UNDERSTANDING THE LIVED EXPERIENCES OF THE HISPANIC AMERICAN MATERNITY PATIENT: INTERSECTION BETWEEN CULTURALLY SENSITIVE NURSING CARE AND NURSING CURRICULUM

by

ANDRAA' MONIQUE PERRIN

MELONDIE R. CARTER, COMMITTEE CHAIR
NORMA CUELLAR
CAROL HOLTZ
RICK HOUSER
AARON KUNTZ

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ABSTRACT

Recent changes in the ethnic composition of the population of the United States pose great challenges for healthcare institutions and healthcare providers. In recent years, policy statements on nursing education indicated that nursing educators recognized the need to increase the cultural caring of the nursing workforce (Swanson, 2012). Salimbene (2014) discussed the importance of considering clients' culture as an integral part of assessing their healthcare needs and planning culturally appropriate nursing care to meet those needs. Currently, there is a paucity of information regarding patients' perceptions of culturally competent care. The purpose of this qualitative study was to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients two to four weeks post-discharge in a WIC program in rural Northeast Georgia. Utilization of a phenomenological research design included interviews with 15 Hispanic American women. Data analysis was conducted using phenomenological analysis methods with the aid of the software program Nvivo 11. Themes that were identified were: Better Future, Better Medical Care, Treatment of Patients, Customs and Practices, and Meaning of Care. This information may aid in creating a culturally competent maternity care curriculum.

DEDICATION

This dissertation is dedicated to the memory of my mother, Rosa Barnett, and everyone who helped me and guided me through the trials and tribulations of creating this manuscript. In particular, my family and close friends who stood by me throughout the time taken to complete this masterpiece.

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CHAPTER 1: INTRODUCTION

Overview of Cultural Caring

Recent changes in the ethnic composition of the population of the United States have posed great challenges for healthcare institutions and healthcare providers. Seright (2012) pointed out that many healthcare providers serving formerly homogeneous populations provide care for culturally and linguistically different groups who have different health beliefs and practices than providers' usual patients. According to Dossey, Keegan, and Gazette (2013), culture not only account for differences in behaviors such as diet and exercise, but also determines important health conditions worthy of attention and what behaviors the client engaged in to restore health and remain healthy. Seright (2012) contended that nurses and other healthcare providers needed better training in how individuals' cultural perceptions affected the approach and responses to healthcare. Seright further asserted that a significant effect occurred between the degree of patients' compliance with and response to treatment and their expectations and the care received. The provision of culturally competent healthcare—healthcare that takes into account issues related to the cultural context of individuals, their families, and communities—is therefore more imperative than ever. Leonard (2010) maintained the provision of culturally competent healthcare resulted in client empowerment, decreased client anxiety, better utilization of healthcare services, improvement of the health status of the client population, and increased overall client satisfaction.

The U.S. Department of Health and Human Services Office of Minority Health (OMH, 2013) also recognized the need for cultural caring. OMH officials believed that it was necessary

to move toward a national consensus regarding cultural and linguistic caring. The OMH (2013) issued recommendations for 14 national standards for culturally and linguistically appropriate services (CLAS) in healthcare. The organization directed these standards toward healthcare organizations. However, the standards apply to individual providers and other groups as well. The OMH encouraged educators from healthcare professions, training institutions, and legal and social services professions to incorporate the standards into their curricula (OMH, 2013).

Population Changes

According to statistics from the United States Citizenship and Immigration Services (2014), nearly 41 million immigrants lived in the United States in 2012. About 20% of all international migrants resided in the United States, which accounted for less than 5% of the world's population. In 2013, the U.S. immigrant population was 38,517,234, or 12.5% of the total U.S. population. The number of foreign-born immigrants living in the United States increased by 1.5% (about 556,000 people) between 2008 and 2013. Mexican-born immigrants accounted for 29.8% of all foreign-born individuals residing in the United States in 2013, by far the largest immigrant group in the United States. Immigrants from the Philippines accounted for 4.5% of foreign born, followed by India and China with 4.3% and 3.7%, respectively. These four countries, together with Vietnam (3.0%), El Salvador (3.0%), Korea (2.6%), Cuba (2.6%), Canada (2.1%), and the Dominican Republic (2.1%), comprised 57.7% of all foreign-born residing in the United States in 2013. The predominance of immigrants from Mexico and Asian countries in the early 21st century starkly contrasted with the trend seen in 1960, when immigrants more likely originated from European countries. Italian-born immigrants made up 13% of all foreign born in 1960, followed by those born in Germany and Canada. According to Baker and Rytina (2013), by January 1, 2013, 13.1 million legal permanent residents (LPR) were living in the United States.

Among them, 8.8 million were eligible for naturalization. The size of the LPR population was slowly changing, not because the number of persons becoming LPRs was fewer, but there was an equal amount of people naturalizing as were becoming LPRs. For a span of 5 years, from 2008 to 2013, both the LPR population and the naturalizing LPR population increased by less than one million.

In 2013, around 25% of 13.1 million LPRs originated from Mexico, making it the leading country of origin. Following consecutively were populations from China, the Philippines, India, and then the Dominican Republican. LPRs from these five countries already represented nearly half (42%) of the whole LPR population in the U.S. and the majority of those who have eligibility to naturalize. Around 57% of the whole LPR population prefer to live in California, New York, Texas, and Florida.

In Robeson County, Georgia, LeDuff (2013) estimated that most of the 10,000 Hispanics living there had arrived within the past 5 years. The author projected that the Asian and Hispanic populations would double by the year 2025. Many of these new immigrants spoke little or no English and had different customs, values, and beliefs about health and illness. These changes 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, 2014).

The swift increase of the Hispanic population in Georgia influenced this study. More than one in 10 Georgians are Hispanic and Asian. In particular, the Hispanic population increased from 1.7% to 5.3% in 2000, and in 2013, the population nearly doubled to 9.1%. Among Georgia voters in the last 2012 elections, the Hispanic population already composed 2.7% of the population. Based on the increase in the Hispanic population in Georgia and very few studies noted in the literature related to the Hispanic population, this current study seemed timely and

pertinent. The purpose of this qualitative study was to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients 2 to 4 weeks post-discharge. The researcher addressed the changes in healthcare delivery, cultural caring in nursing, and cultural caring in nursing practice and nursing education.

Changes in Healthcare Delivery

Healthcare delivery has changed in the United States due to many factors but population changes made a significant impact. McCloskey (2014) noted that not only is the population changing, but so is the way that organizations deliver healthcare. More healthcare services are available in the home than have been available in previous years. This practice calls for greater understanding of the cultural background of clients and their families. Li, Yin, Cai, Temkin-Greener, and Mukamel (2011) agreed that cultural caring is imperative when nurses provide care in the home, especially since they are guests of their patients and have to adhere to the patient's values and lifestyle—in contrast to hospital settings, where patients abide by the rules of the agencies.

According to the U.S. Department of Health and Human Services (2010), the racial and ethnic distribution of the registered nurse (RN) population varied substantially from that of the U.S. population as a whole. The Department reported that 65.6% of the U.S. population was non-Hispanic White, while 83.2% of RNs were non-Hispanic White. Hispanics, Blacks, and American Indians/Alaskan Natives remained underrepresented in the RN population. Slightly overrepresented among RNs, 5.8% of the RN population consisted of Asians, Native Hawaiians, or Pacific Islanders, compared to 4.5% of the U.S. RN population. As previously noted, a significant number of RNs received their initial nursing education in the Philippines or India, which may have contributed to the comparatively high distribution of Asians among RNs. This

current ethnic composition of nurses did not reflect the growing ethnic diversity of the U.S. population. In fact, it is similar to those who created the U.S. healthcare system.

A disparity was the number of Hispanic nurses was not enough to meet the healthcare needs of the growing number of Hispanic population in the country. According to the National Association of Hispanic Nurses (2016), out of the 3,000,000 registered nurses in the U.S., Hispanics only represented 3.6%. This was hardly proportionate to the Hispanics in the country, which accounted for 17% of the U.S. population. Many Hispanic students and parents were not aware of the various opportunities that existed in the nursing fields. Because of the shortage of Hispanic nurses, preparing culturally competent nurses is a priority for care provision in homes and in healthcare institutions.

Cultural Caring in Nursing

Caring has long been established as a critical behavior for professional nursing. The American Association of Colleges of Nursing (AACN, 2011) stated that the baccalaureate nursing curriculum must contain content that prepares the nursing student to "engage in caring and healing techniques that promote a therapeutic nurse-patient relationship" (p. 32). In 1859, Florence Nightingale wrote that the most important component of nursing is caring. Nightingale (1859) described trained nurse caring behaviors as deliberate, holistic actions aimed at creating and maintaining an environment meant to support the natural process of healing. Sitzman (2007) argued:

> The wide range of interpretations of caring in nursing literature has shown that caring means different things to different nurses, depending on amount of professional experience, level of education of the nurses involved, where and how the concept is applied, personal values, and professional focus. (p. 8)

Over the past 2 decades, researchers have conducted studies dedicated to explaining what represents caring practices within clinical practices (Liu, Mok, & Wong, 2009). However, there is still a need to ask what defines a behavior as "caring," and how the nurse's perception of caring compared to the patient's perception.

The delivery of culturally sensitive care is another component of caring nursing behaviors. Many government agencies and professional organizations have included measures in their policies and procedures of operations to improve the interaction between the agency/organization and members of culturally diverse groups. Nursing as a profession, and nursing education in particular, included training to ensure that patient care included providing culturally sensitive care. In 1986, the American Nurses Association (ANA) issued its first intention to strengthen cultural diversity programs in nursing (Lowe & Archibald, 2009).

Seright (2012) believed that the healthcare system contained a predominantly Caucasian population of Northern European descent and philosophy, and that this system suited the individualistic nature of American society. Thus, ideas held by the predominant number of nurses regarding how to demonstrate quality caring resided from the beliefs of the healthcare system's creators. Today, these beliefs and values are no longer compatible with those of the increasingly non-European population in America. Caring for this increasingly multiethnic and multicultural clientele has inevitably posed challenges for healthcare providers, and has required sensitivity to the diversity of clients and the provision of culturally competent care.

The need for nurses sensitive to cultural variations in clients they care for remained well established in the literature. Salimbene (2014) discussed the importance of considering clients' culture as an integral part of assessing their healthcare needs and planning culturally appropriate nursing care to meet those needs. For example, Leininger (1991), a leading cultural caring in

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). Leininger further stated that if professional nursing care is not compatible with the beliefs and values held by the recipients of care, “culture conflicts, noncompliance behaviors, cultural stresses, [and] imposition practices” would result (p.37). In *Cultural Diversity in Health and Illness*, now in its eighth edition, Spector (2013) explored healthcare providers’ understanding of their own perceptions of health and illness, which are issues affecting consumers’ acceptance of healthcare, and health beliefs and practices in selected populations. Additional authors have noted the importance of nurses that adhere cultural values and practices when providing care.

Holland and Hogg (2010) reported the human responses to health and illness were from deeply rooted beliefs, values, and practices from the individual’s culture. Nurses’ ability to interpret these culturally based responses or to plan culturally acceptable interventions undoubtedly affected the care they provided. Holland and Hogg also reported that evidence demonstrated that without cultural caring, nurses tended to subject clients of cultures different from their own to ethnocentric attitudes and practices. Seright (2012) provided the example of patients who avoided eye contact with their healthcare provider. This caused suspicion about the honesty of the patient; however, in reality, the patients were adhering to their cultural practice of showing respect for persons in authority by not looking them directly in the eye. Such a situation would possibly result in inadequate nursing care and unintended adverse results. In addition, Holland and Hogg (2010) posited that without culturally competent healthcare providers, misdiagnosis and unfavorable consequences occurred. As an example of an unfavorable outcome, the researchers cited a misunderstanding of child-rearing practices, which resulted in subsequent arrests of parents following accusations of abuse.

Misunderstandings about cultural expressions of pain have also led to inadequate pain relief in many ailing patients. According to Holland and Hogg (2010), Japanese-Americans, who expected nurses to know best, would not make requests for pain medication but instead expected the nurses to meet their needs. Yet another example of the consequence of not providing competent care within the context of the patient's culture was a Korean mother who blamed her child's illness on the nurse who affectionately patted her son on the head. In the Korean culture, as in many other Asian cultures, touching someone's head has an association with trying to "steal his or her soul" (Salimbene, 2014). Based on the literature discussed, it was noted the importance of determining culturally competent care for the Hispanic American post-maternity patient.

Cultural Caring in Nursing Practice and Education

Swanson (2012) maintained that in recent years, most policy statements on nursing education indicated that nursing educators recognized the need to increase the cultural caring of the nursing workforce. Nursing faculty across the country, over the past 2 decades, have modified nursing curricula either by adding separate courses on cultural diversity or by integrating cultural diversity concepts into existing courses throughout the curricula (Chrisman, 1998). The National Council of State Boards of Nursing (2016) emphasized cultural concepts in the Detailed NCLEX-RN Test Plan. Organizations that accredit nursing educational programs require data on the recruitment and retention of faculty and students from ethnic backgrounds designated as minorities (Swanson, 2012).

Tanner (1996) posed the question, "How culturally-competent are we as faculty?" in an editorial in the *Journal of Nursing Education* (p. 291). Tanner proposed that the development of cultural caring among nursing educators is essential. Tanner (1996) also stated, "Too often, faculty is presumed to be competent in the very skills they are attempting to develop in their students, and

cultural caring is no exception" (p. 291). Koren (2010) also discussed faculty qualifications to teach cultural caring in nursing as one of the critical issues in adapting nursing curricula to meet the challenges posed by the diversification of society. Koren contended that many faculty who taught cultural caring in nursing had a lack of graduate training in cultural caring in nursing, and they taught from a common sense approach. Fewer than 20% of the participants reported learning cultural caring in nursing.

Some faculty reported teaching cultural caring in nursing lacked theory and did not provide appropriate clinical experiences to implement knowledge learned in the classroom. Koren (2010) stated that faculty needed to educate themselves in the field of cultural caring in nursing, so that they may serve graduate and undergraduate students responsibly and "…be effective teachers, mentors, and role models" (Leininger, 1995, p. 11).

Purpose of the Study

The purpose of this qualitative study was to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic maternity patients 2 to 4 weeks post-discharge. The significance of this study was to identify patients' perceptions of nurse caring behaviors that emphasized culturally competent care. Currently, there was a paucity of literature regarding patients' perceptions of culturally competent care. This information may aid in enhancing a culturally competent maternity care curriculum and patient centered design for Hispanic American maternity patients.

The main research question, which the researcher adopted from Liu et al. (2011), was "What are the lived experiences of Hispanic American maternity patients regarding their hospital stay during the birthing process through discharge from the hospital?" Specific questions that the researcher created to obtain information regarding the research question included:

1. What is it like to be a Hispanic giving birth here in the U.S.?
2. What customs, values, beliefs, and/or health practices do you use as a Hispanic giving birth?
3. What customs, values, beliefs, and/or health practices would you like your doctors and nurses to know more about?
4. What does it mean to be cared for when you are giving birth?
5. In what ways did the nursing staff help you as you gave birth?
6. What types of things did the nurses do that made you feel comfortable or cared for?
7. What types of things did the nurse do that made you feel uncomfortable or not cared for?
8. If this was not your first pregnancy, were there differences in how the nurses cared for you with your previous birth?

Definition of Terms

The following definitions applied to this study:

Culture. Culture refers to the sum of beliefs, practices, habits, likes/dislikes, norms, customs, and rituals learned in families during years of socialization and passed on through generations (Spector, 2013).

