0.63.

Cultural Knowledge

The Cultural Knowledge subscale included 14 statements about world-views of diverse cultures and concepts, and facts about cultural diversity. Respondents disagreed with the statement "There is no difference in food digestion among ethnic, racial and cultural groups." (M = 2.38). Disagreement with this statement is considered a favorable response. The respondents were undecided about the following items: "I am knowledgeable about variations in drug metabolism among specific cultural groups" (M = 2.79); "I am aware that biological variations exist in different cultural/racial and ethnic groups" (M = 3.47); "I am knowledgeable about diseases that are common in the countries of origin of recent immigrants to our service area"

(M = 3.28); and, “There are more differences within cultural groups than across cultural groups” (M = 3.04). The participants’ ratings indicated agreement with all other items on this subscale (M= 3.64 to M = 4.33). See Table 8.

Table 8

Cultural Competence Knowledge Subscale: Level of Agreement With Statements Regarding Worldviews of Diverse Cultures, and Concepts and Facts about Cultural Diversity.

Item	M[a]	SD	Response[b] Category
Some cultural groups believe that supernatural forces can cause illness	4.33	0.54	A
I am knowledgeable about the socio-economic and environmental risk factors that contribute to the major health problems of culturally, racially, and ethnically diverse populations served by my nursing program	4.04	0.71	A
I have a clear understanding of the difference in meaning of the following terms: immigrant, alien resident, citizen	4.03	0.74	A
I am knowledgeable about diseases that have a high incidence among cultural, racial, and ethnic groups in our service area	4.03	0.61	A
I require that students be knowledgeable about diseases that have an incidence among clients in our service area, from diverse cultural, racial, and ethnic groups	3.98	0.65	A
My students are expected to demonstrate of knowledge of their clients’ worldview, beliefs, and practices by incorporating this knowledge in their plans of care	3.81	0.70	A
I know the prevailing beliefs, customs, norms, and values of the cultural groups in my service area	3.72	0.74	A
I have a clear understanding of the difference in meaning of the following terms: acculturation, assimilation, and socialization	3.64	1.00	A

(table cont’d)

I am knowledgeable about biological variations that exist among specific cultural, racial, and ethnic groups	3.47	0.92	U
I am knowledgeable about the population percentages of the major ethnic groups living in my service area	3.38	1.01	A
I am knowledgeable about diseases that are common in the countries of origin of recent immigrants to our service area	3.23	0.98	D
There are more differences within cultural groups than across cultural groups	3.04	0.77	U
I am knowledgeable about variations in drug metabolism among specific cultural groups	2.79	0.97	U
There is no difference in food digestion among ethnic, racial, and ethnic backgrounds.	2.38[c]	0.75	U

[a]Mean values based on the response scale 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, 5 = strongly agree
[b]Response categories based on the following scale established by the researcher: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).
[c]Response scale for this item would be reversed for calculating subscale index so that 1 = strongly agree, 2 = agree, 3 = undecided, 4 = disagree, and 5 = strongly disagree

Factor analysis of this subscale using principal components analysis with one factor extracted explained 29.44 % of the variance in the subscale. The results presented in Table 9 indicate that 11 variables met the criteria for retention (i.e., factor loadings $\geq$ .3) and three variables did not. One of the variables deleted from the subscale required reverse coding for interpretation. The variables retained in the subscale were used to compute the cultural knowledge index, which was interpreted to indicate that participants agreed that they were knowledgeable about concepts and facts about cultural diversity and the world-views of diverse cultures (Index = 3.65). The reliability of the subscale was high (Alpha = 0.82)

Table 9

Factor Analysis of the Knowledge Subscale: Factor Analysis of the Knowledge Subscale of the Cultural Competence Scale of Nursing Faculty of Baccalaureate Nursing Programs in Louisiana

Item	Factor Loading	% Variance Explained
I am knowledgeable about the socio-economic and environmental risk factors that contribute to the major health problems of culturally, racially, and ethnically diverse populations served by my nursing program	.71	29.44
I am knowledgeable about biological variations that exist among specific cultural, racial, and ethnic groups	.69	
I know the prevailing beliefs, customs, norms, and values of the cultural groups in my service area	.66	
I am knowledgeable about diseases that are common in the countries of origin of recent immigrants to our service area	.65	
I require that students be knowledgeable about diseases that have a incidence among clients in our service area, from diverse cultural, racial, and ethnic groups	.65	
I am knowledgeable about diseases that have a high incidence among cultural, racial, and ethnic groups in our service area.	.63	
I am knowledgeable about the population percentages of the major ethnic groups living in my service area	.55	
I am knowledgeable about variations in drug Metabolism among specific cultural groups	.53	
I have a clear understanding of the difference in meaning of the following terms: immigrant, alien resident, citizen	.51	
I have a clear understanding of the difference in meaning of the following terms: acculturation, assimilation, and socialization	.50	

(table cont'd)

My students are expected to demonstrate of knowledge of their clients' worldview, beliefs, and practices by incorporating this knowledge in their plans of care	.45
Some cultural groups believe that supernatural forces can cause illness	.25 [b]
There is no difference in food digestion among ethnic, racial, and ethnic backgrounds [a]	.24 [b]
There are more differences within cultural groups than across cultural groups	.19 [b]

[a] Reverse coded item [b] Item deleted from subscale

Cultural Skills

The Cultural Skill subscale consisted of 12 statements regarding the assessment of culturally diverse clients. Respondents indicated disagreement with the statement "I do not feel comfortable asking questions that relate to the client's cultural/racial/ethnic background" (M = 1.97). They agreed most with "I am confident that I can assess conditions such as pallor, jaundice and cyanosis in clients of a race or ethnicity different from my own" (M = 4.00), and "My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially and ethnically diverse groups served by our program" (M = 3.98). See Table 10 for a description of the responses the items on the cultural skills subscale.

Factor analysis of this subscale using principal components analysis with one factor extracted, resulted in four items not meeting the criterion (i.e., factor loading >.3) for retention. Of these, three were items that were reverse coded. The remaining eight items had factor loadings ranging from .36 to .66, and the one factor solution explained 22.10% of the variance. See Table 11. The items retained were used to compute the cultural skill index, which indicated

that the participants agreed that they were competent in assessing culturally diverse clients (M = 3.65). The subscale consisting of the items meeting the criteria for retention was checked for reliability using Cronbach's Alpha internal consistency coefficient (Alpha = 0.69).

Table 10

Cultural Competence Skills Subscale: Level of Agreement With Statements Regarding the Assessment of Culturally Diverse Clients.

Item	M[a]	SD	Response[b] Category
I am confident that I can effectively assess conditions such as pallor, jaundice, and cyanosis in clients of a race or ethnicity different from my own	4.00	0.81	A
My student are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program	3.98	0.83	A
I use the appropriate communication style and protocol to communicate with clients I care for who are of different cultural, racial, and ethnic background	3.92	0.64	A
I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially and ethnically diverse	3.83	0.76	A
I feel confident in using a variety of cultural assessment tools in the health care setting	3.61	0.97	A
The cultural assessment tool that I use elicits information about clients' dietary practices, health beliefs, and social organization	3.45	0.97	U
I am confident that I possess the necessary skills and experience to select and work with appropriate translators needed to care for clients with limited English language proficiency.	3.44	0.96	U

(table cont'd)

When working with clients of limited English language proficiency, family members are most preferable for providing translation services.	3.18[c]	1.00	U
I am knowledgeable about key words and phrases needed to communicate effectively with the major groups with limited language proficiency that are served by our program	3.00	1.00	U
It is more important for my students to conduct cultural assessments on ethnically diverse clients than on other clients	2.49[c]	1.01	D
Determining the degree of acculturation of culturally diverse clients is a desirable but not essential part of conducting a cultural assessment	2.38[c]	0.80	D
I do not feel comfortable asking questions that relate to the client's cultural/racial/ethnic background	1.94[c]	0.74	D

[a]Mean values based on the response scale 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, 5 = strongly agree.
[b]Response categories based on the following scale established by the researcher: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).
[c]Response scale for this item would be reversed for calculating subscale index so that 1 = strongly agree, 2 = agree, 3 = undecided, 4 = disagree, and 5 = strongly disagree

Table 11

Factor Analysis of the Skills Subscale: Factor Analysis of the Skills Subscale of the Cultural Competence Scale of Nursing Faculty of Baccalaureate Nursing Programs in Louisiana

Item	Factor Loading	% Variance Explained
I feel confident in using a variety of cultural assessment tools in the health care setting	.67	22.10
I am confident that I possess the necessary skills and experience to select and work with appropriate translators needed to care for clients with limited English language proficiency	.66	
I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially and ethnically diverse	.64	
I use the appropriate communication style and protocol To communicate with clients I care for who are of different cultural, racial, and ethnic background	.60	
I am knowledgeable of key words and phrases needed to communicate effectively with the major groups with limited English language proficiency that are served by our program	.60	
The cultural assessment tool that I use elicits information about clients' dietary practices, health beliefs and social organization	.55	
My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to culturally, racially, and ethnically diverse groups served by our program	.43	
I am confident that I can effectively assess conditions such as pallor, jaundice, and cyanosis in clients of a race or ethnicity different form my own	.37	

(table cont'd)

When working with clients of limited English language proficiency, family members are most preferable for providing translation services [a]	-.20 [b]
I do not feel comfortable asking questions that relate to the client's cultural/racial/ethnic background. [a]	5.106E.02 [b]
Determining the degree of acculturation of culturally diverse clients is a desirable but not essential part of conducting a cultural assessment [a]	2.825E - 02 [b]
It is more important for my students to conduct cultural assessments on ethnically diverse clients than on other clients [a]	-1.19E – 02 [b]

[c] Reverse coded item [b] Item deleted form subscale

Cultural Encounters

The Cultural Encounters subscale was made up of six statements regarding the interactions with culturally diverse groups. Respondents agreed with the statement "I seek out clinical opportunities for my students to care for clients who are culturally, racially and ethnically diverse" (M = 4.00), but they were undecided about the statement "I attend holiday celebrations within culturally, racially and ethnically diverse communities (M = 2.94), as well as with the statement "I have spent extended periods of time with people from cultural/ethnic/racial groups different from my own" (M = 2.91). See Table 12.

Table 12

Cultural Competence Encounter Subscale: Level of Agreement With Statements Regarding the Respondents' and their Students' Interactions with Culturally Diverse Groups.

Item	M[a]	SD	Response[b] Category
I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse	4.00	0.75	A
I patronize businesses in my service area that are owned by people who are culturally, racially and ethnically diverse	3.90	.78	A
I am in contact with individuals who provide health care services for groups that are culturally, racially, and ethnically diverse	3.85	0.79	A
I am involved socially with cultural/racial/ethnic groups, different from my own, outside of my teaching role and health care setting	3.77	1.00	A
I attend holiday celebrations within culturally, racially, and ethnically diverse communities	2.93	1.06	U
I have spent extended periods of time living (i.e., at least seven consecutive days) living among people from cultural/racial/ethnic groups different from my own	2.91	1.33	U

[a]Mean values based on the response scale 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, 5 = strongly agree
[b]Response categories based on the following scale established by the researcher: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).