Cultural caring. Cultural caring is a process, not an endpoint, in which the nurse continuously strives to achieve the ability to work effectively within the cultural context of an individual, family, or community from a diverse cultural background (Campinha-Bacote, 1994).

Cultural competence. The components of cultural competence are cultural sensitivity, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 1999).

Significance of the Study

This study was significant because childbirth, as well as the time leading to the birth of the child, has social and cultural events that would be full of norms adhered to by pregnant women and their families. In most societies, the dominant culture would have a significant impact on the perception of health issues. The relevant healthcare institutions in Georgia contained the dominant culture. When the cultures of the healthcare providers and the healthcare service users were different, a major issue would develop. With the growth of the Hispanic population in Georgia, identifying culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients was significant to provide culturally sensitive care. The study was important and significant because taking into account cultural factors during the planning and delivery of maternity services would possibly lead to higher updates of services, as well as lower rates of maternal and newborn mortality (Coast, Jones, Portela, & Lattof, 2014).

Theoretical Perspective

Leininger's (2007) theory of culture care diversity and universality conceptualized the theoretical perspective for this qualitative study. Leininger's theory premised a holistic view of the individual. This view included the individual's cultural values, beliefs, behaviors, and symbols of care that influence health or well-being. Leininger conceptualized this theory in the 1950s and developed it for use by nurses and health professionals. Specifically, Leininger defined the theory as "the learned, shared, and transmitted values, beliefs, norms, and life ways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally" (Leininger & McFarland, 2006, p. 13). In order to improve the human condition, caring assists, supports, or enables individuals with cultural care needs. The culture care theory resided from the belief that "care is the essence of nursing and the central, dominant, and unifying focus of nursing"

(Leininger, 2007, p. 35). The culture care theory, and the research method associated with it, provide a means to generate new nursing knowledge in the area of caring. Within the framework of that theory, the current study examined the dynamics within the classroom. Leininger (2006) wrote that care is a phenomenon that requires understanding in order to guide nurses' actions. Caring is rooted in culture, and may be either abstract, concrete, or both. According to Leininger (2007), care could be generic or professional, and ethno nursing research provides a compass for discovering both. Leininger defined generic care as learned and transmitted lay, indigenous, traditional, or local knowledge and practices (Leininger, 2002; 2006) and professional care as formal and explicit cognitively learned professional care knowledge and practices (Leininger, 2007).

The theory also asserted that nurses should seek to discover diversity among cultures and universality about a cultural phenomenon through the ethno nursing research method. Leininger's (2007) ethno nursing research method focused on values, beliefs, and the ways of life for a particular culture. Leininger's holistic approach also focused on the care that promoted the health and well-being of people. In order to appreciate culturally appropriate care, the expression of a culture care phenomena such as comfort needs understanding. Both culture and care were significant to the discovery and understanding of illness, wellness, and other manifestations of health.

The study of culture care using Leininger's (2007) theory could help to uncover subtypes of care-related concepts; among them was comfort care. Comfort care is "essential to health and well-being" (Leininger & McFarland, 2002, p. 57). Leininger (2007) noted that caring was a universal phenomenon. Leininger also suggested that perceptions of caring may vary with one's

cultural background, which contributed to culturally learned behaviors, actions, techniques, processes, and patterns.

Leininger's (2007) assumptions chosen to guide this research were as follows:

1. Culture care concepts, meanings, expressions, patterns, processes, and structural forms of care are different (diversity) and similar (towards commonalities or universalities) among all cultures of the world;
2. Every human culture has generic (lay, folk, or indigenous) care knowledge and practices, and usually professional knowledge and practices, which vary transculturally;
3. Culture care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, religious (or spiritual), kinship (social), political (or legal), educational, economic, technological, ethno historical, and environmental context of a particular culture;
4. Clients who experience nursing care that failed to be reasonably congruent with the clients' beliefs, values, and caring life ways demonstrate signs of cultural conflicts, noncompliance, stresses, ethical or moral concerns, and slow recovery.

Leininger's (2007) assumptions about culture care concepts and congruency with client beliefs helped identify the caring behaviors that the participants perceived in the nurses who provided care. The researcher used Leininger's assumptions to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients 2 to 4 weeks post-discharge. Future researchers could use these findings to assist nurse educators to include more culturally sensitive caring behaviors for Hispanic American maternity patients in their curriculum.

Leininger (2012) contended 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, ethno history, environments, and healthcare systems. Furthermore, each culture has its own lay-care system, which reflects its cultural frame of reference. Professional nurses, on the other hand, represent the values of the professional healthcare system. When the two values meet without conflict, the care provided to the client is congruent and satisfying. However, when the client and professional nurse meet and their values conflict, there are cultural conflicts, stress, non-compliance, and imposition of professional values. Leininger (2012) further theorized that the congruence of the lay-care system and the professional healthcare system values are essential to helping people function, remain healthy, and survive.

Leininger (2012) conceptualized three modalities to guide nursing judgments including: (a) culture care preservation or maintenance, where there is no conflict between lay-care system and professional healthcare system; (b) culture accommodation/negotiation, where the client may demand accommodation to meet his or her needs; and (c) culture care repatterning and restructuring, where the nurse needs to sensitively work with a client to repattern a known harmful lifeway that could bring about unintended effects. Leininger (2012) believed that nurses must be knowledgeable about the cultural beliefs and practices of clients in order to better use any of these three modalities.

Leininger developed a visual diagram entitled Leininger's Sunrise Enabler Model (1991) to explain the Culture Care Theory. Dr. Marilyn McFarland and Dr. Hiba Wehbe-Alamah slightly modified this model (Figure 1) in 2015. The Sunrise Enabler Model was unique in its ability to capture the incorporation of social structure factors, such as religion, politics, economics, cultural history, life span values, kinship, and philosophy of living, as well as environmental factors as

potential influencers of culture care phenomena. The researcher utilized Melo's (2013) sub-items for the cultural and social structure dimensions of the Leininger's Sunrise Model (Figure 2) as a guide for better comprehension of the tenets of the Sunrise Model.

Leininger's assumptions about culture care concepts and congruency with client beliefs were used to help identify caring behaviors the participants identified in the nurses who provided care for them. Also, the assumptions guided how the nurses could have been more culturally sensitive. Leininger's assumptions may be used to help nursing educators formulate curriculum designed to enhance culturally sensitive content in maternity care.

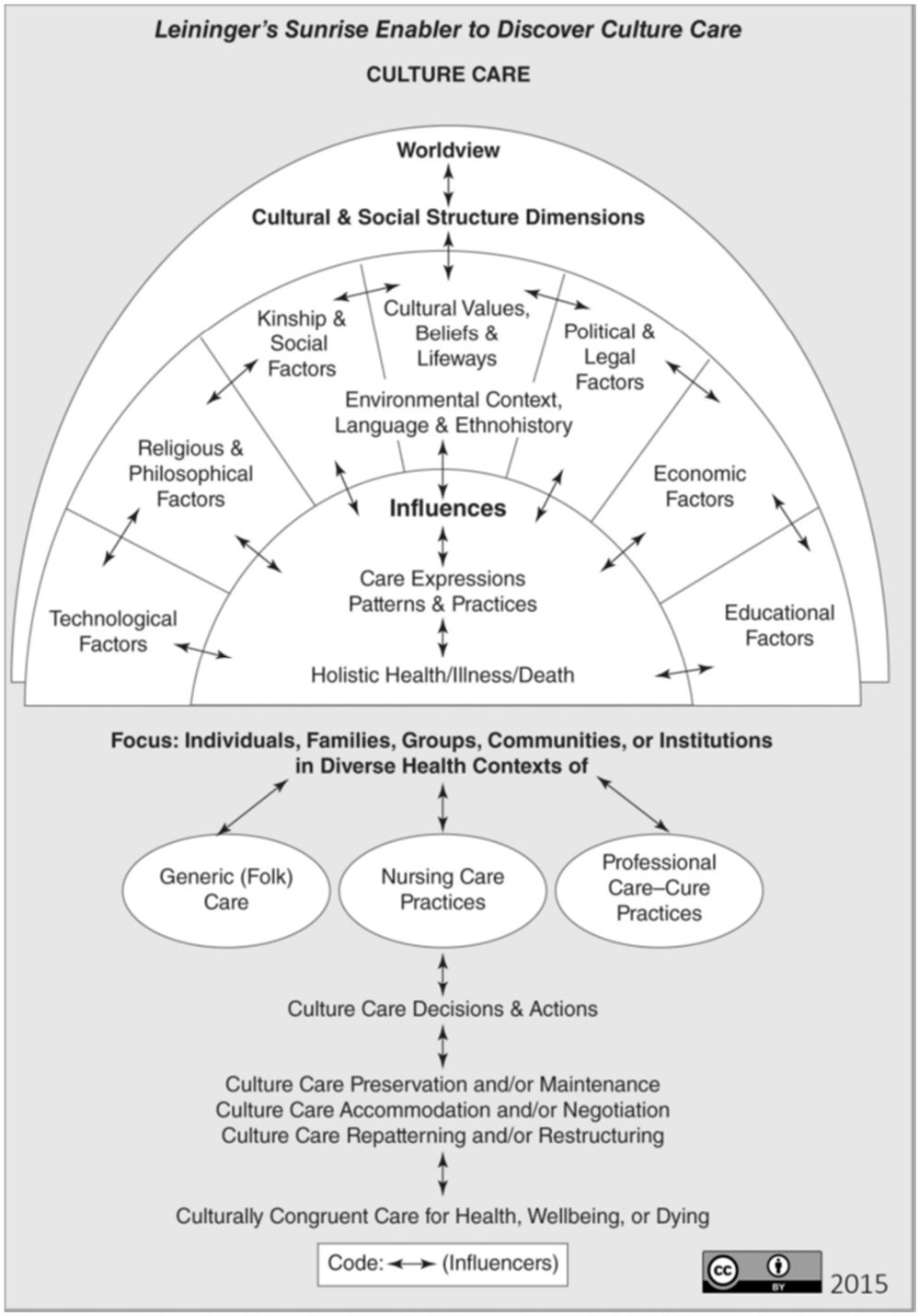

Figure 1. Leininger's sunrise enabler to discover culture care, modified by McFarland and Wehbe-Alamah (2015). Retrieved from http://www.madeleine-leininger.com/cc/sunrise2015.pdf.

Figure 2

Menlo's (2013) Description of the Sunrise Model

Dimensions	Descriptions
Technological Factors	Access to technologies of information, access to means of communication, access to media and press, access to electronic advices at residence, access to health services and technologies, and others.
Religious and Philosophical Factors	Religious practices, consultation to traditional healers, meanings of life, individual strength, beliefs, spirituality and health, personal values, norms and religious beliefs, freedom of thinking and expression, institutional values, priorities and goals, social roles, intra-institutional communication, inter-sector communication, inter-institutional communication, and others.
Kinship and Social Factors	Familiar structure, birth position in the family, family values, roles of the aged, head of household, composition of family, developmental tasks, social status, bereavement of parents, family disease, family kinship/relations, friendship relations, emotional-sexual relationships, emotional situation, networks and social supports, access to culture, leisure and sports, migration, gender relations, social norms, public security, citizenship, access to means of transportation, conjugality, violence, and others.
Cultural Values, Beliefs and Ways of Living	Beliefs, responsibility for health, folk practices of cure and care, perception of official health system, perception of health professionals, spirituality and health, cultural references, sexuality, race and ethnic group, access to culture and information, knowledge, attitudes, behavior, tobacco, alcohol, recreational drugs, physical activities, safety, interests, common foods, hygiene, world views, entertainment and leisure, alternative lifestyles, and others.
Political and Legal Factors	Access to public policies (security, health, education, environment, job, transports, social), access to justice, citizenship, political participation, freedom to think and express, intra-institutional communication, inter-sector communication, inter-institutional communication, and others.
Economic Factors	Familiar outcomes, informal job, formal job, outcome, social class, material situation (goods), work conditions, housing conditions, occupation/profession, buyout of consumer goods, cost of living, and others.
Educational Factors	Knowledge, access to education, literacy (read and write), reading and writing habits, type of school (private or public), schooling, access to information, school violence, intellectual performance, solution of problems, attention, and others.
Environmental Context	Destination of waste, public illumination, access to electricity grid, natural ventilation, drain, asphalt/pavement, septic tank, drinkable water, pollution (air, water, visual, noise), presence of vegetation or forest areas, presence of animals, goods supply (local commerce, to go to other locality, economic self-sufficiency), relations with the natural resources, access to drinking fountain, exposition to pesticide or fertilizers, exposition to chemical, physical agents etc., and others.
Language	Dominant language, contextual use, tone/volume, spatial distancing, eye contact, facial expressions, greetings, touch, language, dialect, and others.
Ethnohistory	Community history, population history, life history, total time living in the community, sense of belonging, social participation in the community, and others.

Source: Melo, L. P. D. (2013). The Sunrise Model: A contribution to the teaching of nursing consultation in collective health. *American Journal of Nursing Research*, 1(1), 20-23.

CHAPTER 2: REVIEW OF LITERATURE

In recent years, there has been a significant increase of the literature concerning increasing cultural diversity in the United States and the consequences of living in a multicultural society. One such consequence is the need for cultural caring in healthcare delivery. This was the focus of the current literature review, which included a historical perspective of cultural caring in nursing, which Leininger (2012) identified as the area of study, research, and practice in nursing focused on providing culturally competent nursing care. The literature on cultural caring in healthcare and on nursing emphasized the definition of cultural caring, as well as its essential components and examples of cultural differences affecting healthcare. Finally, the researcher reviewed a number of studies that examined the status of cultural caring in nursing practice and nursing education.

There were several approaches cited in the literature for increasing the diversity and cultural caring of nursing faculty. For example, Ryan, Twibell, Miller, and Brigham (1996) reported on a project where faculty members sought to increase their skill in teaching cultural caring in nursing by regional networking. Findings revealed that via regional networking, faculty members could determine barriers to teaching cross-cultural concerns, as well as identify the strategies best used to respond to these challenges. Ryan et al. (1996) called for proactive approaches in sharing sources in order to improve the cultural dimensions found in schools of nursing, especially in rural areas sorely lacking cultural diversity. In another project, seminars, print media, and videos educated nursing instructors to "teach and model cultural caring" (Chrisman, 1998, p.45).

In another project aimed at increasing the cultural caring of the workforce, a nursing faculty adopted a short-term cultural immersion and a nurse exchange between Mexico City and Dallas, Texas (Jones, Bond, & Mancini, 1998). Jones et al. (1998) explored a collaborative project designed to meet the unique cultural needs of the growing Hispanic population in a large public health system in Dallas formed among the three community systems of education, healthcare, and the business sector. Included in the project was a short-term cultural immersion program and the development of a nurse exchange program partnered with a sister hospital located in Mexico. Results demonstrated that the initiatives were successful in altering individual views and developing knowledge and skills. Community partnerships with strong commitment by top administrators to the individual level were effective in developing culturally skilled healthcare employees (Jones et al., 1998).

However, there were only three studies cited in the literature concerning the examination of nursing faculties' knowledge of or readiness to teach cultural caring in nursing. Yoder (1996) utilized a grounded theory study to identify the processes that nurse educators engaged in to teach ethnically diverse students. Yoder interviewed 26 nurse educators teaching in California and a group of 17 ethnic minority nurses composed of Asian-Americans, African-Americans, and Mexican-Americans. Yoder found that faculty members possessed varying degrees of cultural sensitivity.

Grossman, Massey, Blais, Geiger, Lowes, and Pereira (1998) surveyed deans and directors of Florida nursing programs regarding their approach to promoting and integrating cultural diversity. Among the 90 deans and directors surveyed, 51% provided responses. Based on the perceptions of the respondents, lack of cultural knowledge, sensitivity, and awareness are the critical issues that minority students face. The researchers concluded that even if there are already

numerous approaches to hiring ethnically diverse faculty and students, better resolution of the issues and barriers requires further action (Grossman et al., 1998).

Kelly (1991) surveyed a national sample of nursing faculty regarding their educational preparation in cultural caring in nursing. Forty-four percent (*n*=26) of the responding universities reported having faculty with cultural caring in nursing preparation; 71% (*n*=19) of the faculty members had taken academic courses in cultural caring in nursing, while 19.2% (*n*=5) held certifications in that field of nursing. The findings also indicated that 56% of all the surveyed universities and colleges had no faculty with cultural caring nursing preparation. Therefore, there is a need for further study of faculty preparedness in teaching cultural caring in nursing. Issues addressed included whether or not current nursing faculties possessed the awareness, knowledge, skills, and professional and personal commitment to prepare culturally competent nurses.

Suliman, Welmann, Omer, and Thomas (2009) explored Saudi patients' perceptions of important caring behaviors, and explored how frequently staff nurses attended these caring behaviors. Suliman et al. surveyed 393 patients across three hospitals located in three different regions of Saudi Arabia. Findings revealed that patients rated overall caring behaviors as important, and they frequently observed these behaviors in their nurses. However, there remained a discrepancy between what the patients perceived as caring and what they experienced. Suliman et al. argued that "many studies have shown that patient perceptions of caring may be incongruent with staff nurse perceptions, especially when the patient and nurses come from different ethnic or cultural backgrounds and hold different interpretations of concepts related to care and caring" (2009, p. 293). However, the majority of the research was non-empirical, and did not address pedagogical approaches to teaching culturally sensitive nursing care from the patients' perspective.

Additionally, several studies that examined the nursing care abilities of baccalaureate nursing students and professional nurses reported low cultural caring levels. Baldonado, Beymer, Barnes, Starsiak, Nemivant, and Anonas-Ternate (1998) used Leininger's (2007) theory of culture care diversity and universality as a framework to explore the transcultural practices of nurses and students. Surveyed registered nurses (RNs) and senior baccalaureate students yielded 767 usable sets of questionnaire responses. None of the nurses and students claimed to have confidence in care for culturally diverse patients. However, the RNs reported that they were considering cultural factors and then modifying their practices at a much more frequent rate compared to students. Nurses and students claimed that their beliefs about transcultural nursing resided from their interactions with patients of different values, cultures, and educational backgrounds. Both nurses and students claimed that there was an overwhelming need to have transcultural nursing. However, despite the efforts to prepare a more culturally competent nursing workforce in the formal educational setting, there were reports that not all students in nursing programs received adequate content in cultural caring in nursing and that the content was inconsistent (Baldonado et al., 1998). The readiness of nursing faculties to prepare culturally competent graduates has also raised questions.

Historical Perspective of Cultural Sensitivity in Nursing

Cultural sensitivity in nursing focuses on developing a body of knowledge through a comparative study of health-illness values, beliefs, and behaviors of people of different cultures. This knowledge helps to construct providing culturally competent nursing care.

Because cultural caring in nursing interested researchers, there was an expansion of knowledge about worldwide cultures resulting from research studies and scholarly discussions among the leaders in the field (Andrews & Boyle, 2010). The Transcultural Nursing Society

(TCNS) was founded in 1974; its mission was "to ensure that the culture care needs of the people of the world will be met by nurses prepared in cultural caring in nursing" (TCNS, 2002, Mission statement, para. 1). Research findings concerning the relationship between culture and the delivery of nursing care were disseminated worldwide through the *Journal of Transcultural Nursing*, the official journal of TCNS, originally published in 1988 with Leininger as its editor. The goal of developing nurses who could deliver nursing care that is culturally congruent (i.e., nurses with cultural caring) is now well accepted. In fact, in a monograph published in 2010, the American Academy of Nursing (AAN) issued priorities and recommendations concerning diversity, marginalization, and culturally competent healthcare (Meleis, 2010).

The AAN recommended that individuals, as well as institutions, make a commitment to culturally competent care, and that those nurse scholars, clinicians, and educators maintain expertise in this field of nursing (Meleis, 2010). Similarly, the AAN recommended establishing methods for teaching nursing faculty, as well as nursing students, to provide culturally competent nursing care. They further recommended regulating content reflecting cultural diversity in nursing schools' curricula with specific attention to continuing education and State Board examinations.

Many nursing programs have begun including more information in their curriculum regarding cultural diversity due to an increase in both culturally diverse student populations and admissions into healthcare facilities of individuals from culturally diverse backgrounds. Bednarz, Schim, and Doorenbos (2010) discussed the many challenges nurse educators face when incorporating the concept of cultural diversity in nursing education. Bednarz et al. utilized an extensive search of the literature to categorize the challenges as perils, pitfalls, and pearls, and provided elaboration on each area and means of meeting the challenges with successful outcomes. Bednarz et al. found that working with an increasingly diverse student body in nursing entailed

both perils and pitfalls. Some nurse educators believed that teaching diverse students and taking into account all of their needs required too much time and effort. Some even believed that because their own nursing learning experiences did not incorporate the concept of cultural diversity, there was no need to do so now. They believed that nursing students should experience struggles in learning in order to prepare for the difficulty of working in the non-academic world. Some believed that adapting to diversity was not part of their job description (Bednarz et al., 2010).

Sanner, Baldwin, Cannella, and Charles (2010) utilized a cultural diversity forum to increase students' awareness of diversity to increase their cultural sensitivity. Sanner et al. (2010) determined the effectiveness of a cultural diversity forum on nursing students' level of cultural sensitivity based on their openness to diversity. Forty-seven students from a public university located in the southeastern United States participated in a workshop designed as a forum. Using the Openness to Diversity/Challenge Scale (ODCS) to measure the construct of cultural sensitivity, the researchers determined that the program or workshop was effective. The ODCS scores revealed that students grew more culturally sensitive or open to diversity. The pre-test and post-test findings led Sanner et al. to suggest that educational forums, such as the cultural diversity forum, could increase most students' cultural sensitivity. Sanner et al. recommended further research in developing effective strategies to increase the cultural sensitivity of baccalaureate nursing students. However, some researchers have advocated the use of Watson's (2012) theory of human caring (Sitzman, 2007; Suliman et al., 2009) and Leininger's (2012) theory of culture care diversity and universality (Lancellotti, 2011; Nelson, 2006; Papadopoulos & Omeri, 2008) to introduce and teach nursing concepts regarding caring behaviors and cultural diversity.

Sitzman (2007) presented a brief overview of Watson's (2012) theory and explored how the theory helped the creation of a course for senior Bachelors of Science in nursing (BSN)

students. By observing the classroom, Sitzman (2007) found that many of the students initially did not know that there were many layers linked to professional caring. However, after they completed the coursework, many students realized these layers and even voiced their commitment to continue exploring and cultivating caring practices even after graduation. Nelson (2006) claimed that Leininger's (2012) theory was easy to understand, applicable across cultures, and easy to use by all healthcare providers who wanted to improve cultural sensitivity. In an editorial article, Papadopoulos and Omeri (2008) highlighted the importance of transcultural nursing, but also detailed the challenges of its application. Papadopoulos and Omeri claimed that transcultural nurses strove to make a difference in the health and well-being of patients, regardless of culture, by continuing engagement in looking for ways to help patients of diverse cultures.

Finally, researchers have contended there is a need to prepare nurses to provide culturally specific care for a diverse population. There is also a need for schools to respond to the needs of culturally diverse students (Mareno & Hart, 2014; Stanley, Hayes, & Silverman, 2014). Stanley et al. (2014) examined nursing students' perceptions on the diverse population they experienced through the clinical environments provided by their schools. Stanley et al. used Denzin's (2001) interpretive interactionism qualitative research method and found meaning among interview data from eight senior level baccalaureate nursing program students. Results indicated that both classroom and clinical experiences of the students were not enough to make student nurses recognize the importance of diversity in delivering care. Stanley et al. (2014) discovered insufficiencies in student nurses' classroom and clinical experiences to provide quality care. As such, the researchers called for more action on the part of nursing schools (Stanley et al., 2014).

Mareno and Hart (2014) discovered the same insufficiencies. Mareno and Hart compared the level of cultural sensitivity, knowledge, skills, and comfort of nurses with undergraduate and

graduate degrees to providing care to patients from diverse populations. Even though cultural competency was a core curriculum standard in nursing programs both at the undergraduate and graduate level, there was still a need to determine if this was enough. Using a prospective, cross-sectional, descriptive study design, the researchers surveyed 365 nurses on their perceptions of their programs. The research revealed that undergraduate degree nurses have lower scores compared to graduate degree nurses regarding their cultural knowledge. In addition, scores on cultural sensitivity, skills, and comfort with diverse patient populations were not different between the groups of students. Both groups of nurses reported that they received limited cultural diversity training in the workplace or even in professional continuing education. Mareno and Hart claimed nursing education needed to address more areas to improve its curriculum and recognize the importance of diversity.

Apart from the need for more culturally inclusive nursing curriculum, literature on nurses' perspectives of culturally diverse care demonstrated that more should be done better prepare nurses to offer culturally responsive care. Cioffi (2003) utilized a qualitative interpretive-descriptive design and interviewed 23 nurses regarding their experiences in communicating with culturally and linguistically diverse (CLD) patients. Interpreters and bilingual health workers conducted the study and utilized combinations of different strategies to communicate with CLD patients; some nurses showed empathy, respect, and a willingness to make an effort in the communication process, while others showed an ethnocentric orientation (Cioffi, 2003). Several other studies from the nurses' perspective (Kim-Godwin, Alexander, Felton, Mackeu, & Kasakoff, 2009; Owens & Randhawa, 2009) revealed the frustrations that nurses experienced when providing culturally sensitive care. Numerous studies from the patients'

perspective utilized quantitative instruments to identify culturally sensitive caring behaviors (Hicks, Tovar, Orav, & Johnson, 2011; Stepanikova, Mollborn, Thom, & Kramer, 2006).

Hicks et al. (2011) designed a focus group discussion with 37 Black and Hispanic men and women recently discharged from an urban academic medical center to determine the specific dimensions of these patients' experiences with care that affected their satisfaction levels. Hicks et al. found that Hispanics and Blacks differ when it came to the factors that shaped their experiences at the healthcare institution. Moreover, even though the patient satisfaction surveys did not measure these constructs, Blacks and Hispanics claimed that their satisfaction levels with the healthcare service they received were affected by the existence and accessibility of translators (for Hispanics), as well as the attitudes of the social workers and nursing staff who attended to them (Hicks et al., 2011).

Stepanikova et al. (2006) examined if racial disparities existed in patients' level of trust in their physicians. Through a survey that measured trust levels, findings revealed that minority users of healthcare services had lesser trust levels. Stepanikova et al. (2006) used survey data from the 2000-2001 wave of the Community Tracking Study (CTS) Household Survey conducted by the Center for Studying Health System Change (2003), and analyzed it using SUDAAN, statistical software by Research Triangle Park Institute. Results presented lower scores on indirect measures of trust in a physician among minority patients (n=37,103). However, when it came to trusting that their doctors would put patients' medical needs above their own, the findings showed no differences in the trust levels of the participants, whether they were minorities or non-Hispanic Whites (Stepanikova et al., 2006).

The researchers that used the qualitative method to describe the lived experiences from the patients' perspective were primarily conducted outside of the country; however, in the United

States, most studies did not include African-American or Hispanic ethnic groups (Chun, Chesla, & Kwan, 2011; Lipson, Weinstein, Gladstone, & Sarnoff, 2003; Ng, Popova, Yau, & Sulman, 2012; Owens, & Randhawa, 2009; Reitmanova, & Gustafson, 2011). In particular, Chun et al. (2011) explored how acculturation affected Type 2 diabetes management and the perceived health of Chinese-American immigrants in the U.S., focusing both on the patients' and their spouses' perceptions. Through interpretive phenomenology, findings revealed that patients and spouses' acculturation experiences affected their management and health through their utilization of healthcare, maintenance of family roles, as well as fostering of community ties. In particular, changing family roles and evaluations of diabetes care and physical environment also affected how the immigrants manage their diabetes.

Lipson et al. (2003) explored the health of the refugees from Bosnia and the Soviet Union living in the United States during the first few years after their resettlement as they attempted to integrate into society. In particular, Lipson et al. examined health, illness, and healthcare using patterns from refugees settling in northern California. Lipson et al. conducted database analysis, medical record review, as well as ethnographic study. The researchers found that the refugees would self-medicate first before approaching hospitals.

Ng et al. (2012) surveyed 279 Chinese in-patients to assess their satisfaction with their healthcare experience in Canada and evaluated how informed they were of hospital routines and how aware they were of Chinese cultural services on-site. Results were generally positive. In particular, findings revealed that patients were more satisfied if they were aware that there were appropriate Chinese resources in the hospitals, such as translators and social workers.

Multicultural Counseling

The literature also addressed the need for professional counselors to become more culturally aware to better meet the demands of an increasingly diverse patient population. Researchers have emphasized multicultural counseling with the goal of providing ethical and effective counseling interventions to culturally diverse clients (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992). Berger, Zane, and Hwang (2014) assessed therapist characteristics, therapeutic orientations, person-level, and agency-level practices on cultural competency of mental health clinicians. Berger et al. gathered data from 221 Los Angeles County mental health clinicians through an online survey, and the results indicated that compared to White therapists, ethnic minority therapists were more committed and involved in their jobs and patients. They were also more likely to utilize a cultural framework in clinical practices and view their agencies as more culturally sensitive. Ethnic minority therapists were also more multiculturally aware; therefore, they could foster better relationships with their clients (Berger et al., 2014).

Barriers to Care

Betancourt, Green, Carrillo, and Ananeh-Firempong II (2003) identified care barriers resulting in health disparities at the organizational, structural (agency), and clinical (client-provider interactions) levels from an extensive literature review that included searches in the *PubMed* database (*MEDLINE*, *PreMEDLINE*, and *HealthSTAR*) for the years 1977-2002, as well as searches of relevant government and foundation publications. An organizational barrier included the lack of availability of minority racial/ethnic healthcare providers, which resulted in inappropriate and unsatisfactory delivery of care for members of minority groups. Structural barriers caused communication problems, including a lack of interpreter services and of culturally and linguistically appropriate health education materials. Clinical barriers pertaining to the

interactions between the client and provider included the influence of sociocultural differences on the provider-client relationship and communication. These barriers in clinical encounters resulted in mistrust, dissatisfaction with care, poor adherence to prescribed regimens, and poorer health outcomes (Betancourt et al., 2003).

Trust influenced health disparities by affecting satisfaction with care, continuity of care with providers, and adherence to prescribed medical regimens (The Stanford Trust Study Physicians, 1999). In a quantitative, prospective, 6-month study assessing and validating the Trust in Physician Scale with 343 clients from primary care practices, participants identified trust as a significant predictor of satisfaction with physician care, continuity with the same physician, and self-reported adherence to medication. The effect of trust continued through the 6-month follow-up assessment (Thom et al., 1999).

Zekeri and Habtemariam (2010) suggested that mistrust influences health disparities, especially within the African-American racial group. A focus groups of 50 African-American undergraduate students identified mistrust as a factor influencing health disparities (Zekeri & Habtemariam, 2010). Participants in the focus groups discussed that mistrust of White healthcare providers and the healthcare system was prevalent and resulted in a reluctance to seek treatment for health conditions, including HIV/AIDS. Participants perceived that this mistrust stemmed from the Tuskegee syphilis experiments conducted by the government from 1932 to 1972 (Zekeri & Habtemariam, 2010).