Factor analysis indicated that all six of the items on the Cultural Encounter Subscale met the criteria for retension (i.e., factor loading $\geq$ .3). This one factor solution accounted for 40.35% of the variance in the subscale. The Cultural Encounter index indicated that the

respondents “agreed” that they had interactions with culturally diverse groups (M = 3.56). This subscale had a reliability of 0.68 (Cronbach’s Alpha). See Table 13.

Table 13

Factor Analysis of the Encounter Subscale: Factor Analysis of the Encounter Subscale of The Cultural Competence Scale of Nursing Faculty of Baccalaureate Nursing Programs in Louisiana

Item	Factor Loading	% Variance Explained
I attend holiday celebrations within culturally, racially, and ethnically diverse communities	.74	40.35
I patronize businesses in my service area that are owned by people who are culturally, racially, and ethnically diverse	.69	
I am in contact with individuals who provide health care services for groups that are culturally, racially, and ethnically diverse	.64	
I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse	.63	
I am involved socially with cultural/racial/ethnic groups, different from my own, outside of my teaching role and health care setting	.59	
I have spent extended periods of time living (i.e., at least seven consecutive days) living among people from cultural/racial/ethnic groups different from my own	.47	

Cultural Desire

The respondents’ motivation and desire to be culturally competent, to care for, and to teach how to care for culturally diverse clients was measured with 11 items on the cultural desire subscale. See Table 14. Respondents indicated that they were “undecided” about the statement “ I screen books, movies and other media sources for negative cultural, racial or ethnic stereotypes

before using them in my courses or sharing them with clients cared for by me or my students" (M 3.28). They disagreed with the statements "I do not have the time to include cultural competence in my course content" (M = 1.91), and "Additional content on cultural competence is not necessary in my program's curriculum" (M = 2.15). The participants agreed with the statements "I am personally and professionally committed to providing nursing care that is culturally competent." (M = 4.33), and "I am personally and professionally committed to teaching how to provide nursing care that is culturally competent." (M = 4.33).

Table 14

Cultural Competence Desire Subscale: Level of Agreement With Statements Regarding the Respondents' Motivation and Desire to be Culturally Competent, to Care for, and to Teach How to Care for Culturally Diverse Clients

Item	M[a]	SD	Response[b] Category
I am personally and professionally committed to providing nursing care that is culturally competent	4.33	.56	A
I am personally and professionally committed to teaching how to provide nursing care that is culturally competent	4.33	.49	A
Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome	4.16	0.72	A
I avail myself of professional development and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups	4.00	0.71	A
I advocate the review of my program's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence	3.81	0.86	A
I keep abreast of the major health concerns and issues of culturally, racially, and ethnically diverse client populations residing in my service area	3.60	0.86	A
I am interested in becoming culturally competent because it is the politically correct thing to do	2.39	1.08	D
I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them with clients cared for by me, or by my students	3.28	1.05	U

(table cont'd)

The Administration of my program should be responsible for seeking clinical experiences with culturally, racially, and ethically diverse groups in our service area	2.18[c]	0.85	D
Additional content on cultural competence is not necessary in my program's curriculum	2.15[c]	0.90	D
I do not have time to include cultural competence in my course content	1.92[c]	0.83	D

[a]Mean values based on the response scale 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, 5 = strongly agree
[b]Response categories based on the following scale established by the researcher: <1.50 = Strongly Disagree (SD); >1.50 – 2.50 = Disagree (D); > 2.50 – 3.50 = Undecided (U); > 3.50 – 4.50 =Agree (A); >4.50 = Strongly Agree (SA).
[c]Response scale for this item would be reversed for calculating subscale index so that 1 = strongly agree, 2 = agree, 3 = undecided, 4 = disagree, 5 = strongly disagree

The principal components technique with one factor extracted was also used in the factor analysis of the cultural desire subscale. Table 15 presents the factor loadings for those eight items meeting the established criterion for retention (i.e., factor loading > .3) as well as those items that were deleted. Of the deleted items, three were reverse coded. The one factor solution accounted for 30.05 % of the variance in the cultural desire subscale. An index was computed for the cultural desire subscale using the eight items retained after factor analysis. In computing this index, the ratings of the item "I do not have the time to include cultural competence in my course content" were reversed, such that Strongly Disagree = 5, Disagree = 4, Undecided = 3, Agree = 2, and Strongly Agree = 1. The cultural desire subscale index was interpreted to indicate that the participants "agreed" that they were motivated and desired to be culturally competent, to care for, and to teach how to care for culturally diverse clients (M = 3.67). The reliability of the cultural desire subscale was Alpha = .76

Table 15

Factor Analysis of the Cultural Desire Subscale: Factor Analysis of the Desire Subscale of The Cultural Competence Scale of Nursing Faculty of Baccalaureate Nursing Programs in Louisiana

Item	Factor Loading	% Variance Explained
I am personally and professionally committed to teaching how to provide nursing care that is culturally competent	.80	30.05
I am personally and professionally committed to Providing nursing care that is culturally competent	.80	
I advocate the review of my program's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence	.65	
Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome	.59	
I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my courses or sharing them with clients cared for by me, or by my students	.59	
I avail myself of professional development and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups	.59	
I keep abreast of the major health concerns and issue of culturally, racially, and ethnically diverse client populations residing in my service area	.56	
I do not have time to include cultural competence In my course content [a]	.43	

(table cont'd)

Additional content on cultural competence is not necessary in my program's curriculum [a]	.26 [b]
I am interested in becoming culturally competent because it is the politically correct thing to do [a]	-5.89E-02 [b]
The Administration of my program should be Responsible for seeking clinical experiences with culturally, racially, and ethically diverse groups in our service area [a]	3.551E-02 [b]

[a] Reverse coded item [b] Item deleted form subscale

Overall Cultural Competence.

Campinha-Bacote's model of cultural competence was the underlying framework of this research study. She maintains that the components of cultural competence are cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire (Campinha-Bacote, 1999). Therefore, the measure of cultural competence was obtained by computing an index of the five component subscales. That is, the mean of the cultural awareness index, the cultural knowledge index, the cultural skills index, the cultural encounter index and the cultural desire subscale were combined to form the index of overall cultural competence. This index indicated that most of the study participants "Agree" that they are culturally aware, and have the knowledge, skills, exposure and desire to provide nursing care that is culturally competent (M = 3.73). She Table 16 for a description of the participants responses.

Table 16

Cultural Competence Subscale Indexes and Overall Cultural Competence Index

Subscale	Mean	Std Deviation
Cultural Awareness	4.14	.36
Cultural Desire	3.67	.42
Cultural Knowledge	3.65	.50
Cultural Skill	3.65	.50
Cultural Encounters	3.56	.62
Overall Cultural Competence	3.73	.38

In summary, factor analysis was conducted on each of the subscales in order to determine their appropriateness in measuring a single construct. Based on the single components analysis with one factor extracted, each subscale with the exception of the cultural encounter subscale, lost from one to four items for a total of 14, because they did not meet the criteria for inclusion (i.e., factor loadings $\geq$.3). Of the 14 items lost, 10 were items that were reverse coded suggesting that stating items negatively affected the participant's responses. The items that were retained were used to compute an index for each subscale. According to the response categories established by the researcher, the resulting indexes were interpreted as follows: The study participants agreed that they were aware of and appreciated cultural diversity (Awareness Index = 4.14); they agreed, to a lesser extent, that they had the motivation and desire to be culturally competent, to care for, and to teach how to care for culturally diverse clients (Desire Index = 3.67); they agreed that they had knowledge about concepts and facts concerning cultural diversity and the world-views of diverse cultures (Knowledge index = 3.65); they agreed that

they had skills for performing cultural assessments (Skills index = 3.65); and, the respondents agreed (even though barely) that they and their students had cultural interactions with culturally diverse groups (Encounter Index = 3.56). There were no disagreements with on either of the subscales, neither was there any strong agreement. Overall, the participants agreed that they were culturally competent. The overall cultural competence index was 3.73.

Objective 4

The fourth objective of this research study was to determine if a relationship exists between the index of each of the subscales (i.e., cultural awareness index, cultural knowledge index, cultural skill index, cultural encounter index, cultural desire index, cultural teaching index) and the overall index of cultural competence. A multiple regression analysis was conducted using a stepwise procedure. For this analysis, overall cultural competence was the dependent variable and the indexes of the subscales (i.e., cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire) were the predictor variables. Table 17 presents the two way correlations between overall cultural competence and the independent variables used in the regression. The model that resulted from the multiple regression analysis indicated that four of the independent variables entered the model and explained 99% of the variance. These variables were cultural knowledge index, the cultural encounter index, the cultural competence desire index, and the cultural skill index. Of these variables, cultural knowledge alone accounted for 73% of the variance in the model. The cultural awareness index was excluded from the model. Table 18 presents the model summary for this analysis.

Table 17

Relationship Between The Cultural Competence Subscales Indexes and Overall Cultural Competence

Subscale	r	p
Cultural Knowledge Index	.85	<.001
Cultural Skill Index	.80	<.001
Cultural Desire	.79	<.001
Cultural Encounter	.78	<.001
Cultural Awareness	.66	<.001

Table 18

Stepwise Multiple Regression Analysis of the Overall Cultural Competence on the Cultural Competence Subscale Indexes

Source of Variation	df	Ms	F-ratio	p
Regression	4	5.554	1515.379	<.001
Residual	158	.004		
Total	162			

Variables in the Equation

Variables	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Cultural Knowledge Index	.73	.73	425.28	< .001	.26
Cultural Encounter Index	.87	.14	180.00	< .001	.33

(table cont'd)

Cultural Desire Index	.94	.07	162.56	< .001	.22
Cultural Skill Index	.98	.04	239.31	< .001	.27

Objective 5

Objective number 5 was to determine if a model exists that explains a significant portion of the variance in the overall cultural competence index, in the index of each of the five subscales of cultural competence, as well as the transcultural teaching scale, from the following demographic and professional characteristics: Age, ethnic background, years in nursing education, languages spoken, specialty area, certification held, ethnic background of students taught and preparation in transcultural nursing. The five subscales of cultural competence and the transcultural teaching behaviors subscale were measured by selected items on the study instrument, and a corresponding index was then created for each. They were defined as follows: The cultural awareness index or responses to statements regarding the respondents' awareness and appreciation of cultural diversity; The cultural knowledge index or responses to statements about the world-views of diverse cultures and concepts, and facts about cultural diversity; the cultural skills index based on responses to statements regarding the assessment of culturally diverse clients; the cultural encounter index, based on responses to statements regarding the respondents' and their students' interactions with culturally diverse groups; the cultural desire index or the respondents level of agreement with statements regarding their motivation and desire to be culturally competent, to care for, and to teach how to care for culturally diverse clients; and, the transcultural teaching behaviors index determined by responses to items on the study instrument regarding the extent to which the respondents included content on transcultural nursing in their courses. To accomplish this objective, seven multiple regression models were

analyzed with each subscale index and overall cultural competence as the dependent variables.

In order to develop the multiple regression models, several of the independent variables were dummy coded. For the variable race/ethnic background, two “yes” or “no” categories were created to reflect African American and Caucasian. A “yes” or “no” category was also created to reflect the variable language other than English spoken. For the variable specialty area, eight “yes” or “no” categories were created to reflect the following nursing specialties: women’s health, psychiatric nursing, gerontological nursing, community health nursing, child health and illness, nursing of childbearing families, nursing administration and adult health nursing. Similarly, “yes” or “no” categories were created for the variables certification held in nursing specialty, and continuing education in transcultural nursing attended in the last five years. Ethnic background of students taught was reflected by the variables percent African Americans students in the program, percent white students in the program, percent black Hispanics students in the program and percent white Hispanics students in the program. The variables age and years in nursing education were also entered as independent variables. A total of nineteen independent variables were used in each multiple regression analysis.