According to the U.S. Office of Minority Health (OMH, 2001), the Institute of Medicine (IOM) has recognized and discussed the influence of trust and mistrust on clinical encounters and health disparities. The IOM viewed mistrust as a normal reaction stemming from explicit discrimination, aversion, or disregard demonstrated by healthcare providers or the healthcare

system that could result in refusal of treatment. The IOM recommended research into the sources of this mistrust. The OMH (2001), in the *National Standards for Culturally and Linguistically Appropriate Services in Healthcare* (CLAS), advocated for a healthcare environment in which clients from diverse cultural backgrounds were comfortable in discussing their cultural health beliefs and practices as they participated in the planning and implementation of their care plans. The OMH encouraged healthcare systems to establish an environment in which these clients could discuss their spiritual beliefs. This environment could only exist when a prevailing sense of trust existed between providers and clients, allowing for openness and discussion of concerns.

Style of Communication by Providers

Stewart, Nápoles-Springer, Gregorich, and Santoyo (2007) conducted a focus group study which consisted of 223 African-American, six White, two Latina, and two multiracial low-income women receiving prenatal care in a public health clinic. The researchers posited that communication styles included the rate and clarity of providers' speech, ability to elicit clients' concerns and the responses to them, use of medical jargon, and provision of appropriate and understandable explanations of test and assessment results. The researchers identified clear, respectful communication by providers (physicians, midwives, nurse practitioners, and physician assistants) as contributing to trust, resulting in increased satisfaction with care and greater adherence to prescribed regimens (Stewart et al., 2007). Participants expressed the importance of understanding issues related to their care and any negative issues concerning their health. In addition, participants expressed the importance of believing that the providers understood and empathized with their personal circumstances. Problems with communication related by participants included use of medical jargon, inability to understand non-U.S. born physicians,

perceptions of misinformation and withholding information, and that providers were not listening to them. These problems created barriers to trust (Stewart et al., 2007).

Residents of the South Bronx in New York City expressed similar problems with communication resulting in deep and pervasive mistrust (Kaplan et al., 2006). Participants in focus groups consisting of 78 African-Americans, 31 Hispanic, and one non-Hispanic White indicated that physicians had failed to take adequate time to answer their questions, listen and attend to their complaints, and communicate sufficiently. They related that the physicians used medical jargon and provided difficult-to-understand instructions about their care plans (Kaplan et al., 2006).

Respondents to The Commonwealth Fund's 2001 Healthcare Quality Survey identified communication factors leading to higher quality client-physician interactions (Saha, Arbelaez, & Cooper, 2003). The researchers discovered differences in the quality of provider-client interactions among the 1153 Latino, 621 Asian, 1,037 African-American, and 3,488 White respondents. Respondents identified factors leading to higher quality interactions and greater satisfaction with care, such as providers spending adequate time with respondents and adequately listening to their concerns. Analysis of Hispanics participants cited spending adequate time with patients was the only significant predictor of satisfaction (Saha et al., 2003).

Communication remained a vital component of cultural competence in medical care (Perloff, Bonder, Ray, Ray, & Siminoff, 2006). Perloff et al. (2006) presented an integrative perspective on the role that doctor-patient communication and cultural competency training play in healthcare disparities and found that congruent physician-client communication was crucial for the establishment of a therapeutic relationship and for the achievement of therapeutic goals. Physicians and clients from differing racial and ethnic background who were not language concordant experienced communication incongruence, which could result in misdiagnosis,

misunderstanding, the inability of the client to articulate needs, and a general breakdown in care (Perloff et al., 2006).

Interpersonal and Decision-Making Style

Decision-making style includes the consideration of the desire and ability of clients to participate in decisions about their care (Stewart et al., 2007). Participatory decision-making styles considered important in provider-client interactions predispose the provider to include the client in decisions (Saha et al., 2003). A telephone survey involving 1,816 African-American, Asian, Latino, and White clients found that greater participatory decision-making was associated with greater satisfaction with care (Cooper-Patrick et al., 1999). Participatory decision-making style was highest in race concordant relationships, with a significant and positive relationship found between race concordance and satisfaction with care. Saha et al. (2003) found an association between participatory decision-making and higher quality interactions. In addition, positive association with participatory decision-making among Latinos resulted in better use of healthcare services (Saha et al., 2003).

Additionally, interpersonal styles of providers and office staff included the amount of compassion and respect the client perceived during an interaction and the amount of ethnic/racial, economic, and educational discrimination and disrespect they perceived from providers and office staff (Stewart et al., 2007). Sheppard et al. (2009) found that expressions of compassion and respect, such as concern and empathy from providers, resulted in greater satisfaction with care for low-income women receiving care in a prenatal public health clinic. Termination of care resulted from insensitive and uncompassionate care. Participants expressed perceptions of discrimination from office staff due to race and lack of insurance coverage these perceptions resulted in mistrust (Sheppard et al., 2009).

Kaplan et al. (2006) used qualitative analysis of nine focus groups of 110 participants and identified interpersonal styles as a factor in the mistrust of providers and clinic staff by residents of the South Bronx in New York City. Participants related incidents of racism, as well as feelings of being disrespected and undervalued, stigmatized, stereotyped, humiliated, and mistreated by providers and office staff, resulting in mistrust and in a reluctance to seek care (Kaplan et al., 2006).

Interpersonal styles of providers affected factors in the adoption of breastfeeding (Cricco-Lizza, 2006). Eleven African-American, low-income, prenatal and postpartum clients in a Special Supplemental Nutrition Program for Women, Infants, and Children clinic participated in an ethnographic study discussing breastfeeding. The providers' personal treatment and sensitive care facilitated their adoption of breastfeeding (Cricco-Lizza, 2006).

Measurement of Communication, Decision Making, and Interpersonal Style

The Interpersonal Processes of Care Survey (Stewart et al., 2007) obtained client information about disparities in the quality of care they received. The tool examined attributes of the interpersonal provider-client relationship including the interpersonal processes of communication, decision-making, and interpersonal styles. These important characteristics of the interpersonal provider-client relationship aided in positive health outcomes for those from minority groups, from lower socioeconomic groups, or those with limited English proficiency (Stewart et al., 2007). Clients responded to questions about the physicians' and office staff members' responses to aspects of communication, decision-making style, and interpersonal style from the past 12 months. Communication questions pertained to hurried communication, elicitation of client concerns, and appropriate explanations of test and assessment results. Patient-centered decision-making questions pertained to how the client and physician made

decisions about the client's healthcare. Interpersonal style questions pertained to the presence of compassionate and respectful interactions, discrimination, and disrespectful office staff (Stewart et al., 2007).

Cross, Bazron, Dennis, and Isaacs (1989) proposed an early and much-used model for cultural competence in their monograph. This model focused on cultural competence at the organizational level, but it was pertinent to understanding the concept at the agency and provider levels as well. According to this model, cultural competence is a set of congruent behaviors, attitudes, and policies that join in a system, agency, or among professionals, and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word "culture" implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (Cross et al., 1989, p. 13). The word "competence" implies having the capacity to function effectively (Cross et al., 1989, p. 13). Although the focus of the model was the cultural competence of organizations caring for seriously emotionally disturbed children and adolescents (Cross et al., 1989), the social work discipline (National Association for Social Workers, 2001) and the OMH (2001) have used this definition and these tenets to describe cultural competence. The OMH (2001) used the definition of cultural competence proposed by Cross et al. (1989) in the seminal CLAS document. This document provided 14 guidelines and mandates for the delivery of culturally and linguistically appropriate services at the organizational level (OMH, 2001).

Cultural competence at the organizational, structural (agency), and clinical (client provider interactions) levels was described by Betancourt et al. (2003). The previously mentioned extensive literature review identified the presence of barriers to care, as well as culturally competent interventions at all levels. Culturally competent interventions identified to address health

disparities at the organizational level included ensuring diversity in the leadership and workforce of the healthcare system by increasing the numbers of racial and ethnic minorities represented. Structural interventions included innovations in healthcare system and structure design to assure that ethnic and racial minorities had full access to quality healthcare. This category included interpreter services and culturally and linguistically appropriate educational materials. A clinical level intervention increased efforts to provide cross-cultural training for providers to enhance their cultural competence. Salient topics suggested for this cross-cultural training included the effects of communication styles and decision-making preferences and the issues of mistrust, prejudice and racism, along with their effects on care delivery (Betancourt et al., 2003).

Despite differences in definitions of cultural competence, researchers have recognized the influence of culture on health beliefs and behaviors and the need to provide quality healthcare to individuals from racial and ethnic minorities at all levels of the healthcare system (i.e., organizational, agency, and provider). Researchers identified the importance behind awareness of personal cultural beliefs, biases and stereotypes, and client cultural beliefs and behaviors. The awareness of the influence of this knowledge on care provision leading to the ability to plan and implement individualized care at all levels of the healthcare systems remained an important point. The ultimate goal was to provide acceptable, individualized cultural care to all clients.

Cultural competence was an ongoing process with the provider always striving for cultural competence (Campinha-Bacote, 2003; Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007). Campinha-Bacote's (2003) model of cultural competence in healthcare delivery considered cultural competence as an ongoing process where "the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the client (individual, family, community)" (p. 14). Campinha-Bacote believed that the healthcare provider

was constantly *becoming* culturally competent rather than *being* culturally competent (Campinha-Bacote, 2003). On the other hand, Giger et al. (2007) defined cultural competence as:

> …having the knowledge, understanding, and skills about a diverse cultural group that allows the healthcare provider to provide acceptable cultural care. Competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural competence includes having general cultural as well as cultural-specific information, so the healthcare provider knows what questions to ask. (p. 100)

Cultural competence was also indicated to be a goal that professionals, agencies, and systems continuously strived to attain (Cross et al., 2013; OMH, 2001) and does not have a specific endpoint (Sue, Arredondo, & McDavis, 1992). Sue et al. (1992) defined cultural competence as awareness of one's own biases and personal worldviews, while at the same time, being sensitive to the effect these beliefs have on one's practice.

The process of cultural competence is nonlinear, with organizations and providers progressing through various stages. Cross et al. (2013) posited that when striving toward cultural competence, organizations moved through a developmental process along a six-point continuum through cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and finally to cultural proficiency. Purnell and Paulanka (2003) believed that providers progressed toward cultural competence through four levels: unconsciously incompetent, consciously incompetent, consciously competent, and unconsciously competent. The levels of unconsciously competent and cultural proficiency were not considered endpoints; rather, individuals and organizations respectively strove to attain higher levels of cultural competence by

conducting and participating in research pertaining to cultural competence (Cross et al., 1989) and continually learning about various cultural groups (Purnell & Paulanka, 2003).

Factors Associated with Cultural Competence

Ethnic matches influenced African-American clients' opinions of their physicians' participatory decision-making styles (Cooper-Patrick et al., 1999). In the previously mentioned study of 1816 respondents to a phone survey, 784 White and 814 African-American clients provided data regarding the participatory decision-making style of their physicians. They also provided their level of satisfaction with overall healthcare; their physicians' technical skills (thoroughness, carefulness, and competence); and explanation of their problem and its treatment, and personal manner (courtesy, respect, sensitivity, and friendliness; Cooper-Patrick et al., 1999). Findings revealed that African-Americans rated their visits as significantly less participatory as Whites did when making adjustments for client age, gender, education, marital status, health status, and length of physician-client relationship. Clients in race-concordant relationships with their physicians rated their visits as significantly more participatory than did clients in race discordant relationships, resulting in higher satisfaction with care (Cooper-Patrick et al., 1999).

Ethnic matches in the client-counselor relationship became a factor in cultural competence, resulting in more favorable treatment outcomes for clients receiving care from counselors (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). A variation of this type of match, cognitive match, may also be a factor in cultural competence resulting in more favorable treatment outcomes. The researchers investigated the effects of cognitive matching in the client-counselor relationship by utilizing a survey of 27 White and 33 Asian-American clients from a community mental health agency. Findings revealed positive treatment outcomes in the cognitively matched dyads. Participants who were cognitively matched with their counselors in perceptions of the presenting problem, coping

orientation (active or avoidant), and expectations about treatment goals felt more affected by the sessions, and more comfortable and positive about the sessions. After controlling for ethnic match and language preference, cognitive matches still resulted in positive findings (Zane et al., 2005). Results from this study implied that while ethnic match may be a factor in cultural competence, cognitive match might be an even stronger factor. Even if counselors were not similar ethnically, they could still effectively try to understand clients' perceptions about problems, coping methods, and types of goals expected in treatment.

Cultural Competence and Maternity

Researchers have established that childbirth and the time around birth is a social and cultural event influenced significantly by norms (Gabrysch & Campbell, 2009a, 2009b; Glei, Goldman, Rodriguez, 2003). In most societies, the dominant culture, which could influence social institutions like healthcare systems, could also affect perception on how to address certain health issues. Moreover, differences between the cultures of healthcare services and service users have become an important issue in the delivery of healthcare service. Patients who perceive that their healthcare providers are insensitive to their cultures also perceive poor quality care. Insensitivity could also lead patients to have lower trust in the services they received and the service providers attending to them (Gabrysch & Campbell, 2009a; 2009b).

Researchers and organizations have demonstrated that cultural factors should be considered in the planning and delivery of maternity care services in order to effectively encourage patients to use their services and reduce maternal and newborn mortality (Camacho, Castro, & Kaufman, 2006; United Nations Population Fund [UNFPA], 2005; WHO, 2003). Moreover, the need for culturally sensitive and appropriate health services and facilities formed the basis of the WHO (2007) mandate of "health for all."

Several researchers have highlighted the importance of cultural sensitivity in maternity care (Coast et al., 2014). These studies revealed that cultural factors could naturally influence the use of skilled maternity care services in different contexts. Coast et al. designed a synthesis of literature that evaluated if cultural factors shaped women's use of maternity services. Gathering materials published from 1990 to 2013, the researchers revealed that cultural factors affected how women utilized maternity services. In particular, this affected how satisfied women were with the services they received. Perceived or actual cultural insensitivity, as well as incompetence of professionals, could lead some women to complain of poor quality care or even cite discrimination. Perceived insensitivity could also discourage women from using certain maternity services (Coast et al., 2014). As such, there were various interventions implemented across countries to address culture consideration when offering maternity services. These interventions included service delivery models, service provider interventions, health education interventions, participatory approaches, as well as mental health interventions. Coast et al. designed these interventions with the idea that cultural factors were important for planning and delivery of services to encourage service uptake among women of various cultural backgrounds (Coast et al., 2014). Small et al. (2014) also asserted that understanding the experiences of pregnant immigrant women was important if the host country wanted to ensure that it was responding appropriately to the phenomenon of increasing global migration. Through a systematic review including studies published from 1989 to 2012, results indicated that immigrant women and local women both desire the same thing: to have a safe delivery under the hands of qualified, attentive, and supportive healthcare providers. Their results also indicated that immigrant women often felt less positive about the care they received because of communication barriers and lack of familiarity with the maternity system of the host country.

Boerleider et al. (2014) cited that cultural practices, lack of knowledge of the maternity care system in the host country, and communication barriers could all affect non-Western women's experiences and perceptions of maternity services provided to them by professionals in their resident western countries. A study interviewing 15 maternity care nurses and assistants on their perceptions of caring for non-Western women revealed that issues concerning traditional practices, socioeconomic status, and communication could make caring for non-Western women difficult and challenging. As such, specific skills and measures were necessary to ensure culturally sensitive maternity services.

Attanasio and Kozhimannil (2015) utilized a cross-sectional, nationally drawn, Web-based survey of women aged 18-45 (*n*=2400). The researchers claimed that Hispanic women highly perceived discrimination in the maternity services they received due to race and ethnicity. Garcia-Esteve et al. (2013) highlighted the problems faced by Hispanic immigrant mothers in relation to postpartum depression and health behaviors. They discovered that Hispanic immigrant mothers were socioeconomically disadvantaged, younger, and had unsupportive partners. These factors made them more likely to develop postpartum depression and unsavory pregnancy habits, including unplanned and induced abortions. They needed culturally sensitive maternity services to address their unique psychosocial and perinatal mental health needs (Garcia-Esteve et al., 2013).

Experiences of Hispanic Patients

Research involving only Hispanic patients was very limited. A study consisting of dyads of 116 clients and their physicians from primary care clinics noted the influence of language on cultural competence in the care of Spanish-speaking clients (Fernandez et al., 2004). The study explored the specific ways that language ability affected health communication for Spanish speakers, and determined if aspects of physicians' self-rated cultural competence—other than

Spanish language skill—affected health communication. Findings revealed that when physicians had a greater self-rated fluency in Spanish and higher self-rated cultural competence, the Spanish-speaking clients were more likely to discuss their problems and concerns. Additionally, physicians with low self-rated fluency in Spanish who used professional interpreters were unable to elicit clients' problems and concerns as competently as the Spanish-speaking physicians could (Fernandez et al., 2004). Findings supported the importance of language concordance and cultural competence in helping Spanish-speaking clients discuss their problems more openly, resulting in higher quality of care and a reduction of health disparities.

Hispanics' Cultural Beliefs on Childbirth Healthcare Services

Leach, Wojnar, and Pettinato (2014) deigned a descriptive phenomenological investigation of miscarriage experience among Latina immigrant women in the United States and Canada. Gathering data from nine women through in-depth interview, Leach et al. found that cultural expectations influence the experience of miscarriage and healthcare services sought afterward. Results showed that most Latina immigrants who experienced miscarriage think it is right to just internalize their grief. However, in reality, they are longing for the support of healthcare providers and friends, apart from their family. The findings may serve as an important framework for understanding the healthcare needs of Latina women after miscarriage (Leach et al., 2014).

An earlier study by Lujan (2010) found that religious beliefs of Hispanic clients can affect their access to healthcare during childbirth. According to Lujan, 80% of Hispanics in the United States are Catholic, even though a percentage of this also practices Protestanism. Although only a few Hispanic Catholics are officially enrolled in parish rosters, religion becomes more important for them when confronted with health challenges such as childbirth, illness, and death. For healthcare to be considered culturally competent, the religious beliefs and activity of Hispanic

clients should be assessed by healthcare providers. Some clients would even be more satisfied with providers who would refer them to the clergy or pastor to receive some care in a timely manner.

Juliane Milburn of the University of Virginia School of Nursing doctoral candidate reported that Hispanic pregnant women form a unique group of women because they are less likely to utilize pain relief in labor (UVA Today, 2014). According to a 2011 CDC report, there was an increasing number of women who would opt to use epidural during vaginal births. However, most Hispanics prefer to experience childbirth pain in full because of their cultural beliefs, which include their religious beliefs. Nearly 45% of Hispanic women refused to take an epidural, compared to just 26% of women from all other races. Interviewing 17 Hispanic mothers nationwide for 2 years, Milburn uncovered several themes on Hispanic mothers' access to healthcare. The researcher found that Hispanics believe labor and childbirth are battles they must brave and overcome (UVA Today, 2014). In addition, they believe that pain is a natural part of the process and therefore should not be suppressed. They believe the pain will be better for the babies. Based on their religious beliefs, a mother's role is perceived by Hispanics as akin to that of the Virgin Mary's—a sacrifice that they should make, no matter how painful it is to give birth (UVA Today, 2014).

Nursing

Cultural competence is essential in nursing, as nurses are at the forefront of providing care to clients at the bedside and in the community (Bau, 2007). The Code of Ethics for Nurses identified the core values of nurses as respect for human dignity, a primary commitment to the client, and protection of client privacy (ANA, 2011). Cultural competence was an outgrowth of these core competencies, which apply when nurses provide care that is sensitive to the needs of all clients, regardless of racial or ethnic background. In addition to the Code of Ethics for Nurses,

which indirectly addressed cultural competence in nursing overall, the Quad Council of Public Health Nursing Organizations (PHN) identified competencies related to cultural competence for public health nurses (Quad Council PHN Competencies, 2011). Domain #4 identified cultural competency skills in which the public health nurse should show proficiency, such as using appropriate skills for interacting sensitively, effectively, and professionally with clients from diverse racial and ethnic backgrounds. Additionally, the public health nurse was to identify the role of culture in determining the delivery of services and to adapt approaches to problems that account for cultural differences (Quad Council PHN Competencies, 2011).

The constructs of cultural diversity, cultural knowledge, cultural understanding, cultural skills, cultural sensitivity, and cultural sensitivity comprise cultural competence in nursing. Researchers have performed concept analyses that have identified these constructs as antecedents of cultural competence. Identification has also occurred in regards to attributes and consequences of cultural competence (Burchum, 2002; Smith, 1998; Suh, 2009). Attributes of cultural competence in nursing included ability, openness, and flexibility (Suh, 2009). Ability measures the nurse's skill in effectively caring for ethnically diverse populations, while openness involves nurses having an open mind, acceptance, and respect, as well as being nonjudgmental and having an objective attitude to cultural attributes. Flexibility includes an ability to adapt oneself to different situations by embracing relativistic perspectives, intersubjectivity, and commitment to and appreciation of other cultures. Identified antecedents to cultural competence in nursing included cultural sensitivity, cultural knowledge, cultural interaction/encounters, and cultural skill (Burchum, 2002; Suh, 2009).

These antecedents are similar to constructs named in theoretical frameworks describing cultural competence (Campinha-Bacote, 2003; Kim-Godwin, Clarke, & Barton, 2001; Schim,

Doorenbos, & Borse, 2006). Burchum (2002) proposed that cultural understanding is an antecedent, and described it as "ongoing development of insights related to the influence of culture on the beliefs, values, and behavior of diverse groups of people" (p. 7). This related to the previously discussed constructs of cultural sensitivity and awareness.

Burchum (2002) also proposed that cultural proficiency represented a commitment to change. Some activities that demonstrated evidence of cultural proficiency were those that provide for new knowledge and cultural skills and the sharing of this information through publication, education, or other means (Burchum, 2002). Smith (1998) included cultural liaisons and linkages as antecedents to cultural competence in nursing. Cultural liaisons and linkages were important to overcoming economic barriers to care access. Smith (1998) proposed a greater distribution of culturally competent healthcare providers as a means to help overcome these barriers (Smith, 1998).

Consequences of cultural competence in nursing found in the client's subjective experiences when receiving culturally-competent nursing care included holistic nursing care, increased quality of life, good perceptions of healthcare providers and adherence to treatment, client empowerment, feelings of respect, decreased anxiety and fear of the healthcare system, greater percentage of cultural group members seeking and receiving appropriate healthcare, and greater satisfaction with the healthcare system (Smith, 1998; Suh, 2009). Additional consequences of cultural competence included increased quality of nursing care, performance, and cost effectiveness with the overall outcome of decreased health disparities (Suh, 2009), and improved health status of minority populations (Smith, 1998).

Various factors influenced the cultural competence of nurses providing care in all settings, including the community. Nurses' attitudes about caring for culturally diverse clients was central

to the construct of cultural sensitivity. A survey of 300 registered nurses (Whites, African-Americans, Jewish, and Latino) employed by hospitals and other healthcare facilities found that open- and closed-mindedness influenced nurses' attitudes toward culturally-competent care (Bonaparte, 1979). Open-minded nurses were more likely to have positive attitudes toward culturally diverse clients and more likely to seek information about the clients' diet, language, social patterns, values, and other factors that may influence nursing care, reflecting the value of the attribute of openness in cultural competence (Suh, 2009). Closed-minded nurses were more likely to demonstrate negative attitudes and to avoid clients from different cultures, consciously or unconsciously.

Factors influencing cultural competence of nurses providing care in the community include educational levels and participation in cultural diversity educational experiences. Findings from a survey of 107 hospice nurses showed cultural sensitivity and awareness significantly associated with the nurses having a baccalaureate degree or higher. Prior diversity training was significantly associated with cultural competence behaviors (Schim et al., 2006). A sample of 113 interdisciplinary hospice workers, 40% of whom were nurses, discovered similar findings (Doorenbos & Schim, 2004). Participants reporting participation in a previous diversity training experience and those who had baccalaureate degrees or higher had significantly higher cultural competence scores (Doorenbos & Schim, 2004). Seventy-six public health nurses participated in a study measuring cultural competence prior to and after a 5-week cultural competence workshop (Cooper-Braithwaite, 2005). Findings revealed that nurses with higher levels of education further increased their levels of cultural competence and cultural knowledge compared with nurses with lower levels of education (Cooper-Braithwaite, 2005).

Overall, the nurses' levels of cultural competence and skill increased significantly after the workshop (Cooper-Braithwaite, 2005). Qualitative and quantitative findings indicated that participants experienced higher levels of self-confidence in caring for diverse populations after the intervention. Participants reported a change in behavior and practice, application of knowledge to practice, heightened cultural sensitivity, and a greater willingness to conduct cultural assessments on clients from diverse ethnicities because of the educational intervention (Cooper-Braithwaite, 2005). Similarly, Schim et al. (2006), using a quasi-experimental, longitudinal, crossover design, tested the effects of an educational intervention by conducting a cultural diversity class with 130 hospice workers (41 nurses). Cultural competence scores increased significantly after the class for those in the intervention groups and for the wait list control group after they participated in the class (Schim et al., 2006).

The consequences of cultural competence in nursing include holistic nursing care, increased quality of life, good perceptions of healthcare providers and adherence to treatment, client empowerment, feelings of respect, decreased anxiety and fear of the healthcare system, greater percentage of cultural group members seeking and receiving appropriate healthcare, and greater satisfaction with the healthcare system (Smith, 1998; Suh, 2004). Open-minded nurses were more likely to have positive attitudes toward culturally diverse clients and more likely to seek information about the clients' diet, language, social patterns, values, and other factors that may have influenced nursing care, reflecting the value of the attribute of openness in cultural competence (Suh, 2004).

Additional consequences of cultural competence include increased quality of nursing care, performance, and cost effectiveness, with the overall outcome of decreased health disparities (Suh, 2004) and improved health status of minority populations (Smith, 1998). Closed-minded nurses

were more likely to demonstrate negative attitudes and consciously or unconsciously avoided clients from different cultures.

Educational levels and participation in cultural diversity educational experiences are also factors influencing cultural competence of nurses providing care in the community. The OMH (2001) in the CLAS advocated for a healthcare environment where clients from diverse cultural backgrounds feel comfortable in discussing their cultural health beliefs and practices as they participate in the planning and implementation of their plans of care. Findings support the importance of language concordance and cultural competence in helping Spanish-speaking clients discussed their problems more openly, resulting in higher quality of care and a reduction of health disparities.

Examination of the literature supported the need for more culturally competent healthcare providers and more research on factors that improves cultural care from the culturally diverse patients' perspective including Hispanic patients. Therefore, there was an inferred necessity for more research to improve cultural competence in nursing. Research involving the lived experiences in Hispanic American women after delivery would help close the gap in the research, and would improve nursing curriculums and aid nurses in becoming more culturally competent.

CHAPTER 3: METHODOLOGY

In this chapter, the researcher discusses the research methodology utilized in the study. This will include a qualitative research overview, a description of the data collection and analysis, and the instrumentation and procedures.

Qualitative Research Overview

The researcher utilized the qualitative research method. Previously, qualitative research inquiry was unacceptable as a legitimate mode of inquiry for the social behavioral and health sciences. However, within the last 14 years, it has become more accepted (Creswell, 2012). There was a surge in qualitative methodology nursing research during the 1990s. The development of culturally appropriate interventions and gaining increased competence in the care of diverse populations have become apparent, as nursing discovered the richness of "thick description and the emic perspective" (DeSantis & Ugarriza, 2013, p. 353).

According to Creswell (2012), qualitative research:

> …is an inquiry process of understanding, based on a distinct methodological tradition of inquiry that explores a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 249)

There are five philosophical assumptions that construct qualitative research. These philosophical assumptions include the existence of physical life with multiple realities (ontology), the representation of the theory of knowledge (epistemology), the researcher's acknowledgement that the research is value-laden with biases present (axiology), the language of

research (rhetoric), and the ways of knowing the research process (methodology; Creswell, 2012). Creswell posited that qualitative research consists of several common characteristics, as follows:

1. The research is field focused with data collection obtained at the site of the participant's experience and with observation of behaviors and/or actions within their context;
2. The researcher collects his or her data and tends not to use questionnaires or instruments developed by other researchers;
3. The researcher utilizes multiple data collection forms such as interviews, observations, and documents, as opposed to a single data source;
4. The researcher explores patterns and categories from the broad to the specific, which may have involved collaborating with the participants interactively;
5. The researcher focuses on the participants' perspectives, their meanings, and their subjective views;
6. The research process evolves as the researcher takes cues from the participants' views of the problem or issue;
7. The cultural lens the researcher uses to view the study includes the framing of human behavior and belief within a social-political context;
8. The researcher uses observations from sight and hearing, and understands that multiple realities of the problem may emerge;
9. The researcher develops a complex picture of the problem or issue by identifying the complex interactions of factors in any situation. (pp. 37-39)

The purpose of this qualitative study was to identify culturally sensitive caring behaviors of

professional nurses, from the perspective of Hispanic American maternity patients 2-4 weeks post-discharge. The researcher also aimed to assist nursing faculty to include the identified culturally sensitive caring behaviors from the results to include in maternity nursing courses. The information gleaned from studying the experiences of several individuals, discharged 2 to 4 weeks from a mother/baby unit, aided the researcher in achieving the purposes of the research.

Design

This study utilized the phenomenological research design. The utilization of this design provided an opportunity to describe the meaning of experiences of a phenomenon (or topic or concept) for several Hispanic American individuals. Creswell (2012) noted,"In a phenomenological study, the researcher reduces the experiences to a central meaning or the 'essence' of the experience" (p. 236). The intent of phenomenological research was to capture the meaning of participants' lived experiences via an interpretive process that provided a fresh perspective regarding the phenomenon under examination. The researcher gathered the data and reduced it to significant statements and themes to develop a textual description of the subjects' experiences (how they experienced conditions, situations, or context). A combination of structural and textural descriptions observed by a researcher conveyed an overall "essence" of the experience (Creswell, 2012; Polit & Beck, 2011). Phenomenology contributed to a deeper understanding of lived experiences by exposing taken-for granted assumptions about the ways of knowing.

Setting

The setting of the study was at a Women, Infant, and Children's (WIC) Program at a county health department in rural Northeast Georgia. WIC provides women and children in low-income and culturally diverse families with services that improve pregnancy outcomes, reduce infant mortality, and give children a healthy start through nutritious food supplements and

nutrition education. These services include nutrition counseling and education, breast-feeding support and education, a health resource library, and vouchers for food supplements. The patient population was Hispanic American.