A stepwise procedure was used for entering the independent variables for each of the multiple regression analyses conducted because of the exploratory nature of this part of the study. The resulting models included the variables whose addition increased the explained variance of the model by at least one percent, while at the same time maintaining the significance of the model. Prior to conducting the multiple regression analyses, the 19 independent variables were examined to detect the presence of multi-collinearity. The procedure used for this examination was the one suggested by Lewis-Beck (1980). This procedure consists of regressing each independent variable on all other independent variables to consider the relationship of each

independent variable with the other independent variables. According to Lewis-Beck, any R^2 that is near 1.0 as a result of this procedure is indicative of high multicollinearity. When this procedure was conducted, the variables percent African Americans in the program and percent Whites in the program were found to be almost perfectly collinear. According to Narusis (1990) one should assign more importance as a predictor variable to the one that is more highly correlated (i.e., has a larger absolute value) with the dependent variable. In this case, the variable percent Caucasians students in the nursing program had a higher correlation with each dependent variable than did percent African Americans students in the program. The variable percent African American students in the program was therefore eliminated from the analyses and percent Caucasian students in the program was retained.

Multiple Regression of the Cultural Competence Teaching Index on Selected Variables

Table 19 shows the bi-variate correlations between the cultural competence teaching index and selected demographic and professional characteristics of the respondents. The result of the multiple regression analysis of the cultural competence teaching index on the 19selected variables is presented in Table 20. The variables continuing education in transcultural nursing and the nursing specialty Women's Health were included in the model and explained 15% of the variance in the model. Both of these variables were associated with an increase in the cultural competence teaching index. The variables Percent Asian students in the program and percent white Hispanics each increased the explained variance in the model by one percent, however the equation was not significant with their addition.

Table 19

Relationship Between Selected Characteristics and The Cultural Competence Teaching Subscale Index

Characteristics	r	p
Certification [a]	.05	.25
Administration[b]	.04	.32
Other language	.11	.07
Child Health & Illness	-.04	.31
Childbearing [b]	.13	.05
Community Health [b]	.10	.09
Adult Health [b]	-.01	.44
Caucasian	-.09	.13
African American	-.03	.39
Years Teaching	.13	.06
Gerontology [b]	.00	.49
Women's Health [b]	.16	.02
Psych-Mental Health [b]	-.01	.44
Percent Asians [c]	.13	.05
Percent White Hispanics [c]	-.07	.20
Percent Black Hispanic s[c]	.13	.05
Continuing Education [d]	.37	.00
Age	.07	.17

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program [d] Continuing education in transcultural nursing

Table 20

Stepwise Multiple Regression Analysis of the Cultural Competence Teaching Index on Selected Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	2	2.154	14.521	<.001
Residual	160	.148		
Total	162			

(table cont'd)

Variables in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing Education[a]	.13	.13	25.42	<.001 .	.34
Women's Health[b]	.15	.02	3.26	.05	.15

[a]Continuing education in transcultural nursing
[b]Nursing specialty area

Variables Not in the Equation

Variable	t	Sign t
Certification [a]	.62	.53
Administration[b]	.58	.56
Other language	-.01	.99
Child Health & Illness	-.86	.39
Childbearing [b]	.35	.72
Community Health [b]	.93	.35
Adult Health [b]	.39	.69
Caucasian	-.87	.39
African American	-.60	.95
Years Teaching	1.160	.25
Gerontology [b]	.19	.85
Psych-Mental Health [b]	.115	.91
Percent Asians [c]	1.30	.19
Percent White Hispanics [c]	-.87	.39
Percent Black Hispanic s[c]	1.27	.20
Percent Whites[c]	-.05	.95
Age	.65	.52

[a] Hold certification in specialty area [b]Nursing specialty area [c]Students in nursing program

Multiple Regression Analysis of the Cultural Competence Subscales on Selected Variables

Awareness Subscale. The results of the multiple regression analysis of the cultural competence awareness index on the selected independent variables indicated that only the variable continuing education in transcultural nursing met the criteria for

inclusion in the model. This variable explained six percent of the variance in the model and it was associated with an increase in cultural competence awareness. Table 21 presents the two-way correlations between the cultural awareness index and selected variables.

Table 21

Relationship Between Selected Characteristics and The Cultural Competence Awareness Subscale Index

Characteristics	r	p
Certification [a]	.02	.40
Administration[b]	.13	.05
Other language	.00	.48
Child Health & Illness	.01	.44
Childbearing [b]	.08	.16
Community Health [b]	.04	.31
Adult Health [b]	-.02	.39
Caucasian	-.06	.22
African American	.02	.42
Years Teaching	.11	.08
Gerontology [b]	.02	.40
Women's Health [b]	.09	.11
Psych-Mental Health [b]	.04	.29
Percent Asians [c]	.06	.22
Percent White Hispanics [c]	-.06	.20
Percent Black Hispanic s[c]	.16	.02
Percent Whites [c]	-.02	.41
Continuing Education [d]	.25	.00
Age	.04	.30

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program
[d] Continuing education in transcultural nursing

Table 22

Stepwise Multiple Regression Analysis of the Cultural Competence Awareness Index on Selected Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	1	1.255	10.498	<.001
Residual	161	.120		
Total	162			

Variable in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing Education [a]	.06	.06	10.498	<.001	.25

[a] Continuing education in transcultural nursing

Variables Not in the Equation

Variable	t	Sign t
Certification [a]	.26	.79
Administration [b]	1.62	.11
Other language	-.73	.45
Child Health & Illness	-.11	.92
Childbearing [b]	.70	.48
Community Health [b]	.33	.89
Adult Health [b]	-.60	.95
Caucasian	-.53	.59
African American	.26	.79
Years Teaching	1.14	.25
Gerontology [b]	.51	.61
Women's Health [b]	.96	.34
Psych-Mental Health [b]	.76	.45
Percent Asians [c]	.46	.64
Percent White Hispanics [c]	-.67	.50

(table cont'd)

Percent Black Hispanics[c]	1.74	.08
Percent Whites[c]	.42	.68
Age	.28	.78

[a] Hold certification in specialty area [b]Nursing specialty area [c]Students in nursing program

Knowledge Subscale. The multiple regression analysis of the cultural competence knowledge subscale on the selected independent variables on the other hand, indicated that four variables entered the regression model, and accounted for 22% of the explained variance. These variables were continuing education in transcultural nursing, community health nursing specialty, women's health nursing specialty and the percent Asian students in the nursing program. The percent white Hispanic students in the nursing program also contributed to at least a one percent increase in the explained variance but the regression model did not remain significant with the addition of this variable. See table 23 for the two-way correlations between selected variables and the cultural knowledge index. The summary of the multiple regression analysis of the cultural knowledge index on the selected independent variables is presented in Table 24.

Table 23

Relationship Between Selected Characteristics and The Cultural Competence Knowledge Subscale Index

Characteristics	r	p
Certification [a]	.05	.25
Administration[b]	.06	.22
Other language	.19	.01
Child Health & Illness	-.02	.40
Childbearing [b]	.05	.28
Community Health [b]	.20	.01

(table cont'd)

Adult Health [b]	-.03	.35
Caucasian	-.10	.10
African American	.01	.42
Years Teaching	.63	.21
Gerontology [b]	.03	.37
Women's Health [b]	.17	.01
Psych-Mental Health [b]	.01	.44
Percent Asians [c]	.18	.01
Percent White Hispanics [c]	- .10	.09
Percent Black Hispanic s[c]	.17	.01
Percent Whites [c]	-.09	.11
Continuing Education [d]	.39	.00
Age	.01	.43

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program [d] Continuing education in transcultural nursing

Table 24

Stepwise Multiple Regression Analysis of the Cultural Competence Knowledge Index on Selected Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	4	2.187	11.108	<.001
Residual	158	.197		
Total	162			

Variables in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing Education [a]	.16	.16	29.82	<.001	.35
Community Health[b]	.18	.02	4.79	.030	.16

(table cont'd)

Women's Health[b]	.20	.02	4.01	.047	.15
Percent Asians[c]	.22	.02	3.76	.054	.18

[a] Continuing education in transcultural nursing [b] Nursing specialty area [c] Students in program

Variables Not in the Equation

Variable	t	Sign t
Certification [a]	.76	.45
Administration [b]	.76	.45
Other language	1.35	.18
Child Health & Illness [b]	-.69	.49
Childbearing [b]	.07	.94
Adult Health [b]	-.04	.97
Caucasian	-.96	.34
African American	.32	.75
Years Teaching	.32	.75
Gerontology [b]	.79	.43
Psych-Mental Health [b]	.43	.66
Percent White Hispanics [c]	-1.09	.28
Percent Black Hispanics [c]	1.79	.07
Percent Whites [c]	-.25	.80
Age	-.23	.82

[a] Hold certification in specialty area [b]Nursing specialty area [c]Students in nursing program

Skills Subscale. Table 25 presents the two way correlations between the cultural competence skills index and selected variables. See Table 26 for the results of the multiple regression analysis of the cultural competence skills index on these characteristics. The variables continuing education in transcultural nursing, percent white students in the nursing program, percent black Hispanics students in the nursing program, percent Asian students in the nursing program, and percent white Hispanics in the nursing program contributed to 24% of the variance in the model and the regression equation remained significant with their addition to the model. There was a positive correlation between continuing education in transcultural nursing, percent

black Hispanic and Asian students in the program, and the dependent variable cultural competence skills index. Percent White and white Hispanic students tended to be associated with a decrease in the cultural competence skill index.

Table 25

Relationship Between Selected Characteristics and The Cultural Competence Skills Subscale Index

Characteristics	r	p
Certification [a]	-.01	.42
Administration[b]	-.03	.34
Other language	.19	.00
Child Health & Illness	-.03	.35
Childbearing [b]	.13	.04
Community Health [b]	.18	.01
Adult Health [b]	.04	.29
Caucasian	-.13	.05
African American	.08	.15
Years Teaching	.04	.30
Gerontology [b]	-.04	.30
Women's Health [b]	.10	.10
Psych-Mental Health [b]	-.08	.15
Percent Asians [c]	.19	.01
Percent White Hispanics [c]	-.15	.03
Percent Black Hispanic s[c]	.21	.00
Percent Whites [c]	-.25	.00
Continuing Education [d]	.38	.00
Age	.00	.49

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program
[d] Continuing education in transcultural nursing

Table 26

Stepwise Multiple Regression Analysis of the Cultural Competence Skills Index on Selected Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	5	1.971	9.916	<.001
Residual	157	.199		
Total	162			

Variables in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing Education [a]	.14	.14	26.77	<.001	.30
Percent Whites [b]	.17	.03	5.83	.017	-.16
Percent Black Hispanics [b]	.20	.03	5.19	.024	.14
Percent White Hispanics [b]	.22	.02	3.46	.065	-.19
Percent Asians [b]	.24	.02	4.96	.027	.16

[a] Continuing education in transcultural nursing
[b] Students in nursing program

Variable Not in the Equation

Variable	t	Sign p
Certification [a]	.07	.94
Administration [b]	-1.33	.18
Other language	2.05	.04
Child Health & Illness	-.76	.44
Childbearing [b]	1.63	.10

(table cont'd)

Community Health [b]	1.58	.12
Adult Health [b]	.68	.49
Caucasian	-.64	.52
African American	.06	.95
Years Teaching	-.08	.93
Gerontology [b]	-.24	.81
Women's Health [b]	1.55	.12
Psych-Mental Health [b]	-.80	.42
Age	-.84	.42

[a] Holds certification in specialty area [b]Nursing specialty area

Cultural Encounter Subscale. The two-way correlations between the cultural encounter subscale index and selected variables are presented in Table 27. The results of the multiple regression analysis of the cultural encounter index on selected variables, which are presented in Table 28 indicate that only two variables contributed significantly to the model, and they explained 14% of the variance while maintaining a significant equation. These variables were continuing education in transcultural nursing, and the nursing specialty women's health. Both of these variables were associated with an increase in the cultural encounter index.