Sample

The interviewees in this study consisted of 15 women from Hispanic cultural backgrounds who were 2 to 4 weeks post-discharge from a mother/baby unit. All participants were all of Mexican origin. Quota sampling was the sampling technique used for this study (Acharya, Prakash, Saxena, & Nigam, 2013). Quota sampling was the best method to ensure proportionate representation of subjects, according to the trait that the researcher used as the basis for the quota. It was also the most appropriate method when the distribution of target population was already known across a set of groups, and when the researcher desired to have a representative for each population being studied (Brick, 2011). This method did not rely on random selection. There were already predetermined categories that the researcher used to identify who could fit into the study. Interviewers received participants until completion of quotas. This method was also the best method for making sure minorities had proportionate and proper representation into sample (Acharya et al, 2013; Brick, 2011). For the current study, the participants shared their experiences regarding culturally competent nursing care when delivering a live infant in the U.S. The researcher drew the convenience sample of 15 Hispanic women from a population of women participating in the local health department's WIC Supplemental Food Program. Recruitment continued until data saturation occurred. The researcher was aware that data saturation occurred at the point that the participants related no new information, achieving redundancy (Polit & Beck, 2011; Vandall-Walker, Jenson, & Oberle, 2012). Phenomenological studies' typical sample size may range from one to 10 persons (Morse, 2013; Starks & Trinidad, 2012). The inclusion criteria

consisted of: (a) a Hispanic American female between the ages of 20 and 35 years; (b) an English-speaking individual; (c) an individual participating in the WIC program; (d) an individual that was 2-4 weeks post-discharge from the mother/baby unit with delivery of a live infant from one of the two local hospitals; and (e) an individual with willingness to share her experiences regarding culturally-competent nursing care delivery on an obstetrical unit. Each participant received compensation of a $10 gift card from Wal-Mart.

Data Collection

The researcher collected data from September 2015 through October 2015, using 30-45 minute interviews with the selected interviewees. The interviewees completed a demographic questionnaire, which took approximately 10 minutes to complete (see Appendix E). The researcher then asked the interviewees to participate in a follow-up interview that was approximately 30-45 minutes. The format utilized for the individual and follow-up interviews were included (see Appendix B for the Interview Protocol, Appendix C for the follow-up Interview Protocol, and Appendix F for the Proposed Timeline).

To assist with the collection of data, the researcher utilized a field log, which included notations from the interviews. With permission from interviewees, the researcher audio-recorded and later transcribed all interview sessions. The researcher used a field diary to detail her thoughts, feelings, experiences, and perceptions throughout the research process. The field diary contained both descriptive and personal notes to help achieve analytic distance from the actual data (Polit & Beck, 2011). Areas of primary concern during data collection included gaining trust, the pace of data collection, emotional involvement with participants, and reflexivity (Polit & Beck, 2011).

Instrumentation

The primary instrument consisted of an interview using a semi-structured guide, which the researcher individually conducted (see Appendix B for the Interview Protocol). The researcher used the study of Liu et al. (2009), which examined the meaning of caring behaviors from the perspective of cancer patients in Beijing, China, to aid in the formation of a semi-structured interview format. The qualitative researcher maintained both validity and reliability throughout the steps in the process of research. Procedures to maintain reliability in this study included documenting as many steps of the procedures as possible, checking transcripts to ensure obvious mistakes made during transcription were not present, writing memos regarding the codes and their definitions, and constantly comparing data (Creswell, 2012). The validity of the research demonstrated such traits as trustworthiness, authenticity, and credibility. The following strategies demonstrated the validity of this study: member checking; using rich, thick description in discussing the findings; clarifying the researcher's bias; utilizing a second reader; and using discrepant information (Creswell, 2009).

Procedures

The researcher met with the gatekeepers at the health department. The researcher presented the gatekeepers with the cover letter defining the purpose of the study and a copy of the informed consent form utilized for the study (see Appendix A for the Informed Consent, and Appendix D for the Cover Letter). The completion of all necessary paperwork between the health department and The University of Alabama occurred prior to the researcher gaining entrance into the facility. Once the researcher gained admittance into the facility, the researcher met with the three nurses who worked with the WIC Program. The purpose of the meeting was to explain the significance of the cover letter that the nurses presented to the potential study participants. In addition, the nurses

provided the cover letter to clients who were in the 36th week of their pregnancy. The WIC Program nurses had the opportunity to ask the researcher questions during the meeting.

The second stage of the study started in September 2015, when the WIC Program nurses distributed the cover letters. The potential participants obtained the researcher's contact information from the cover letter, and at that time, contacted the researcher if the individual desired to participate in the study. Those individuals who agreed to participate in the study met with the researcher for a face-to-face interview 2-4 weeks post-discharge from a mother/baby unit. At the time of the initial meeting, held at the health department facility, the participant had the opportunity to read, ask questions, and sign the informed consent prior to the semi-structured interview.

The third stage consisted of analyzing the data. The researcher coded the data and identified overall themes. The researcher utilized a primary supervisor whose role was to assist in data analysis in the identification and verification of code names and themes. The researcher performed member checks on those individuals who agreed to participate. The researcher performed these member checks by restating and summarizing the information and then questioning the participants to determine accuracy at the completion of the interview. Finally, the researcher compiled the findings and discussed in the discussion section of the researcher's dissertation (see Appendix E for Proposed Timeline).

Data Analysis

The purpose of this qualitative study was to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients 2-4 weeks post-discharge. The best method to achieve insight into a study of this nature was a phenomenological approach. The main goal of phenomenology was to study how individuals

make meaning of their lived experience (Creswell, 2012, 2009; Polit & Beck, 2011; Van Manen, 1990). When conducting phenomenological studies, the researcher searched for common patterns shared by participants (Polit & Beck, 2011). Van Manen's (1990) three-step approach of analyzing phenomenological data included: (a) the holistic approach (researcher viewed the text as a whole and attempted to capture the meanings), (b) the selective approach (highlights statements or phrases that appeared essential to the experience), and (c) the detailed approach (analyzing each sentence; Polit & Beck, 2011). The researcher used this three-step approach to identify the themes in this study.

The researcher audio-recorded all interviews. Each interview lasted from 45 minutes to an hour. The researcher transcribed all interviews verbatim. First, the primary researcher read the transcripts completely. When reading, the researcher noted preliminary themes or ideas that stood out on a separate paper or in the margins of the transcript (Smith & Dunworth, 2003). Multiple reviews of lengthier transcripts aided in a better sense of information gathered (Smith & Dunworth, 2003).

After attaining a general sense of the transcripts, the researcher revisited the transcripts to determine the themes more accurately. The researcher divided the emerging themes into meaning units (Smith & Dunworth, 2003). Each meaning unit referred to a unique topic of the participant's experience of the phenomenon. To highlight each meaning unit, the researcher marked the start to the end of the meaning unit (Smith & Dunworth, 2003).

A code assigned to each meaning unit defined each meaning unit. To code each transcript, each meaning unit received a number recorded in the margins. Using a separate paper, the researcher recorded all the numbers from the transcript, and then recorded the corresponding code for each meaning unit against its respective number (Smith & Dunworth, 2003). The process of

coding each meaning unit allowed the researcher to make sense of the experiences of the participants through their verbal responses (Smith & Dunworth, 2003).

In succession, the researcher moved onto the next transcript only when she had completely analyzed the current manuscript. Each transcript used these steps until the researcher had analyzed all interviews (Smith & Dunworth, 2003). Aiding the coding process was the computer software program Nvivo 11. After the coding by hand, each transcript analysis used the Nvivo 11 software program. The researcher then re-coded each of the transcripts. The preliminary codes completed by hand served as a guide (Smith & Dunworth, 2003).

Once the researcher coded all of the transcripts using the Nvivo 11, the researcher grouped or categorized the codes into clusters. Each cluster of codes signified a similar topic or theme; therefore, a sub-theme inferred to each cluster of codes grouped together to present an overarching theme or master theme (Smith & Dunworth, 2003).

The researcher used similar codes to identify master themes, and continuously checked transcripts to see if the original code or sub-theme still aligned with the corresponding meaning unit, known as the audit-trail. The entire data analysis required the researcher's total immersion in the data.

On various points of the analysis process, and as the researcher coded the transcripts, the researcher consulted and verified code names and themes with their primary supervisor. The supervisor scrutinized the transcripts to confirm whether the evaluations remained correct and ensured the quality of material collected. Interrater agreement occurred on around 90% of master themes and sub-themes between the supervisor and the researcher. The researcher did not employ independent coders, as researchers in the literature have suggested (Smith & Dunworth, 2003).

Ethical Considerations

The researcher obtained approval to conduct the study from The University of Alabama's Institutional Review Board (IRB) and the health department's Institutional Review Board (IRB) prior to the start of the study. The researcher fully informed all informants about the purpose of the study. Participants maintained their anonymity, and their participation in the study occurred on a voluntary basis. The researcher informed all participants that they could withdraw from the study at any time without affecting their participation in the WIC Program.

Informed Consent

Prior to initiating all research, all universities require ethical standards for conducting research with human beings and most formally established research ethics committees and institutionalized procedures to guarantee that informed consent is obtained (Rudestam & Newton, 2012). According to Rudestam and Newton, an informed consent should contain the following elements: (a) information identified to the participant who is conducting the study, (b) information regarding why the particular person was singled out for participation, (c) information regarding the time commitment, (d) information regarding whether there are any expected benefits, (e) information regarding whether there were any potential risks and management of risks, (f) information explaining the study and offering to answer questions, (g) information explaining that participation remained voluntary, (h) information providing the participants with a copy of the informed consent form, (i) information advising the participants of any payment and explaining the limits of confidentiality to the participants, and (j) information about debriefing. The researcher included the previously listed elements in this study's informed consent form (see Appendix A for the Informed Consent Form).

Summary

The research methodology for this study was a phenomenological approach. Qualitative research was the best-suited approach for the participants to identify from their viewpoint how nurses demonstrated culturally sensitive care and how nurses could have been more culturally sensitive. The population of the study included the participants of the WIC Program. The author attained a sample of 15 participants from the population based on the inclusion criteria of: (a) Hispanic American females between the ages of 20 and 35 years, (b) English-speaking individuals, (c) WIC program participants, (d) patients 2-4 weeks post-discharge from the mother/baby unit with delivery of a live infant from one of the two local hospitals, and (e) willingness to share experiences regarding culturally competent nursing care delivery on an maternity unit. This chapter contained information on the data collection process and analysis. In the next chapter, the researcher presents the results and findings from the conducted study.

CHAPTER 4: PRESENTATION OF FINDINGS

The purpose of this qualitative study was to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients 2 to 4weeks post-discharge by analyzing the lived experiences of Hispanic American maternity patients in the United States. All participants were of Mexican origin. The demographic questionnaire was used to identify whether the participants spoke English on a regular or non-regular basis. The sample contained 15 participants. Three participants were between the ages of 20 and 24 (Participant 2, Participant 12, and Participant 14); six were between the ages of 30 and 34 (Participant 4, Participant 7, Participant 8, Participant 9, Participant 10, and Participant 15); and three were between the ages of 35 and 39 (Participant 1, Participant 11, and Participant 13); Nine participants were also non-regular English speakers (Participant 1, Participant 2, Participant 4, Participant 5, Participant 8, Participant 11, Participant 13, Participant 14, and Participant 15), and six were regular English-speakers (Participant 3, Participant 6, Participant 7, Participant 9, Participant 10, and Participant 12). Table 1 presents a summary of participant demographic information.

The researcher conducted data analysis using phenomenological analysis methods with the aid of the software program Nvivo 11. The researcher examined the themes, patterns, and relationships that emerged from data analysis contextually using Van Manen's (1990) reduction methods in phenomenological study. The researcher grouped information into large conceptual categories derived from theoretical frameworks. The researcher analyzed the interviews for broad themes, and coded these themes during analysis. The researcher used a translator to

interview participants who preferred speaking in their native language. The researcher coded several subthemes for to explain the variation in participant experiences. The researcher used five research questions to understand emerging themes and patterns in participant responses.

The researcher used two rounds of interviews to examine participant experiences. The researcher conducted Phase I interviews in person, and conducted additional telephone interviews during the Phase II stage to determine if additional information could be obtained. Telephone interviews lasted 5 to 7 minutes and were shorter than in-person interviews. Seven participants agreed to participant during the Phase II interviews. Four interviews were completed. One participant's phone number was no longer a working number, and the researcher could not contact two participants. Results from Phase II interviews confirmed findings from Phase I interviews. The researcher gleaned no new information from this step.

Differences in experiences between regular and non-regular English speakers and younger and older age groups were apparent. Older individuals (aged 30 to 39) experienced outcomes that reflected space, body, and time. These participants focused on the safety and future of their children, and had consistent birthing experiences over time. Non-regular English speakers described experiences that focused on space, body, materiality, and relationships. These participants expressed concerns about the future, patient treatment, modernity, respect and cultural competency, and well-being. The researcher documented the participants' education level, but education level only affected participant experiences within the imparting knowledge and information theme.

Table 1

Summary of Participant Demographic Information

Participant	Age Group	Length of time in U.S.	English Spoken in Home	Spanish Spoken in Home	Marital Status	Education	Para
1	35-39	10-14 yrs	No	Yes	Married	Some High School	6
2	20-24	20+ yrs	No	Yes	Married	HS Graduate	2
3	25-29	20+ yrs	Yes	Yes	Divorced	Some High School	7
4	30-34	10-14 yrs	No	Yes	Married	HS Graduate	1
5	25-29	10-14 yrs	No	Yes	Married	Some High School	3
6	25-29	5-9 yrs	Yes	Yes	Married	Some High School	3
7	30-34	15-19 yrs	Yes	Yes	Unmarried Couple	Some College	3
8	30-34	15-19 yrs	No	Yes	Separated	HS Graduate	2
9	30-34	15-19 yrs	Yes	Yes	Never Been Married	Some High School	4
10	30-34	10-14 yrs	Yes	Yes	Married	Some High School	3
11	35-39	20+ yrs	No	Yes	Married	Some High School	1
12	20-24	20+ yrs	Yes	Yes	Unmarried Couple	HS Graduate	1
13	35-39	10-14 yrs	No	Yes	Married	Some High School	2
14	20-24	10-14 yrs	No	Yes	Married	Elementary-MS	5
15	30-34	15-19 yrs	NO	Yes	Married	Elementary-MS	4

Research Question 1

The first research question was, "How does giving birth in the United States differ from other places?" This question centered on examining how participants had experienced birth in different geographical locations, while focusing on comparing experiences in the United States to other places. The researcher categorized themes under this question as birth experiences in the United States.

Birth Experiences in the United States

Several symbolic themes emerged in understanding birth experiences in the United States. Themes regarding the future of children in the United States were common in the participants.

Among this theme, the researcher found several subthemes, including opportunities available and success for both parents and children. Other main themes included better medical care, treatment of patients, and differences in care between the United States and other countries, and comfort. Table 2 displays the number of occurrences and percent of occurrences for the theme and subthemes. Six participants mentioned having a better future in the United States, three mentioned having better medical care, two noted differences in care in the United States, two mentioned better treatment of patients in the United States, and three mentioned having a more comfortable experience.

Better future. Six of the participants expressed the main theme of having a better future for themselves and their children when discussing experiences giving birth in the United States (Table 2). Concern for the future was more common in the older participants (age 35-39). Participants expressed the desire to provide more opportunities for their children, and they could achieve this by moving to the United States. Many of the participants also mentioned that having their children learn English was important for their success. A greater number of participants that did not speak English regularly felt that future opportunities for their children were important, whereas other themes came from participants that spoke English regularly. Regardless of whether the participant spoke English regularly, the participants considered English necessary for children to learn. Participant 1 did not speak English regularly, but she supported the theme by stating:

> "Being Hispanic in the United States is tough because there's not as many opportunities for me but there's a lot of opportunities for my children to have a better future."

Participant 10, who speaks English regularly, also supported the theme, but mentioned English as an important tool for success:

> "The experience was great, the most difficult thing ... most important thing was to learn

English to improve jobs and to improve the quality of life and the children's lives, English is very important."