Table 27

Relationship Between Selected Characteristics and The Cultural Competence Encounter Subscale Index

Characteristics	r	p
Certification [a]	.09	.12
Administration[b]	-.01	.43
Other language	.19	.01
Child Health & Illness	-.04	.33
Childbearing [b]	.16	.02
Community Health [b]	.07	.20
Adult Health [b]	-.05	.28
Caucasian	-.14	.04
African American	.04	.33

(table cont'd)

Years Teaching	.05	.26
Gerontology [b]	-.01	.46
Women's Health [b]	.23	.02
Psych-Mental Health [b]	-.01	.44
Percent Asians [c]	.12	.07
Percent White Hispanics [c]	-.08	.15
Percent Black Hispanic s[c]	.05	.25
Percent Whites [c]	-.02	.42
Continuing Education [d]	.31	.00
Age	.06	.23

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program
[d] Continuing education in transcultural nursing

Table 28

Stepwise Multiple Regression Analysis of the Cultural Encounter Index on Selected Respondent Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	2	4.205	12.571	<.001
Residual	160	.334		
Total	162			

Variables in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing Education[a]	.10	.10	17.17	<.001	.28
Women's Health[b]	.14	.4	7.30	.008	.20

[a]Continuing education in transcultural nursing [b]Nursing specialty of respondents

(table cont'd)

Variables Not in the Equation

Variables	t	Sign t
Certification [a]	1.26	.21
Administration[b]	-.23	.82
Other language	1.59	.11
Child Health & Illness	-.80	.43
Childbearing [b]	1.67	.10
Community Health [b]	.39	.70
Adult Health [b]	-.33	.75
Caucasian	-1.52	.13
African American	.53	.59
Years Teaching	.26	.80
Gerontology [b]	.22	.83
Psych-Mental Health [b]	.06	.95
Percent Asians [c]	1.14	.26
Percent White Hispanics [c]	-.84	.40
Percent Black Hispanic s[c]	.19	.85
Percent Whites [c]	.63	.53
Age	.47	.64

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program

Cultural Desire Subscale Index. The two-way correlations between the cultural desire subscale index and selected variables are presented in Table 29. Table 30 presents the results of the multiple regression analysis of the cultural competence desire index on selected variables. Four of these variables were included in the model, accounting for 18% of the variance. Continuing education in transcultural nursing, the nursing specialty childbearing, and the percent Asian students in the nursing program were associated with an increase in the cultural competence desire index. The variable Caucasian respondent was associated with a decrease in the cultural competence desire index.

Table 29

Relationship Between Selected Characteristics and The Cultural Competence Desire Subscale Index

Characteristics	r	p
Certification [a]	.03	.34
Administration[b]	.03	.35
Other language	.16	.02
Child Health & Illness	-.04	.37
Childbearing [b]	.24	.00
Community Health [b]	.11	.07
Adult Health [b]	-.09	.13
Caucasian	-.19	.01
African American	.12	.06
Years Teaching	.07	.18
Gerontology [b]	-.05	.25
Women's Health [b]	.13	.05
Psych-Mental Health [b]	-.06	.22
Percent Asians [c]	.16	.02
Percent White Hispanics [c]	-.07	.17
Percent Black Hispanic s[c]	.09	.11
Percent Whites [c]	-.17	.01
Continuing Education [d]	.32	.00
Age	.01	.46

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program [d] Continuing education in transcultural nursing

Table 30

Stepwise Multiple Regression Analysis of the Cultural Competence Desire Index on Selected Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	4	1.295	8.651	<.001
Residual	158	.150		
Total	162			

(table cont'd)

Variable in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing education [a]	.10	.10	18.13	<.001	.27
Childbearing [b]	.13	.03	6.12	.014	.19
Caucasians[c]	.16	.03	4.70	.032	-.16
Percent Asians[d]	.18	.02	3.95	.049	.15

[a]Continuing education in transcultural nursing [b]Nursing specialty of respondents
[c]Race/ethnicity of respondent [d]Students in nursing programs

Variables Not in the Equation

Variables	t	Sign t
Certification [a]	.45	.65
Administration[b]	.35	.72
Other language	1.15	.25
Child Health & Illness	-.81	.42
Community Health [b]	.99	.32
Adult Health [b]	-.91	.36
African American	1.75	.08
Years Teaching	.55	.59
Gerontology [b]	-.36	.72
Women's Health	1.37	.17
Psych-Mental Health [b]	-.60	.55
Percent White Hispanics [c]	-.73	.46
Percent Black Hispanic s[c]	.79	.43
Percent Whites [c]	-1.50	.14
Age	-.23	.82

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program

Multiple Regression Analysis of Overall Cultural Competence on Selected Variables

Table 32 presents the results of the multiple regression analysis of overall cultural competence on the 19 independent variables. The two-way correlations between the overall cultural competence index and selected variables are presented in Table 31. Four of these variables were included in the model, and they accounted for 26% of the explained variance, and the model remained significant with their addition. The variables continuing education in transcultural nursing, the nursing specialty women's health, and the percent of Asian students in the program were all associated with an increase in the overall cultural competence of the respondent. The variable percent white Hispanics in the nursing program on the other hand, was associated with a decrease in overall cultural competence. The inclusion of the variables Caucasian respondents and percent black Hispanics in the model did increase the explained variance by one percent, but the equation did not maintain its significance when these two variables were added.

Table 31

Relationship Between Selected Characteristics and The Overall Cultural Competence Index

Characteristics	r	p
Certification [a]	.05	.26
Administration[b]	.03	.34
Other language	.19	.01
Child Health & Illness	-.03	.35
Childbearing [b]	.16	.02
Community Health [b]	.16	.02
Adult Health [b]	-.04	.33
Caucasian	-.16	.02
African American	.07	.19
Years Teaching	.08	.15
Gerontology [b]	-.02	.43

(table cont'd)

Women's Health [b]	.19	.01
Psych-Mental Health [b]	-.03	.36
Percent Asians [c]	.19	.01
Percent White Hispanics [c]	-.12	.06
Percent Black Hispanic s[c]	.17	.01
Percent Whites [c]	-.14	.04
Continuing Education [d]	.43	.00
Age	.03	.34

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program
[d] Continuing education in transcultural nursing

Table 32

Stepwise Multiple Regression Analysis of the Cultural Competence Skills Index on Selected Characteristics

Source of Variation	df	Ms	F-ratio	p
Regression	4	1.463	13.642	<.001
Residual	158	.107		
Total	162			

Variables in the Equation

Independent Variable	R^2 Cumulative	R^2 Change	F Change	p Change	Beta
Continuing Education[a]	.18	.18	35.84	<.001	.38
Women's Health[b]	.21	.02	4.81	.030	.19
Percent Asians[c]	.23	.02	4.42	.04	.20
Percent White Hispanics[c]	.26	.03	6.22	.01	-.18

[a]Continuing education in transcultural nursing [b]Nursing specialty area [c]Students in program

(table cont'd)

Variables Not in the Equation

Variables	t	Sign t
Certification [a]	.75	.46
Administration[b]	.39	.69
Other language	1.44	.15
Child Health & Illness	-.90	.37
Community Health [b]	1.50	.14
Adult Health [b]	-.10	.92
Caucasian	-1.82	.07
African American	1.07	.29
Years Teaching	.55	.58
Gerontology [b]	.26	.79
Psych-Mental Health [b]	-.09	.93
Percent Black Hispanic s[c]	1.72	.09
Percent Whites [c]	-.77	.44
Age	.00	.99

[a] Holds certification in specialty area [b]Nursing specialty area [c]Students in nursing program

CHAPTER 5

SUMMARY. CONCLUSSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to examine the level of cultural competence among faculty teaching in baccalaureate nursing programs in Louisiana and to identify factors associated with the levels of cultural competence of the respondents. Cultural competence was defined as "A process, not an endpoint, in which the nurse continuously strives to achieve the ability to effectively work within the cultural context of an individual, family or community from a diverse cultural background (Campinha –Bacote, 1994). According to Campinha-Bacote (1999), the components of cultural competence are cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. This model was therefore the framework on which the study instrument was based.

This research study was designed to accomplish the following objectives:

1. To describe the nursing faculty of baccalaureate nursing programs in Louisiana regarding the following variables: Age, sex, ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certifications held, and ethnic background of students taught, and the preparation in transcultural nursing (formal or informal).
2. To describe the extent to which the respondents include transcultural nursing concepts in the courses they teach.
3. To determine the cultural competence of faculty in baccalaureate nursing programs in Louisiana as measured by the scales of the "Cultural Diversity Questionnaire for Nurse Educators." This instrument included an overall measure of cultural competence and

sub-scale scores including cultural awareness, cultural knowledge, cultural skills, cultural encounters, cultural desire, and transcultural teaching behaviors.

4. To determine if a relationship exists between each of the sub-scales and the overall scale of cultural competence as measured by the "Cultural Diversity Questionnaire for Nurse Educators."

5. To determine if a model exists that explains a significant portion of the variance in each of the scales of cultural competence as measured by the "Cultural Diversity Questionnaire for Nurse Educators" from the following selected demographic and professional characteristics: Age, sex, ethnic background, country of origin, years in nursing education, languages spoken, specialty area, certification held, and ethnic background of students taught and preparation in transcultural nursing.

The population of this study was defined as the faculty of baccalaureate nursing programs in Louisiana. This population was chosen as the focus of this study because these programs prepare over a third of all registered nurses (RN's) nationwide and most RN's in the state of Louisiana. This faculty is therefore charged with preparing a majority of the RN's who are responsible for the care of an increasingly diverse population. A list of all (i.e., 13) education programs in Louisiana offering a Bachelor of Science degree in nursing (BSN) was obtained from the Louisiana State Board of Nursing, the official regulatory agency for nursing education and practice in the State of Louisiana (Louisiana State Board of Nursing, 2002). The names of faculty members of these programs were obtained either from published directories available from the official website of their respective universities, directly from the Deans/Director of these programs, or from other published sources. All faculty names obtained from these sources

were included in the study population. A total of 313 nursing faculty of baccalaureate nursing programs were included in the initial study sample.

The data for this research study was collected between March and May in the spring of 2003. Data was collected via a mailed survey utilizing the Cultural Diversity Questionnaire for Nurse Educators, a researcher designed instrument consisting of 55 items intended to measure the respondents' level of each of the components of cultural competence, and 17 items on demographic characteristics, teaching experience and areas of specialization of the respondents. The major findings of this study are summarized below:

1. The study participants were overwhelmingly female (96.3%, n = 157) and predominantly Caucasian (74.8%, n = 122), with a mean age of 49.4. Almost all of the participants (96.3%, n = 155) were born in the U.S. but close to a third (30.7%, n =50) stated that they speak another language. The respondents have spent an average of 14 years in nursing education, with 31 years being the highest number of years spent teaching nursing. The study participants estimated that 72.7 % of their students are White and 22.8% are African American. Most respondents (68.1%, n =111) listed a Masters' degree as their highest degree held and half (50.9%, n = 83) reported having attended a continuing education program in transcultural nursing within the past five years. The nursing specialty areas listed most frequently were Adult Health (52.8%, n = 77), Community Health (19%, n = 31), Child Health/Illness (17.2%, n = 28), Psych-Mental Health (14.7%, 24), Childbearing (11%, n = 18), Women's Health (9.2%, n = 15) and Gerontology (9.2%, n = 15). As many as 46% of the study participants hold national certification in their nursing specialty area. Only five respondents listed transcultural

nursing as a specialty area and neither of these reported being certified in that area.

2. The second major finding involved the respondents' level of agreement with statements regarding their inclusion of transcultural nursing concepts in the classroom as well as in the clinical practice setting. The index computed on this subscale, the cultural competence teaching behaviors subscale, was M = 3.97, indicating that the participants "Agreed" that they included transcultural nursing concepts in the classroom and in the clinical practice setting.
3. The third major finding was the cultural competence of the study participants as measured by their responses to the items on each of the five subscales representing the components of cultural competence on the Cultural Diversity Questionnaire for Nurse Educators. These were: 1) The Cultural Awareness Subscale; 2) The Cultural Knowledge Subscale; 3) The Cultural Skills Subscale; 4) The Cultural Encounters Subscale; and, 5) The Cultural Desire Subscale. A factor analysis was conducted on each of the subscales to determine how well the items fit in measuring a single construct. The items retained on each subscale were then used to compute an index or a mean of the responses on each subscale. The participants responses were interpreted based on the following response categories established by the researcher for that purpose: < 1.50 = Strongly Disagree (SD); 1.50 – 2.50 = Disagree (D); > 2.50-3.50 = Undecided (U); > 3.50 – 4.50 = Agree (A); and > 4.50 = Strongly Agree (SA). The results indicate that the study participants "agreed" that they were aware of and appreciated cultural diversity (cultural awareness index, M = 4.14). They also "agreed", to a lesser extent, that they had the motivation and desire to be culturally competent (cultural desire index M, = 3.67), to care for, and to teach how to care for culturally diverse clients (transcultural teaching behaviors index, M

= 3.97); that they had knowledge about concepts and facts concerning cultural diversity and the world-views of diverse cultures (cultural knowledge index M = 3.65); and, that they had skills for performing cultural assessments (Cultural Skill Index M = 3.65). The respondents also "agreed" (even though barely) that they and their students had cultural encounters or interactions with culturally diverse groups (Index M = 3.56). The mean of the Overall Cultural Competence Index, which is a composite of the indexes of the five components of cultural competence (i.e., Cultural Awareness, Cultural Knowledge, Cultural Skill, Cultural Encounter, Cultural Desire), was 3.73.

4. The relationship that exists between the index of each of the subscales (i.e., cultural awareness index, cultural knowledge index, cultural skill index, cultural encounter index, cultural desire index) and the overall index of cultural competence was the fourth major finding of this study. When the overall cultural competence index was regressed on the index of each subscale, four of the indexes (i.e., the cultural knowledge index, the cultural skill index, the cultural encounter index, and the cultural desire index) entered the model and explained 98% of the variance while maintaining a significant equation ($p < .001$). More importantly, the cultural knowledge index alone explained 73% of the variance in the model. The cultural awareness index was excluded from the model.
5. The fifth major finding involved explaining a significant portion of the variance in the overall cultural competence index, in the index of each of the five subscales of cultural competence, as well as the transcultural teaching behavior subscale, from selected demographic and professional characteristics of the respondents. A stepwise multiple regression analysis was conducted with each cultural competence index as the dependent variable and selected demographic and professional characteristics of the respondents as

the independent variables. The following are the specific findings:

a. Cultural Competence Teaching Index. The variables continuing education in transcultural nursing and the nursing specialty Women's Health were included in the model and explained 15% of the variance. Both of these variables were associated with an increase in the cultural competence teaching index.

b. Cultural Awareness Index. Only the variable continuing education in transcultural nursing met the criteria for inclusion in the model. This variable explained six percent of the variance in the model and it was associated with an increase in cultural competence awareness.

c. Cultural Knowledge Index. Four variables entered the regression model, accounted for 22% of the explained variance, and were associated with an increase in the cultural knowledge index. These variables were continuing education in transcultural nursing, community health nursing specialty, women's health nursing specialty and the percent Asian students in the nursing program.

d. Cultural Competence Skills Index. The variables continuing education in transcultural nursing, percent white students in the nursing program, percent black Hispanics students in the nursing program, percent Asian students in the nursing program, and percent white Hispanics in the nursing program explained 24% of the variance in the model and the regression equation remained significant with their addition. Continuing education in transcultural nursing, percent black Hispanic and percent Asian students in the nursing program, were associated with an increase in the cultural competence skills index, while Percent White and Percent White Hispanic students tended to be associated with a decrease in the

cultural competence skill index.

e. Cultural Encounter Index. Only the variables continuing education in transcultural nursing, and the nursing specialty women's health contributed significantly to the model, explaining 14% of the variance while maintaining a significant equation. Both of these variables were associated with an increase in the cultural encounter index.

f. Cultural Desire Index. The variables Continuing education in transcultural nursing, the nursing specialty childbearing, and the percent Asian students in the nursing program were associated with an increase in the cultural competence desire index. In contrast, the variable Caucasian respondent was associated with a decrease in the cultural competence desire index. These four variables explained 18% of the variance in the model.

g. Overall Cultural Competence Index. Twenty six percent of the variance in the model was explained by the variables continuing education in transcultural nursing, the nursing specialty women's health, the percent of Asian students in the program and the percent white Hispanics in the nursing program. The first three variables were associated with an increase in the overall cultural competence of the respondent, whereas the variable percent white Hispanics was associated with a decrease in overall cultural competence.

Conclusions and Recommendations

One limitation of this study is that the findings can only be generalized to nursing faculty of Baccalaureate nursing programs in Louisiana since the sample was limited to them. Another limitation is that the data obtained from this research is based solely on self-report of the

respondents. Therefore the researcher relied on the candor of the respondents in reporting their perceptions and teaching practices regarding cultural diversity in the classroom as well as in the clinical area. The researcher derived the following conclusions and recommendations based on the findings of this study with the above limitations in mind.

Objective 1

Transcultural nursing, the field of nursing focused on the study of different cultures with respect to health-illness values and beliefs in order to provide culture specific care, was not one of the leading specialty areas among the respondents of this study. This area of nursing was also not the focus of continuing education among the study participants These conclusions are based on the following findings: Only 3% (n = 5) of the respondents indicated that transcultural nursing was one of their specialty areas, and none of these respondents hold certification in that area. Furthermore, only half (50.9%, n = 83) of the study participants indicated that they had completed a continuing education program in this field of nursing over the previous five years.

Continuing education in nursing is mandated for licensure renewal in the state of Louisiana, with a minimum requirement of five hours per year for all fulltime practicing nurses, and 10 hours for part time practitioners (Louisiana State Board of Nursing, n.d.). According to the Rules and Regulations of the Board, certification in a specialty area can also be used to fulfill the continuing education requirement, if the requirements for maintaining certification exceed the minimum number or hours required by the Board of Nursing. This researcher therefore concludes that registered nurses choose the continuing education programs they attend, based on interest in a particular area of nursing as indicated by their specialty area, or according to certification requirements. Based on the findings of this study (i.e., 3% of respondents include transcultural nursing as a specialty area and none of these hold certification in that specialty

area), the likelihood of the respondents engaging in continuing education in transcultural nursing is low.

The importance of faculty preparation in transcultural nursing has been underscored in the literature. Leininger (1995) discussed faculty qualifications to teach transcultural nursing as one of the critical issues in achieving the objective of preparing practitioners to meet the challenges posed by diversification of our society. She noted that fewer than 20% of faculty nationwide had educational preparation in transcultural nursing. This is consistent with findings in a national survey by Kelly (1991) where 19% of the faculty were found to hold certification in transcultural nursing. Because none of the respondents in of this study were certified in transcultural nursing, the researcher recommends that administrators of baccalaureate nursing education programs in Louisiana encourage and reward nursing faculty for engaging in continuing education in this field of nursing if they intend to have faculty equipped with the knowledge and skills required to teach students how to provide care that is culturally competent. This researcher also recommends that graduate programs in transcultural nursing be designed and implemented so that new faculty will be prepared to teach this content and serve as role models for future nursing students. The mean age of the study respondents was 50, which is similar to that reported by the American Association of Colleges of Nursing (AACN, American Association of Colleges of Nursing, 2003) in a recent national survey. The AACN found that doctoral and masters prepared faculty had mean ages of 53.5 and 48.8 respectively, and predict that between 2004 and 2012, over 200 of the doctorally prepared faculty will be eligible for retirement This finding underscores the need to create graduate programs in transcultural

nursing. A changing of the guard in nursing education is imminent and the appropriate preparation in transcultural nursing of incoming faculty is nursing more urgent now than ever.

Objective 2

The participants of this study agreed that they included content on transcultural nursing in the classroom as well as in the clinical practice setting. This conclusion was derived following interpretation of the teaching subscale index (M = 3.97), based on the response categories established by the researcher where : < 1.50 = Strongly Disagree (SD); 1.50 – 2.50 = Disagree (D); > 2.50-3.50 = Undecided (U); > 3.50 – 4.50 = Agree (A); and > 4.50 = Strongly Agree (SA). The study participants responded favorably (i.e., they agreed) to almost all items regarding teaching transcultural nursing but they did not strongly disagree nor did they strongly agree with any of the items. This response pattern is not unusual with Likert type items where respondents tend to avoid the extremes (Albaum, 1997). The researcher however examined responses to each item on this subscale to identify the items with the most and least favorable responses. Respondents were most favorable about their commitment to teach cultural competence (M = 4.33). They responded least favorably to "I screen books movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in courses or sharing them with clients cared for by me or my students" (M = 3.29). According to Byrne, Weddle, Davis and McGinnis (2003), bias in instructional materials may occur when generalizations are made about specific groups, thus leading to stereotyping, or with the omission of information about particular groups. For example, a textbook that omits a discussion of "Mongolian spots, keloids, or assessment techniques for darkly pigmented people" would be considered biased (Byrne, etal., p. 278). This researcher recommends that policies be instituted in Baccalaureate nursing programs to mandate the reviewing of instructional materials with the intent to reduce bias.

Finally, this researcher recommends, as did Ryan, Twibell, Miller and Brigham (1996), that methods for tracking content on transcultural nursing throughout the curriculum be instituted. If cultural competence were included as one of the terminal competencies of students in baccalaureate nursing programs, both faculty and students would be held more accountable for achieving this goal.