Table 2

Summary of Findings for Theme 1: Better Future

	Number of occurrences (*n*=6)	Percent of occurrences (*n*=15)
1) The United States offers a better future for Hispanic individuals	6	40%
Subtheme: There are more opportunities for children in the United States	6	40%
Subtheme: Parents and children can both be more successful in the United States	5	33%

Better medical care. Having better medical care was also an important theme (Table 3 and 4). In addition, participants mentioned differences between care in the United States and in other places. There were two subthemes within the theme about differences in care, including quality of care and fear about the unknown. Many participants felt that the infrastructure of healthcare in the United States was better than in their home countries, and considered this factor when describing their experiences giving birth. Participant 8 mentioned fear about giving birth in the U.S., but noted that she was confident in the capabilities of the hospital staff. Participant 8 supported this theme, and mentioned:

"I went to the hospital scared because the first time they didn't make sure that I was not in pain, they just gave me the medicine but they didn't make sure that I was not hurting, so I was scared but this time everything went fine. This time everything was great, the nursing staff were there to give me medicine and food whenever I ask, so everything went fine."

Participant 6 speaks English regularly, and also supported this theme and mentioned:

"I really like the hospital and the infrastructure and the medical care especially, it's

amazing comparing to where I come from."

Table 3

Summary of Findings for Theme 2: Better Medical Care

	Number of occurrences (*n*=3)	Percent of occurrences (*n*=15)
2) The United States offers better medical care	3	20%

Table 4

Summary of Findings for Theme 3: Differences in Quality of Care

	Number of occurrences (*n*=2)	Percent of occurrences (*n*=15)
3) There are differences in care in the U.S. and in other places	2	13%
Subtheme: Quality of care	2	13%
Subtheme: Fear about the unknown	1	6%

Treatment of patients. The treatment of patients was the fourth main theme observed, and having a comfortable experience was the fifth main theme (Table 5 and 6). Participants that did not speak English regularly more often mentioned treatment of patients was an important factor. Participant 2, who does not speak English regularly, described this experience, stating,

> "I was born here and have been living here all my life, so it was like I am an American, I didn't feel rejected or anything."

Participant 8, who also does not speak English regularly, supported the positive treatment of patients theme stating:

> "It was great because I was treated well and well taken care of while in here in the United States."

Comfort was mentioned the most frequently in the youngest individuals (age 20 to 29). In this sense, comfort related to cultural acceptance and a sense of belonging. Participant 5, who does not

speak English regularly, described the positive theme of comfort stating:

> "I like being at the hospital because I felt cared for and important and well taken care of more than in my country, way more."

Table 5

Summary of Findings for Theme 4: Treatment of Patients

	Number of occurrences (*n*=2)	Percent of occurrences (*n*=15)
4) Patients are treated better in the United States	2	13%

Table 6

Summary of Findings for Theme 5: Comfort

	Number of occurrences (*n*=4)	Percent of occurrences (*n*=15)
5) The experience was more comfortable in the United States	4	27%

Research Question 2

The second research question was, "How do Hispanic women define care while giving birth?" Several themes emerged when examining customs and practices during the birthing process. This question focused on how participants connect with their bodies, care for their bodies, and experience bodily care. Themes fell into two categories, including experiences with customs and practices and meaning of care.

Customs and Practices

A large number of participants found modernity to be important due to safety concerns. Another common theme centered on rest and care, where several subthemes developed, including beliefs on covering and staying warm, health and diet, lactation, and adequate periods of rest. When discussing cultural beliefs, Participant 3, who speaks English regularly, stated:

"To cover yourself and stay home for 40 days and because you know you can get sick and that's bad for the baby but you always cover and make sure you protect yourself from the wind, it's very important. To get cold while you're lactating you will stop producing milk."

Themes on the importance of medical expertise and religion were also observed. Medical expertise was more often considered in older individuals (30-39), whereas rest and care was mentioned younger individuals (20-29). Two participants found medical expertise to be the most important factor, one believed in a mix of modern and traditional practices, five found modern practices to be the most applicable to their situation, two expressed religious desires, and five mentioned themes on rest and care.

Modernity. Modern practices were preferred in several patients. Table 7 displays the number of occurrences and percent of occurrences for this theme. This theme was more prevalent in married participants, but present across all age ranges. Leininger (2007) described the need to facilitate the maintenance of health and well-being through cultural care. From the participants' perspectives, modern practices were able to easily facilitate and maintain health. The participants linked modernity with better care due to the ability to receive care quickly from healthcare professionals in case there were problems. Participant 5, as a non-regular English speaker, supported this phenomenon:

"…I think that everything is going faster and it's better. You get attention right away which is great."

Table 7

Summary of Findings for Theme 1: Modernity

	Number of occurrences (*n*=5)	Percent of occurrences (*n*=15)
1) Use of modern practices is preferred	5	33%

Rest and care. Themes of rest and care were also significant during the study. Table 8 displays the number of occurrences and percent of occurrences for this theme. The researcher found four subthemes, including covering and staying warm, lactation practices, health and diet practices, and rest periods. This theme was congruent with the tenet of Culture Care Theory that acknowledged that every human culture has concepts of care knowledge and practice embedded and transmitted transculturally. Lactation was mentioned more often in younger individuals (20-29), whereas health and diet practices were mentioned relatively equally in the age groups. Health and diet practices were also equal between regular English speakers and non-regular English speakers and among married and unmarried individuals. Several participants mentioned customs that their families had passed down. Participant 2 does not speak English regularly, but described beliefs on health, covering, and lactation passed down through family members:

> "The pregnant woman should not step on the floor barefoot because it can lower the milk. The back shouldn't be left bare, it should be covered because that can affect the milk and that comes from my grandmother teaching me that."

Participant 12 is a regular English speaker, and described her family beliefs as:

> "With my family, every time you have a baby, you go and stay with your grandma or mom for 40 days and they give you some type of medicine and some kind of teas for you to clean out everything and be on a diet."

Participant 7 is a regular English speaker, and similarly described her experiences with health and diet practices passed down through family members:

> "As a custom, I drank green tea that I learned from my grandma when I had the pain in my stomach. I had a lot of air in my stomach, and the pain killers didn't do anything for it, so drinking green tea helped make me feel much better."

Participant 14 does not speak English regularly, but described her experiences with health practiced passed down through family members:

> "For 40 days you shouldn't drive and eat things that will hurt your lactation, those first 40 days you should take care of yourself pretty well."

Table 8

Summary of Findings for Theme 2: Rest and Care

	Number of occurrences (*n*=5)	Percent of occurrences (*n*=15)
2) Rest and care practices	5	33%
Subtheme: Covering and staying warm	2	13%
Subtheme: Lactation practices	4	27%
Subtheme: Health and diet practices	5	33%
Subtheme: Rest periods	2	13%

Meaning of Care

When addressing what it means to be cared for when giving birth, the researcher found several themes. Major themes that emerged included mitigating problems, safety, and treatment of patients. The researcher observed themes on doctor involvement and accessibility and respecting patient decisions. One participant discussed doctor involvement and accessibility, five discussed mitigating problems and safety, one discussed respecting patient decisions, and seven discussed treatment of patients. Several subthemes of the treatment of patients theme were also examined. Subthemes included care, being made to feel important, and patience. These themes were congruent with the tenet of Culture Care Theory that suggested culturally based care benefited and contributed to the well-being of individuals.

Mitigating problems and safety concerns. One major theme associated with care during the birthing process was mitigating problems and safety concerns. Table 9 displays the number of occurrences and percent of occurrences for theme 1. Participants from several age groups

mentioned this theme, but it was the most frequently mentioned in individuals between the ages of 30 and 39. This theme was also more commonly mentioned in regular English-speaking individuals. The ability to mitigate problems in an emergency situation was significantly important and considered an aspect of quality care to many participants. It is possible that many of the non-regular English speakers, who already believed medical staff was well-trained, considered the ability to mitigate problems as a skill embedded within the handling of the birthing process. Thus, they equated care with personal aspects, such as patience and respect. Participant 3, who speaks English regularly, highlighted the mitigating problems in an emergency theme in her response:

> "I believe that the doctor and the nurses that are taking care of me are good and it is very important to me that they stay on top of everything. If I have a hemorrhage or something like that, they would be there quickly."

In addition, Participant 10, who regularly speaks English, preferred the hospital for emergency problems by stating:

> "I had both of my children at the hospital because it's just safe to be there for your children, because anything can happen a risk or an infection or something you are in the hospital, you are taken care of. The hospital you are in God's, the doctors', and the nurses' hands, you know they're there for you and that you are okay because stuff can happen but you are in the hospital so you know that you are safe."

Table 9

Summary of Findings for Theme 1: Mitigating Problems and Safety Concerns

	Number of occurrences (*n*=5)	Percent of occurrences (*n*=15)
1) Mitigating problems and safety	5	33%

Treatment of patients. Another important theme associated with what it means to be

cared for was the treatment of patients. Table 10 displays the number of occurrences and percent of occurrences for Theme 2. This theme was associated with three subthemes, including being taken care of, being made to feel important, and having patience. Treatment of patients was mentioned more often in non-regular English speakers and married individuals, whereas the ability to mitigate problems was more often mentioned in regular English speakers. Being taken care of was mentioned equally across age groups, but patience was mentioned more frequently in younger individuals (age 20-29). The main theme and subtheme of being made to feel important was supported by comments from Participant 5, who does not speak English regularly:

> "I liked to be at the hospital because I felt cared for and important and well taken care of more than in my country, way more."

Participant 12, who speaks English regularly and was one of the younger individuals, commented supporting patient treatment in regards to patience:

> "Yeah, I was just so moody and they were still being nice to me and patient. I appreciate their patience they had."

Table 10

Summary of Findings for Theme 2: Treatment of Patients

	Number of occurrences (*n*=8)	Percent of occurrences (*n*=15)
2) Treatment of patients	8	53%
Subtheme: Being taken care of/assistance	8	53%
Subtheme: Made to feel important	3	20%
Subtheme: Patience	3	20%

Research Question 3

The third research question was, "What customs, practices, beliefs, or technology help Hispanic women give birth?" This research question examined how materials, beliefs, and

technology influence the birthing processes. The researcher grouped themes under this question into the categories of customs, practices, beliefs, and technology.

Customs, Practices, Beliefs, and Technology

Participants expressed themes about what they would like medical staff to know about rest, respect and cultural competency, medical expertise, and religion. Healing was also a theme that came up during analysis. Subthemes of medical expertise included having good training and providing information about patient concerns. Two participants mentioned healing, five mentioned medical expertise, three mentioned religion, and four mentioned respect and cultural competency as significant themes. The tenet of Culture Care Theory that focuses on the influence of worldview, language, religious and social aspects of a culture on concepts and practices of care was supported by these themes.

Modern medical expertise. Medical expertise was a major theme in patient preferences of what they would like medical staff to know. Table 10 displays the number of occurrences and percent of occurrences for this theme. Many participants felt that medical staff were trained well and needed to continue doing what they were doing. Participant 3, who speaks English regularly, supported the theme of trained staff with her response:

> "I thought that the nurses helped me a lot with learning about lactation and how to take care of the baby, tips that I didn't know about like how to take care of the baby."

Medical expertise was mentioned in all age groups and equally in regular English-speaking and non-regular English-speaking individuals, but occurred the most frequently with individuals between the ages of 30 and 39. Good training was mentioned more frequently in older participants (age 30-39). Participant 5, who does not speak English regularly, discussed medical expertise:

> "The health practices here are much better and doctors and nurses are great, they don't

need to learn anything else because they are going their job great."

One participant wanted medical staff to provide more information about patient concerns. Participant 13, who does not speak English regularly, discussed information about patient concerns and stated:

"I would like doctors and nurses to investigate about cancer and about AIDS because it's going around and you need more research about it."

Participant 12 speaks English regularly, and discussed learning the importance of abstinence after having a baby from family and medical staff, stating:

"Yeah, my grandma gave me 40 days before having more intimacy with my boyfriend and I waited 3 months. I wanted to make sure I was really healed because after I had my baby I was scared. I was, what if I stay like this? I was scared."

Table 11

Summary of Findings for Theme 1: Medical Expertise

	Number of occurrences (*n*=8)	Percent of occurrences (*n*=15)
1) Medical expertise	8	53%
Subtheme: Good training	7	47%
Subtheme: Providing information about patient concerns	1	6%

Respect and cultural competency. Respect and cultural competency was a significant theme for many participants. The number of occurrences and percent of occurrences for theme 2 is displayed in Table 12. Non-regular English speakers mentioned needs for cultural competency more frequently than regular English speakers. This is possibly due to experiences with language barriers and frustrations with medical staff not understanding patients. This theme was mentioned relatively equally among age groups. This theme was also mentioned more frequently in married

individuals. Participant 4 does not speak English regularly and discussed respect and cultural competence positively; when asked what she would like doctors and nurses to know more about, she stated:

> "They respect our practices, they know and value our practices and beliefs as Hispanics, they do respect it."

Table 12

Summary of Findings for Theme 2: Respect and Cultural Competency

	Number of occurrences (*n*=4)	Percent of occurrences (*n*=15)
2) Respect and cultural competency	4	27%

Religion. Religion was a theme mentioned by some participants. In Table 13, the number of occurrences and percent of occurrences is displayed for Theme 3. Religion was mentioned equally among age groups, married and unmarried individuals, and regular English speakers and non-regular English speakers. Patients expressed that they desired medical staff to understand their religious requests and respect their beliefs. Participant 6, who does not speak English regularly, supported the desire to have medical staff understand her religious request and beliefs stating:

> "I'd like nurses and doctors to know more about religion, for example praying before doing surgery on my baby boy and they insist a lot about birth control and I don't think that's okay to do. Yeah, because it's not my religion to do that."

Religion was one of the few themes that was equally expressed among several demographic groups. Participant 8, who does not speak English regularly, supported this theme and stated:

> "I'm Catholic, so I would like a little bit more time to pray and be involved with my religion a little bit."

Table 13

Summary of Findings for Theme 3: Religion

	Number of occurrences (*n*=4)	Percent of occurrences (*n*=15)
3) Religion	4	27%

Research Question 4

The fourth research question asked, "How do Hispanic women experience maternity care with hospital nursing staff?" In this question, the researcher analyzed relationships with medical staff, and grouped themes into three categories: experiences with staff assistance, experiences with comfort, and experiences with discomfort.

Staff Assistance

Main themes, including bedside manners, care, imparting knowledge and helpful information, and support were observed related to perceptions of staff assistance. Taking initiative was another observed theme. Subthemes centering on assistance with the baby, assistance with medical procedures, timeliness, and well-being and needs were observed with the care theme. Three participants mentioned bedside manners, seven mentioned care, five mentioned imparting knowledge and helpful information, three mentioned support, and two mentioned taking initiative. These themes support the tenet of Culture Care Theory that suggest that beneficial care only occurs when cultural values are known and used appropriately and in meaningful ways.

Bedside manners. Bedside manners were mentioned by some participants. Good bedside manners were characterized by tone, personable mannerisms, positive outlook, and respect for patients. Table 14 displays the number of occurrences and percent of occurrences for this theme. Bedside manners were more often mentioned in younger participants (age 20-29). Participants stated that the nurses were often nice, helpful, and positive, and this put the participants at ease and helped during the birthing process. Participant 9, who speaks English regularly stated:

"They were really supportive. Nice. Making sure you were taken care of." Participant 12, a regular English speaker, also supported this theme while describing her experience:

> "They were trying to keep me calm, because before I started pushing I was nervous and I was really scared for what I was going to go through, but they allowed my mom and my boyfriend and my grandma in there and they were just telling me to relax. I was just so nervous, and I just wanted the baby to get here already. They helped a lot."