Objective 3

The study participants responded favorably to most items on the study instrument indicating the following: They agreed that they were aware of and appreciated cultural diversity, and that they were knowledgeable about world views of diverse cultures, and facts about cultural diversity. They also agreed that they possessed the skills to assess culturally diverse clients, and that they and their students had interactions with culturally diverse groups. Finally, they agreed that they were committed to care for and teach how to care for clients that were culturally diverse. These conclusions are based on the findings in this study regarding each of the cultural competence subscales.

The cultural awareness index (M = 4.14) was the highest index of all. This finding is not surprising because cultural awareness is consistently identified in the literature as a necessary component of cultural competence (Campinha-Bacote, 1998; Cross, 1988; Mason, Cross, Rider & Friesen, 1988; Purnell & Paulanka, 1998). Cross (1998) described cultural competence as a developmental process moving on a continuum of six positions from left to right. According to this model, cultural awareness is in the fifth position, and it is characteristic of basic cultural competence where there is acceptance, respect and valuing of differences. Immediately to the left of cultural awareness is cultural pre-competence characterized by a realization that diverse populations are not adequately served and attempts are made to make improvements. To the right

of awareness is advanced cultural competence, which includes awareness, plus efforts to expand cultural knowledge through research. Purnell and Paulanka on the other hand describe cultural awareness as the first step in the process of developing cultural competence followed by knowledge of diverse cultures, acceptance and respect and adaptation of care to the clients' culture. The instrument used to measure cultural awareness for this research also included statements regarding acceptance and respect for other cultures (which according to Purnell and Paulanka is beyond the first step of cultural competence) as part of the measure of cultural awareness. Based on the above conceptualizations of cultural competence by Cross, and Purnell and Paulanka, and the findings of this research study, which indicate that the participants are culturally aware, this researcher concludes that the respondents are at least beyond the beginning of the continuum of cultural competence.

The cultural desire index (M = 3.67), the cultural knowledge index (M = 3.65), and the cultural skill index (M = 3.65) also support the conclusion that the respondents agreed that they are competent in those areas. A closer look at the items on the cultural skills subscale indicated that the respondents were undecided about their skills in communicating with patients with limited English language proficiency and about selecting and working with translators. These finding are consistent with those of Jones, Bond and Mancini (1998) who reported that when asked what their major problem was in carrying out their role, nurses working with Mexican patients cited either "communicating effectively" or "the language barrier" (p. 285). The importance of using a client's language of preference to avoid errors and misunderstandings is recognized by standards for culturally and linguistically appropriate services (CLAS) in healthcare of the Office of Minority Health (Office of Minority Health, 2000). The standard related to language states that health care organizations should provide interpreters or bilingual

staff to assure “competence of language assistance.” This researcher recommends that because of the increasing numbers of new immigrants in the population, a major effort be made to increase the foreign language skills, as well as the skills for working with translators, among faculty of baccalaureate programs. This researcher also recommends that a foreign language requirement be added to all undergraduate and graduate nursing curricula to increase the likelihood that future nursing faculty will have the language skills to communicate effectively with clients with limited English language ability. The specific foreign language to be studied should be determined by the foreign language needs in the service area.

The cultural encounter index (M = 3.56) was the lowest of the subscale indexes. This index was also on the lower end of the “agree” response category, which the researcher established to interpret the responses. Nevertheless, these findings indicate that the study participants agreed that they had interactions with groups that were culturally diverse. The importance of cultural encounters in improving communication skills and in ridding health care providers of stereotypes is underscored in the literature (Campinha-Bacote, 1998; Jones, Bond & Mancini, 1998; Mason, Cross, Rider & Friesen, 1988). Ryan, Twibell, Brigham and Bennett (2000) believe that the lack of actual experience with diverse cultures is one of the barriers to developing a curriculum that is more culturally focused. They reported that students involved in a cultural immersion experience identified increased awareness of the need for cultural competence, recognition of personal biases, and the need to understand different communication patterns as major outcomes of the experience.

This researcher recommends that administrators encourage and reward more opportunities for cultural encounters for nursing faculty. These cultural encounter programs could be done on a local level, or international level. Opportunities for international cultural and

language immersion programs abound, but cost may be a factor. On a local level, faculty should be encouraged to choose clinical sites that facilitate interactions with patients and staff that are culturally different from them.

Objective 4

A model does exist that enables the researcher to predict the respondent's overall level of cultural competence when the index of each cultural competence subscale is considered. This conclusion is supported by the results of a stepwise multiple regression analysis of the overall cultural competence index on the subscale indexes, resulting in a model where cultural knowledge, cultural skills, cultural encounters and cultural desire explained 99% of the variance. In fact, the variables cultural knowledge (R^2 = .73) and cultural encounters (R^2 = .14) explained as much as 87% of the variance in the model, with cultural knowledge far outweighing any of the other variables in explanatory power. Cultural awareness was excluded from the model.

At a roundtable discussion that was part of a project to increase skills of faculty to teach transcultural nursing concepts, concerns about promoting stereotypes and lack of knowledge about cross-cultural nursing theory and concepts were some of the reasons given for faculty's lack of commitment to teach transcultural nursing (Ryan, Twibell, Miller & Brigham, 1996). In fact, the participants of the roundtable discussion concluded that if they were better prepared to teach transcultural nursing concepts, they would be more confident and willing to do so. The participants in this study "agreed" that they had the knowledge of concepts regarding cultural diversity (M = 3.67). However, given the strength of this variable (i.e., cultural knowledge) in predicting cultural competence in the multiple regression model described above, this researcher recommends that faculty engaged in activities to increase their knowledge of trancultural nursing concepts be encouraged and rewarded by administrators of baccalaureate nursing programs.

Strategies for developing knowledge regarding cultural competence among nursing faculty and strategies for teaching cultural competence should be a leading topic of faculty development conferences and workshops.

Objective 5

Models do exist that increase the researcher's ability to predict the respondents' level of competence on each of the cultural competence subscales as well as the level of overall cultural competence. While the predictive power of the models varied for each subscale, the variable continuing education in transcultural nursing in the previous five years was consistently associated with an increase in each subscale index and it explained the greatest portion of the variance for each of the subscales, as well as for the overall cultural competence of the respondents. In addition, the nursing specialties women's health, childbearing and community health were included in the explanation of several of the multiple regression models. Finally, the percent Asians and black Hispanics in the program were also associated with increased levels of selected subscale indexes, while the presence of white Hispanics and Caucasian respondents were associated with a decrease in selected subscale indexes. Each cultural competence subscale index, as well as the overall cultural index was regressed on the variables age, ethnic background, years in nursing education, other language spoken, specialty area, certification held, ethnic background of students taught, and continuing education in transcultural nursing, yielding the following results which support the researcher's conclusions.

The model with the least explanatory power was the regression model of the cultural awareness index on the selected independent variables, in which continuing education, the only variable entering the model, explained six percent of the variance in the model. The variables continuing education in transcultural nursing, community health nursing specialty, women's

health nursing specialty and the percent Asian students in the nursing program were associated with an increase in the cultural knowledge index and they explained 22% of the variance in the multiple regression model of cultural knowledge on the selected variables. The variable continuing education in transcultural nursing also entered the multiple regression of the cultural skills index on the selected variables. In addition, the variables percent Black Hispanic students and percent Asian students in the nursing program, as well as the nursing specialty Childbearing entered the model and were associated with an increase in the cultural skills index. The variable percent white students in the nursing program on the other hand, contributed to a decrease in the cultural skills index. The variables entering the cultural skills multiple regression model, together explained 26% of the variance.

Similar patterns were observed in the multiple regression of the other indexes on the selected independent variables. For example, the result of the multiple regression of the cultural encounter index on the selected independent variable was that continuing education in transcultural nursing and the nursing specialty women's health were associated with an increase in the cultural encounter index and together they explained 14% of the variance in the model. The very same variables (i.e., continuing education in transcultural nursing and the nursing specialty women's health) explained 15% of the variance in the multiple regression of the cultural teaching index on the selected independent variables. Similarly, continuing education in transcultural nursing, along with the nursing specialty childbearing and the percent Asian students were the variables associated with an increase in the cultural desire index, while the variable Caucasian respondent was associated with a decrease in the cultural desire index. These four variables explained 18% of the variance in the cultural desire multiple regression model. Finally, 26% of the variance in the overall cultural competence regression model was explained

by the variables continuing education in transcultural nursing, the nursing specialty women's health, the percent Asian students in the program and the percent white Hispanic students in the program. All of these variables except percent white Hispanic students in the program were associated with an increase in the overall cultural competence index.

As described above, the percent of Asian students in the nursing program was associated with an increase in the indexes of the cultural knowledge, cultural skills, cultural desire and overall cultural competence, and the percent black Hispanic students in the program was associated with an increase in overall cultural competence index. The literature provides a framework for interpreting the results of these analyses. One explanation for this relationship could be that the presence of these minority students served as cultural encounters for the respondents and thus increased their cultural competence levels. Campinha-Bacote (1998), maintains that direct interactions with individuals of different cultures allow the participants to validate, clarify, and modify perception of other cultures. Similarly, Jones, Bond and Mancini (1998) reported that interactions with individuals of different cultures resulted in evaluation of differences and examination of one's values and beliefs.

The association of the variable Caucasian respondent with a decrease in the cultural encounters index should be investigated further. Similarly, the association of the variable percent Whites with a lower cultural skills index also warrants further investigation.

Women's health as a nursing specialty was found to be significantly associated with increasing overall cultural competence on the following subscale indexes: Cultural knowledge, cultural encounters, and cultural teaching. This field of nursing "...focuses on the physical, psychological and social needs of women throughout their lives" (Perry, 1997, p. 1). Thus, women health nurses recognize the effect that factors such as race, access, age, and violence

have on the health outcomes of women and they maintain that "To understand women's health, practitioners must view women holistically and in the context in which they live" (Lowdermilk, Perry & Bobak, 2000, p. 3). This approach to providing healthcare is consistent with the goals of cultural competence, which include providing care to individuals within the context in which they live and the significant association of this specialty area with increased cultural competence is not surprising. Community health nursing was associated with increasing the cultural knowledge index, and the childbearing nursing specialty was associated with increasing the cultural desire index. These findings are also not unexpected since community health, as the term implies, focuses on providing care not only for the individual living within a community, but for the community as a whole. It involves developing knowledge about communities through assessment and interactions with their members. Similarly, childbearing is viewed as a time of "…transition and social celebration …signaling a realignment of existing cultural roles and responsibilities, psychological and biologic states, and social relationships" (Lowdermilk, Perry & Bobak, 2003). This researcher recommends further investigation of the differences in cultural competence among faculty in selected nursing specialties. This researcher also recommends that a dialogue be initiated between nursing faculty in the above nursing specialties (i.e., women's health, childbearing, community health) and faculty with other practice interests, to share teaching practices and devise strategies for improving cultural competence among all nursing faculty.

The above models strongly support the role that preparation in transcultural nursing, through continuing education, plays in increasing each of the cultural competence indexes as measured by the research instrument used in this study. The models also validate the finding discussed earlier, that the overall cultural competence of the respondents was explained for the

most part by their level of cultural knowledge, which was associated with an increase in their overall level of cultural competence. Furthermore, the above models support claims in the literature that an improvement in cultural knowledge is a key factor in improving the ability and commitment of nursing faculty to teach cultural competence (Kelly, 1991; Leininger, 1995; Ryan, Twibell, Miller & Bringham, 1996). These models lead this researcher to reiterate the recommendations made earlier: Strategies for developing knowledge regarding cultural competence in nursing faculty must be developed and implemented.

In a recent article, Duffy (2001) questioned the current approach to teaching cultural competence in nursing and cited the lack of evidence that teaching cultural competence in nursing increases cultural understanding or sensitivity, as the rationale for her criticism. In particular, she was critical of the practice of emphasizing cultural differences and the description of group characteristics, which she claims leads to stereotyping. Bond, Kardong-Edgren, and Jones also suggested that alternative teaching strategies be implemented to "move students along the continuum of cultural learning" (Bond, Kardong-Edgren & Jones, 2001, p. 305). Their suggestion was prompted by their findings that there was a low level of cultural knowledge among generic BSN students, practicing nurses and Masters'-level RN's. They proposed more clinical experiences with "real-world patients" and a more applied focus rather than "didactic teaching techniques." While Duffy and Bond, Kardong-Edgren and Jones may be accurate in suggesting a revamping of the way cultural competence is taught in schools of nursing, this researcher contends that nursing faculty also need to critically examine their preparation for implementing current or new strategies for teaching transcultural nursing. This research study showed that cultural knowledge is a critical component of cultural competence. Very few of the respondents cited transcultural nursing as a specialty area, none of them were certified in

transcultural nursing, and only one half of them had any continuing education in transcultural nursing in the previous five years. According to the findings of this study, continuing education in transcultral nursing in the previous five years was the variable that was most consistently associated with an increase in the index of overall cultural competence as well as the index of each of the cultural competence subscales. While the respondents of this research study agreed that they were knowledgeable about transcultural nursing, their charge to prepare nurses to care for patients in an increasingly diverse society demands that their level of transcultural nursing knowledge be at least maintained if not increased. This researcher believes that with increased preparation in transcultural nursing, faculty of baccalaureate nursing programs will be able to agree strongly, rather than to simply agree, that they are effective in providing and teaching how to provide care that is within the cultural context of individuals, families and communities from diverse cultural backgrounds.

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APPENDIX A

Cultural Diversity Questionnaire for Nurse Educators

The following statements are about your clinical and teaching practices, and your beliefs and attitudes regarding caring for culturally, racially, and ethically diverse clients. Statements about teaching relate only to your activities with undergraduate nursing students. Please circle the term that most accurately reflects your level of agreement with each statement.

1. What I believe about health, illness and preventive health is strictly based on science.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

2. Some cultural groups believe that supernatural forces can cause illness.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

3. I feel confident in using a variety of cultural assessment tools in the health care setting.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

4. It is more important for my students to conduct cultural assessments on ethnically diverse clients than on other clients.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

5. I do not have time to include cultural competence in my course content.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

6. I am involved socially with cultural/racial/ethnic groups, different from my own, outside of my teaching role and healthcare setting.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

7. Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

8. Individuals of different cultural/racial/ ethnic groups have perceptions of health, illness, and preventive health that are no different from my own.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

9. The same approach should be followed when caring for all patients, regardless of culture, race, ethnic, or religious background, or worldview.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

10. I am knowledgeable about variations in drug metabolism among specific cultural groups.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

11. Determining the degree of acculturation of culturally diverse clients is a desirable but not essential part of conducting a cultural assessment.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

12. I avail myself of professional development and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups

    Strongly Agree Agree Undecided Disagree Strongly Disagree

13. I am aware that biological variations exist in different cultural, racial, and ethnic groups.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

14. I use the appropriate communication style and protocol to communicate with clients who are of different cultural, racial, and ethnic backgrounds.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

15. There is no difference in food digestion among ethnic, racial, and cultural groups.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

16. My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

17. When I care for a client, I consider how the difference between our perceptions of health, illness and preventive health could affect the outcome of my care.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

18. I am knowledgeable about biological variations that exist among specific cultural, racial, and ethnic groups.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

19. I am knowledgeable of keywords and phrases needed to communicate effectively with the major groups with limited English language proficiency that are served by our program.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

20. I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

21. I am knowledgeable about diseases that have a high incidence among cultural, racial, and ethnic groups in our service area.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

22. I am in contact with individuals, who provide health services to groups that are culturally, racially, and ethnically diverse

    Strongly Agree Agree Undecided Disagree Strongly Disagree

23. I require that students be knowledgeable about diseases that have a high incidence among clients in our service area, from diverse cultural, racial, and ethnic groups.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

24. I am aware of some of the stereotyping attitudes and preconceived notions and feelings that I have towards members of other cultural, racial, or ethnic groups.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

25. I have a clear understanding of the difference in meaning of the following terms: acculturation, assimilation, and socialization.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

26. I am confident that I possess the necessary skills and experience to select and work with appropriate translators as needed to care for clients with limited English language proficiency.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

27. I keep abreast of the major health concerns and issues of culturally, racially, and ethnically diverse client populations residing in my program's service area.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

28. I attend holiday celebrations within culturally, racially, and ethnically diverse communities.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

29. My students are expected to demonstrate knowledge of their clients' worldviews, beliefs, and practices by incorporating this knowledge in their plans of care.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

30. I am knowledgeable about diseases that are common in the countries of origin of recent immigrants to our service area.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

31. When working with clients of limited English language proficiency, family members are most preferable for providing interpretation services.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

32. I have spent extended periods of time (i.e., at least seven consecutive days) living among people from cultural/ethnic/racial groups different from my own.

    Strongly Agree Agree Undecided Disagree Strongly Disagree

33. I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my courses or sharing them with clients cared for by me, or by my students.

Strongly Agree Agree Undecided Disagree Strongly Disagree

34. I am interested in becoming culturally competent because it is the politically correct thing to do.

Strongly Agree Agree Undecided Disagree Strongly Disagree

35. I am personally and professionally committed to providing nursing care that is culturally competent.

Strongly Agree Agree Undecided Disagree Strongly Disagree

36. I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.

Strongly Agree Agree Undecided Disagree Strongly Disagree

37. I advocate for the review of my program's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence.

Strongly Agree Agree Undecided Disagree Strongly Disagree

38. The administrators of my program should be the ones responsible for seeking out clinical experiences with culturally, racially, and ethnically diverse groups in our service area.

Strongly Agree Agree Undecided Disagree Strongly Disagree

39. I teach my students that the client's culture is a determining factor in the client's perception of health and illness and in his or her adherence to the prescribed treatment regimen.

Strongly Agree Agree Undecided Disagree Strongly Disagree

40. I am knowledgeable about the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my nursing program.

Strongly Agree Agree Undecided Disagree Strongly Disagree

41. I patronize businesses in my service area that are owned by people who are culturally, racially and ethnically diverse.

Strongly Agree Agree Undecided Disagree Strongly Disagree

42. I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural, racial, and ethnic groups.

Strongly Agree Agree Undecided Disagree Strongly Disagree

43. I know the prevailing beliefs, customs, norms and values of the cultural, racial, and ethnic groups, other than my own, residing in our service area**.**

Strongly Agree Agree Undecided Disagree Strongly Disagree

44. I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially and ethnically diverse.

Strongly Agree Agree Undecided Disagree Strongly Disagree

45. Additional content on cultural competence is not necessary in my program's curriculum.

Strongly Agree Agree Undecided Disagree Strongly Disagree

46. The cultural assessment tool that I use elicits information about clients' dietary practices, health beliefs and social organization.

Strongly Agree Agree Undecided Disagree Strongly Disagree

47. There are more differences within cultural groups than across cultural groups.

Strongly Agree Agree Undecided Disagree Strongly Disagree

48. I am knowledgeable about the population percentages of the major ethnic groups living in my service area.

Strongly Agree Agree Undecided Disagree Strongly Disagree

49. I do not feel comfortable asking questions that relate to the client's cultural/racial/ethnic background.

Strongly Agree Agree Undecided Disagree Strongly Disagree

50. I teach my students that when working with clients who are culturally, racially, or ethnically different they should become familiar with indigenous beliefs and practices.

Strongly Agree Agree Undecided Disagree Strongly Disagree

51. I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients.

Strongly Agree Agree Undecided Disagree Strongly Disagree

52. What I believe about health, illness and preventive health is influenced by my culture.

Strongly Agree Agree Undecided Disagree Strongly Disagree

53. I have a clear understanding of the difference in meaning of the following terms: immigrant, alien resident and citizen.

Strongly Agree Agree Undecided Disagree Strongly Disagree

54. I accept that male-female roles may vary significantly among different cultures and ethnic groups.

Strongly Agree Agree Undecided Disagree Strongly Disagree

55. I am confident that I can effectively assess conditions such as pallor, jaundice, and cyanosis in clients of a race or ethnicity different from my own.

Strongly Agree Agree Undecided Disagree Strongly Disagree

Please provide the following information about yourself:

56. Which of the following best describes your employment status?
    1. _____ Fulltime
    2. _____ Part-time
    3. _____ Adjunct

57. What is your academic rank?
    1. _____ Full Professor
    2. _____ Associate Professor
    3. _____ Assistant Professor
    4. _____ Instructor

58. At what level in your nursing program do you teach? (Please check all that apply)
    1. _____ Associate
    2. _____ Baccalaureate
    3. _____ Master's
    4. _____ Ph.D.

59. How long have you been teaching nursing? If less than a year, please give the number of months.
    1. _____Months
    2. _____Years

60. Age: _____

61. Sex: Male _____ Female _____

62. Were you born in the United States?
    1. ____Yes
    2. ____ No

63. If no, what is your country of origin? _____

64. What is your race/ethnic background? _____

65. What language(s) other than English do you speak?
    1. ___ None 4. ____ Arabic 7. ____ German 11. ___ Dutch
    2. ___ Spanish 5. ____ Mandarin 8. ____ Portuguese 12. ___ Japanese
    3. ___ French 6. ____ Cantonese 9. ____ Italian 13. ___ Other. Please list: _____

66. What is your highest degree attained?
    1. _____ Bachelors
    2. _____ Masters
    3. _____ Doctorate

67. What is your nursing specialty area? (Please check all that apply)
    1. ____ Adult Health
    2. _____ Community Health
    3. _____ Child Health and Illness
    4. _____ Childbearing
    5. _____ Psychiatric Nursing
    6. _____ Women's Health
    7. _____ Nursing Administration
    8. _____ Transcultural Nursing

9. _____ Gerontology
10. _____ Other _____

68. Do you hold any certifications in your specialty area?
1. _____ Yes
2. _____ No

69. If yes, please list your certification(s) _____

70. Have you attended/completed any continuing education programs on transcultural nursing/cultural competence in the past five years?
1. _____ Yes
2. _____ No

71. If yes, approximately how many continuing education hours have you earned in this area?
_____

72. Estimate the percentage of each of the following groups in your nursing program:
1. _____ Whites
2. _____ African Americans
3. _____ Black Hispanics
4. _____ White Hispanics
5. _____ Asians
6. _____ Others

Comments
_____
_____
_____
_____
_____

Thank You!

APPENDIX B

CULTURAL COMPETENCE SUBSCALES

1. Cultural Awareness Subscale Items	Item Number
What I believe about health, illness and preventive health is strictly based on science (Researcher)	1
Individuals of different cultural and ethnic groups have perceptions of health, illness, and preventive health that are no different from my own. (Goode, 2000)	8
The same approach should be followed when caring for all patients regardless of culture race, ethnic or religious background or worldview (Researcher)	9
I am aware that biological variations exist in different cultural/racial/ethnic groups. (Campinha-Bacote, 1998)	13
When I care for a client, I consider how the difference between our perceptions of health, illness and preventive health could affect the outcome of my care. (Researcher)	17
I am aware of some of the stereotyping attitudes and preconceived notions and feelings that I have towards members of other ethnic groups. (Campinha-Bacote, 1998)	24
I teach my students that the client's culture is a determining factor in the client's perception of health and illness and in his or her adherence to the prescribed treatment regimen. (Researcher)	39*
I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural and ethnic groups. (Researcher)	42*
I teach my students that when working with clients that are culturally and ethnically different they should become familiar with indigenous beliefs and practices. (Ward 2001)	50*
I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients. (Researcher)	51

* Item on Transcultural Teaching Behaviors Subscale

What I believe about health, illness, and preventive health is influenced by my culture. (Researcher)	52
I accept that male-female roles may vary significantly among different cultures and ethnic groups (Goode, 2000).	54

2. Cultural Knowledge Subscale Items

Some cultural groups believe that supernatural forces can cause of illness. (Researcher)	2
I am knowledgeable about variations in drug metabolism among specific cultural/racial/eithnic groups. (Campinha-Bacote, 1998)	10
There is no difference in food digestion among racial/ethnic groups. (Researcher)	15
I am knowledgeable of biological variations that exist among different ethnic groups. (Campinha-Bacote, 1998)	18
I am knowledgeable about diseases that have a high incidence among certain cultural, racial and ethnic groups. (Researcher)	21
I have a clear understanding of the difference in meaning of the following terms: acculturation, assimilation and socialization (Researcher)	25
My students are expected to demonstrate knowledge of their clients' worldviews, beliefs and practices by incorporating this knowledge in their plans of care. (Researcher)	29*
I am knowledgeable about diseases that are common I the countries of origin of recent immigrants to our service area. (Researcher)	30
I am knowledgeable about the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my nursing program. (Goode, 2000)	40
Know the prevailing beliefs, customs, norms and values of the cultural and ethnic groups in my service area. (Mason, 1995)	43

* Item on Transcultural Teaching Behaviors Subscale

There are more differences within cultural groups than across cultural groups. (Campinha-Bacote, 1998)	47
I am knowledgeable about the population percentages of the major ethnic groups living in my service area. (Mason, 1995)	48
I have a clear understanding of the difference in meaning of the following terms: immigrant, alien resident and citizen. (Researcher)	53

3. Cultural Skills Subscale Items

I feel confident in using a variety of cultural assessment tools in the health care setting. (Researcher)	3
It is more important for my students to conduct cultural assessments on ethnically diverse clients than on other clients. (Campinha-Bacote, 1998)	4*
Determining the degree of acculturation of culturally diverse clients is a desirable but not essential part of conducting a cultural assessment. (Researcher)	11
I use the appropriate communication style and protocol to communicate with clients of different cultural/racial and ethnic backgrounds. (Mason, 1995)	14
My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by our program. (Ward, 2001)	16*
I am knowledgeable of key-words and phrases needed to communicate effectively with the major groups with limited English language proficiency that are serve by our program. (Researcher)	19
I am confident that I possess the necessary skills and experience to select and work with appropriate translators as needed to care for clients with limited English language proficiency. (Researcher)	26
When working with clients of limited English language proficiency, family members are most preferable for providing interpretation services. (Researcher)	31

* Item on Transcultural Teaching Behaviors Subscale

I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are racially and ethnically diverse. (Researcher)	44*
The cultural assessment tool that I use elicits information about clients' dietary practices, health beliefs and social organization. Researcher)	46
I do not feel comfortable in asking questions that relate to the client's ethnic/cultural background. (Campinha-Bacote, 1998)	49
I am confident that I can effectively assess conditions such as pallor, jaundice and cyanosis in clients of a race or ethnicity different from my own. (Researcher)	55
4. Cultural Encounters Subscale Items	
I am involved socially with cultural/racial/ethnic groups, different from my own, outside of my teaching role and healthcare setting. (Campinha-Bacote, 1998)	6
I seek out clinical opportunities for my students to care for clients who are culturally, racially and ethnically diverse. (Researcher)	20*
I am in contact with individuals who provide health services to groups that are culturally, racially and ethnically diverse. (Researcher)	22
I attend holiday celebrations within culturally, racially and ethnically diverse communities. (Mason, 1995)	28
I have spent extended periods of time (i.e., at least seven consecutive days) with people from cultural/racial/ethnic groups different from my own. (Researcher)	32
I patronize businesses in my service area that are owned by people who are culturally, racially and ethnically diverse. (Mason, 1995)	41
5. Cultural Desire Subscale Items	
I do not have the time to include cultural competence in my course content. (Researcher)	5

* Item on Transcultural Teaching Behaviors Subscale

Caring for clients that are culturally, racially or ethnically diverse is a challenge that I welcome. (Researcher)	7
I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally racially and ethnically diverse groups. (Goode, 2000)	12
I keep abreast of the major health concerns and issues for culturally, racially and ethnically diverse client populations residing in my program's service area. (Goode, 2000)	27
I am interested in becoming culturally competent because it is the politically correct thing to do. (Researcher)	34
I am personally and professionally committed to providing nursing care that is culturally competent. (Researcher)	35
I am personally and professionally committed to teaching how to provide nursing care that is culturally competent. (Researcher)	36*
I advocate for the review of my program's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence. (Goode, 2000)	37
The Administration of my program should be responsible for seeking out clinical experiences with culturally, racially and ethnically diverse groups in our service area. (Researcher)	38
Additional content on cultural competence is not necessary in my program's curriculum. (Researcher)	45

APPENDIX C

Blueprint for a Measure to Assess Cultural Competence Using the Subscales Cultural Awareness, Cultural Knowledge, Cultural Skills, Cultural Encounters and Cultural Desire

	Content									
Objectives	Diverse Groups, Beliefs and Values	Personal Values	Teaching Practices and Expectations	Cultural Orientation	Disease Incidence Among Populations	Biological Variation	Definition of Concepts	Communication	Motivation And Commitment	Total
Ascertain Faculty's Awareness of Cultural Diversity	#8, #9, #13, #54	#1, #52, #17, #24, #51	#39, #42, #50							12
Evaluate Faculty's Knowledge regarding Cultural Diversity	#2, #43, #47, #48		#23, #29,		#21, #30, #40	#10, #18, #15	#25 ,#53			14
Determine Faculty's Cultural Assessment Skills	#3, #46		#4, #16 #44	#11		#55		#19, #26, #31, #14, #49		12
Determine Extent of Faculty's Cultural Encounters	#6, #28, #32, #41, #22		#20							6
Ascertain Faculty's Desire for Cultural Competence			#33, #36						#5, #7, #12, #27, #34, #35, #37, #38 #45,	11
Total	15	5	11	1	3	4	2	5	9	55

Note: The numbers in each cell are the item numbers representing selected objectives and the corresponding content areas.

APPENDIX D

Cover Letter

Dear Colleague:

I am a doctoral student at Louisiana State University and a faculty member in the school of nursing at Southeastern Louisiana University. I am requesting your participation in a study I am conducting on cultural competence and nursing education, in partial fulfillment of the requirements for my dissertation.

The importance of the provision of health care that is mindful of cultural differences has been widely established in the literature. However, studies that examined the nursing care abilities of baccalaureate nursing students, as well as professional nurses, reported low confidence levels regarding the provision of culturally congruent care. I am therefore interested in studying the contribution of nursing education to the practice of nursing care that is within the cultural context of the individuals, families and communities served.

I would like you to participate in this research by completing the enclosed Cultural Diversity Questionnaire for Nurse Educators. The time that is required to complete the questionnaire is approximately 20 minutes. Please return the completed questionnaire immediately. Completion and return of the questionnaire is your indication of consent to voluntarily participate in this research. Even though your responses to all items on the questionnaire would be most helpful in exploring the issue under study, you do not have to answer every question and you may terminate participation at anytime once you have begun. The codes on the questionnaire will be used solely for following up on non-respondents. Your responses will be kept confidential and will be stored in a computer database to which only I have password access. All data will be reported anonymously.

Your participation in this research and the candor of your responses are of utmost importance in gaining understanding of nursing faculty perceptions, practice and contributions to this field of nursing. I have enclosed a self addressed, stamped envelope for your reply. If you have any questions regarding this study, please do not hesitate to contact me via e-mail at lsealey@selu.edu or by telephone at (225) 765-2324. Thank you for your time and I look forward to hearing from you.

Sincerely,

Lorinda J. Sealey RNC, MS
PhD Candidate

APPENDIX E

First Follow-Up Letter

Date

Dear

Two weeks ago you were sent a copy of the Cultural Diversity Questionnaire for Nurse Educators, a questionnaire regarding your perceptions and practices concerning cultural competence in nursing care and education. If you have already completed the questionnaire, I thank you very much. If you have not yet done so, I urge you to complete and return it as soon as possible.

Please address any concerns or questions you may have about this study to me at lsealey@selu.edu or you may call me at (225) 765-2324. Thank you.

Sincerely,

Lorinda J. Sealey, RNC, MS
PhD Candidate

APPENDIX F

Second Follow-Up Letter

Date

Dear

Six weeks ago you were sent a copy of the Cultural Diversity Questionnaire for Nurse Educators, a questionnaire regarding your perceptions and practices concerning cultural competence in nursing care and education. If you have already completed the questionnaire, I thank you very much. If you have not yet done so, I urge you to complete and return it as soon as possible.

I have enclosed another packet, including a cover letter explaining the procedures for responding to the questionnaire and a copy of the questionnaire. Please place your completed questionnaire in the self-addressed stamped envelope provided for your convenience. Your participation in this research is strictly voluntary. Your responses are very important to increasing understanding about nursing faculty perceptions and practices in this field of nursing.

Please address any concerns or questions you may have about this study to me at lsealey@selu.edu or you may call me at (225) 765-2324. Thank you.

Sincerely,

Lorinda J. Sealey, RNC, MS
PhD Candidate

VITA

Lorinda J. Sealey was born in Panama, daughter of the late Cynthia and Rex Sealey. She graduated from Paraiso High School, Paraiso, Panama. She received an associate degree from Canal Zone College, Panama, a bachelor of science in nursing from the University of Texas at Austin, in May 1972, and her masters degree in community health nursing from Arizona State University, in August 1979. She received her doctor of philosophy degree in Vocational Education in December, 2003.

She began her nursing career at New York Hospital, Cornell Medical Center, as a staff nurse in 1972. Since then she has practiced nursing and health education in a variety of settings. In the fall of 1989, she joined the faculty at Southeastern Louisiana University, School of Nursing where she is currently an instructor. She is certified in Maternal Newborn Nursing by the National Credentialing Center and is a member of the American Nurses Association, the Louisiana State Nurses Association, The Association of Women's Health Obstetric and Neonatal Nurses and the Rho Zeta Chapter of Sigma Theta Tau, the National Nursing Honor Society.