Table 14

Summary of Findings for Theme 1: Bedside Manners

	Number of occurrences (*n*=3)	Percent of occurrences (*n*=15)
1) Bedside manners	3	20%

Care. Care was a significant theme described in participant experiences with the nursing staff. Table 15 displays the number of occurrences and percent of occurrences for this theme. Subthemes on assistance with the baby, assistance with medical procedures, timeliness, and well-being and needs were observed. Participant 9, who speaks English regularly, spoke positively in regards to the subtheme assistance with the baby:

> "I came to the office and told them that I wanted to breastfeed so they called the lactation nurse and she supported me even before my baby was here. When I was there at the hospital to have my baby, she came back and I was fine with breastfeeding."

Participant 12, who speaks English regularly, shared her experience with a medical procedure:

> "Yeah, I was induced because my blood pressure went up. They were trying to keep me calm, because before I started pushing I was nervous and I was really scared for what I was going to go through, but they allowed my mom and my

boyfriend and my grandma in there and they were just telling me to relax. I was just so nervous. I just wanted to get there already. They helped a lot."

Well-being and needs were mentioned more often in individuals in the 30-39 age group and timeliness was more frequently mentioned in younger individuals (age 20-29). Care themes were more often expressed in regular English-speaking participants than non-regular English-speaking participants. Care themes were also more often expressed in participants that had been living in the United States for a longer period of time. Participant 2, a non-regular English speaker, described themes of care and subthemes of timeliness and well-being:

"When I felt cold, the blankets were right there the next second. I felt that everything that was asked for was taken care of in a very timely manner and they were showing genuine care."

Table 15

Summary of Findings for Theme 2: Care

	Number of occurrences (*n*=8)	Percent of occurrences (*n*=15)
2) Care	8	53%
Subtheme: Assistance with baby	5	33%
Subtheme: Assistance with medical procedures	2	13%
Subtheme: Timeliness	4	26%
Subtheme: Well-being and needs	8	53%

Imparting knowledge and helpful information. Many participants stated that imparting knowledge and helpful information was a significant theme. The number of occurrences and percent of occurrences for this theme are present in Table 16. Participants stated that it was helpful when medical staff provided them with knowledge and information on healing and taking care of the baby. Participant 6, who regularly speaks English, remarked about her healing process and

receiving information about how to take care of her baby:

> "I learned about how to take care of the baby from the nurses. I couldn't get up because of my C-section and they changed the baby and helped me to the bathroom and with the medicine in a timely manner so it was great."

The providing knowledge and information theme was mentioned more frequently in regular English-speaking individuals. A higher number of participants with high school as the highest level of education received mentioned this theme. This was also more frequently mentioned with participants who had been living in the United States for 14 years or less. This theme was described in comments by Participant 3, a regular English speaker:

> "The nurses helped me a lot, they teach me how to lactate because I didn't know how to, they take me to the bathroom in a timely manner, bring me food and bathe me when I needed it."

Table 16

Summary of Findings for Theme 3: Imparting Knowledge and Helpful Information

	Number of occurrences (*n*=5)	Percent of occurrences (*n*=15)
3) Imparting knowledge and helpful information	5	33%

Support. Support was a common theme for participants. Table 17 displays the number of occurrences and percent of occurrences for theme 4. Support was more often mentioned in regular English-speaking participants. Support was mentioned with various ages, marital status, education level, and length of time living in the United States. While care and well-being were themes more often mentioned in non-regular English speakers, themes of imparting knowledge and support were considered more significant to regular English speakers. Participant 4, who does speak English regularly, supported the care and well-being theme by stating:

"They helped me with everything that I asked and encourage me in everything that I did. Everything was great. There was nothing that made me feel uncomfortable."

Table 17

Summary of Findings for Theme 4: Support

	Number of occurrences (*n*=3)	Percent of occurrences (*n*=15)
4) Support	3	20%

Comfort

Main themes observed included bedside manners, care, and support. Subthemes of the care theme included comfort, well-being and needs, and timeliness. Subthemes of the support theme included encouragement, personalization, and safety. Five participants mentioned bedside manners, seven mentioned care, and five mentioned support. These themes similarly support the Culture Care Theory tenet centered on beneficial care occurring through appropriate and meaningful mechanisms.

Bedside manners. Bedside manners was a theme also mentioned in the context of comfort. Table 18 displays the number of occurrences and percent of occurrences for this theme. In this context, bedside manners was associated with friendliness and attentiveness. Bedside manners was mentioned more frequently in older individuals (age 30-39) and in married, non-regular English speakers. Participant 10, a regular English speaker, supported this theme in her comments:

"The nurses were there to ask me how I was, every time to take care of the baby they were there all the time and taking well care of me that I had no complaints whatsoever."

Participant 13, a non-regular English speaker, also described her experiences and perceptions of comfort, stating that:

"Nurses often asked how you're doing and if you're feeling okay, so as you feel taken care of because they ask several times."

Table 18

Summary of Findings for Theme 1: Bedside Manners

	Number of occurrences (*n*=5)	Percent of occurrences (*n*=15)
1) Bedside manners	5	33%

Care. Care was a common theme expressed in participants. Table 19 displays the number of occurrences and percent of occurrences for theme 2. Subthemes of the care theme included comfort, well-being and needs, and timeliness. Timeliness was mentioned more often in younger individuals (age 20-29) and married individuals, whereas comfort and well-being were mentioned relatively equally among age groups, regular English-speaking, and length of time living in the United States. The care theme was generally more common among non-regular English speaking individuals. Participant 5's comments, as a non-regular English speaker, supported this theme:

> "I felt taken care of when my baby was coming. Well it turned out great because the baby was coming very fast and I felt that I was taken care for."

Table 19

Summary of Findings for Theme 2: Care

	Number of occurrences (*n*=10)	Percent of occurrences (*n*=15)
2) Care	10	67%
Subtheme: Comfort	3	20%
Subtheme: Well-being and needs	10	67%
Subtheme: Timeliness	5	33%

Support. Support was a common theme observed during data analysis. Subthemes of encouragement, personalization, and safety were observed in the main theme. Table 20 displays the number of occurrences and percent of occurrences for Theme 3. Encouragement centered on

making patients feel valued, personalization involved special accommodations made to make patients feel comfortable and cared for, and safety involved reassuring patients that everything would be find and that the hospital staff are capable of mitigating problems if needed. Support was mentioned more frequently in older individuals (age 30-39) and in married individuals, but was relatively equal among educational status. Encouragement was more significant in older individuals (age 30-39) and in non-regular English speakers. Participant 9 speaks English regularly and described themes of support in her comments:

> "When I had my third child they give me a little card that all the nurses that were in there in labor with me gave me, saying that it was really nice to work with me probably because I wasn't screaming. That's one thing that I remember that they did special. Other than that just being really attentive, like when I say I'm cold they got me a blanket, really nice, making sure that you had your water, and you weren't in pain."

Participant 15, a non-regular English speaker, also supported this theme by stating:

> "They are very patient and very nice and very supportive. My baby couldn't grab the nipple to drink milk and it was hard for her and made her very fussy, so the nurse helped me through the process of how to do it."

Participant 1, a non-regular English speaker, supported this theme, but also placed value on the quality of care received:

> "There was a lot of support from doctors and nurses because all the times I had to go to the hospital, I had to go alone. All the help that I got while I was there was very valuable to me."

Table 20

Summary of Findings for Theme 3: Support

	Number of occurrences (*n*=5)	Percent of occurrences (*n*=15)
3) Support	5	33%
Subtheme: Encouragement	5	33%
Subtheme: Personalization	1	6%
Subtheme: Safety	1	6%

Discomfort

The main themes reported when analyzing discomfort were the feeling of adequate care (no discomfort) and experiencing bad bedside manners. Doctors being less supportive and attentive, and a lack of respect for patient wishes were other themes observed. Nine participants reported feeling they received adequate care, two reported experiencing bad bedside manners, one reported doctors being less supportive and attentive, and one reported a lack of respect for patient's wishes. These final three themes mentioned supported the Culture Care Theory tenet that stated that when care fails to align with patient beliefs and values, resulting stress and moral concerns may occur.

Adequate care. Feelings of receiving adequate care were expressed in several participants. Table 21 displays the number of occurrences and percent of occurrences for this theme. Many felt that they had no complaints or concerns about the medical staff and the quality of care they were receiving. Non-regular English speakers reported adequate care more frequently than regular English speakers. Adequate care was also reported more often in married and older individuals (age 30-39). Participant 9, a regular English-speaker, supported this theme, stating:

> "Nothing really bad happened to me. They are really nice with everything that they do. They love their job, so they really treat you good. I haven't had no bad experience. I have heard people that complained but me personally no, they did pretty good."

Participant 4, who does not regularly speak English, supported this theme with her response:

> "The nurses, they care about you because I thought it was going to be awful but the

attention from everybody was amazing and they treated me great."

Table 21

Summary of Findings for Theme 1: Adequate Care

	Number of occurrences (*n*=9)	Percent of occurrences (*n*=15)
1) Feelings of receiving adequate care	9	60%

Bad bedside manners. Bad bedside manners were reported in some participants. Table 22 displays the number of occurrences and percent of occurrences for this theme. Whereas non-regular English speakers mentioned feeling their care was adequate more often, regular English speakers more frequently mentioned experiencing bad bedside manners. Bad bedside manners, in this context, were associated with rudeness and strictness. Participant 3, who speaks English regularly, expanded on this, stating:

> "The nurses come and whatever they do they're in a hurry or with bad temper. Not all of them are that way but I experienced that some nurses come out with an attitude that they shouldn't have because they're maybe stressed out or something like that."

Participant 12, who speaks English regularly, supported this theme in her comments:

> "It was just one time that all of my friends came at once from my neighborhood and they came to see me and I guess it's part of their rules that not a lot of people are allowed in the room and one of the nurses just said it, in a rude way but I was tired, Yeah, I said you can just get out and come see me later.' That was just it, I guess it was part of the rules, we didn't know."

Table 22

Summary of Findings for Theme 2: Bad Bedside Manners

	Number of occurrences (*n*=2)	Percent of occurrences (*n*=15)
2) Bad bedside manners	2	13%

Research Question 5

The fifth research question asked, "How do birth experiences in Hispanic women differ over time?" In this question, the researcher analyzed the participants' birthing experiences with multiple pregnancies over time. The researcher grouped the themes into the category of variation in birth experiences.

Variation in Birth Experiences

Main themes observed included experiencing different levels of care or experiencing no difference in care. Subthemes of the levels of care theme included attentiveness, bedside manners, medical expertise, and translation problems. Four participants reported experiencing different levels of care while six reported experiencing no differences in care. These themes were congruent with the theoretical tenet of Culture Care Theory that cultural contexts had an impact on the knowledge and experiences of care by individuals in a particular community.

Different levels of care. Several participants mentioned experiencing different levels of care among different birthing experiences. Table 23 displays the number of occurrences and percent of occurrences for levels of care. Different levels of care were reported relatively equally among age groups. Non-regular English speakers more frequently mentioned experiencing differences in bedside manners than regular English speakers, but this was equal among age groups, length of time living in the United States, education level, and marital status. Translation problems were reported in both regular English speakers and non-regular English speakers. Participant 6, a regular English speaker, expanded on this theme stating:

> "I think we need more Spanish speaking staff because sometimes the nurses that don't speak the language they get irritated because they don't understand and then they use the

telephone line to speak Spanish and it takes a long time, so I think maybe a bit more staff to speak the language."

Participant 13, a non-regular English speaker, similarly mentioned issues with translation:

> "More translators or people that speak Spanish in the hospital are needed because it's a real need and there's not as many people."

Participant 3, a regular English speaker, summarized the experience of having different levels of care stating:

> "I feel that there's two types of nurses, they're rough and bad and everything, and there's some that are sweet and really take care of you and they're really nice. All of my experience has been like that, you get real good nurses or just regular, like, bad attitude. Yeah."

Table 23

Summary of Findings for Theme 1: Different Levels of Care

	Number of occurrences (*n*=4)	Percent of occurrences (*n*=15)
1) Experiences of different levels of care	4	27%
Subtheme: Bedside manners	2	13%
Subtheme: Translation problems	2	13%

No difference in care. No difference in care was commonly reported in the participants. Table 24 displays the number of occurrences and percent of occurrences for this theme. Experiencing no difference in care was relatively equal among non-regular and regular English speakers, but was more frequently observed in individuals that were married, who have lived in the United States longer, and belonging to the age group of 30 to 39. Participant 2, who does not speak

English regularly, supported this theme stating:

> "I'm lucky and glad that with both of my pregnancies the nurses were amazing. They asked to help me go to the bathroom and walk but I never felt forced or coerced in any way. I felt a lot of encouragement. The second baby, she was C-section and the second day I was walking so I felt a lot of compliments from the nurses and a lot of encouragement ... amazing experience every time the nurses have been amazing and I have no complaints whatsoever about my experience."

Table 24

Summary of Findings for Theme 2: No Difference in Care

	Number of occurrences (*n*=6)	Percent of occurrences (*n*=15)
2) No difference in care	6	40%

Summary

This study revealed several different birthing experiences for Hispanic women in the United States. A positive finding from the participants was that most of them reported their experiences with their nursing care positively. This was a much different finding than was published in the earlier literature. This finding indicated the focus on cultural care in nursing curriculums for the past few years could have made a positive impact. However, there is work still to perform with the Hispanic population. There is a continued need to focus on Hispanic health beliefs and practices in nursing curriculums. In addition, other themes identified in this study should be included in nursing curriculums of maternity patients. Three of the Hispanic participants mentioned the significance of making healthy decisions for 40 days after delivery. The importance of this time-frame should be included in the curriculum as well as Hispanic practices about staying covered and warm for lactation purposes passed down for generations.

The findings meshed well with Leininger's Culture Care Theory. According to Leininger,

if nurses were knowledgeable about the cultural beliefs and practices of clients, they could apply various cultural care modalities to make the clients satisfied with the care. Because of the inclusion of cultural care in nursing curriculums for the past few years, nurses could have become well-versed in the needs of the Hispanics and therefore would be able to either just preserve and maintain culture care, accommodate their patients' needs, or restructure their care practices. These are the three modalities posited by Leininger (2012) under the Culture Care Theory.

The findings also further supported Leininger's (2012) theory, that every person lives and dies within a cultural frame of reference, which is comprised of specific cultural values, worldviews, social structure, language uses, ethno history, environments, and healthcare systems. Each culture has its own lay-care system, which corresponds to its cultural frame of reference. Professional nurses, on the other hand, represent the values of the professional healthcare system. When the two values meet without conflict, patient care received would be satisfying and more effective.

The most significant differences in themes and perceptions in the study occurred in regular and non-regular English speakers and younger and older age groups. For non-regular English speakers, concerns about the future, patient treatment, modernity, respect and cultural competency, and well-being were important themes. For regular English speakers, mitigating problems and safety concerns, imparting knowledge and helpful information, support, and bedside manners were the most important themes. Concerns about the future and opportunities for children, concerns about medical expertise and training, mitigating problems and safety, comfort, well-being, and experiencing no differences in care among multiple pregnancies were expressed more often in older individuals. Younger individuals (age 20 to 29) more frequently mentioned concerns about lactation, rest and healing, patience, bedside manners, timeliness, and experienced

different levels of care among multiple pregnancies. Religion and respect and cultural competency were deemed significant among all age groups.

Results from Phase II interviews yielded no new information with participants agreeing with findings and identifying themselves with either the older or younger age groups. It is important to note that the Phase II interviewees seemed apprehensive on the phone, due to possible issues with immigration status. This research sheds light on perceptions of care, birthing processes, and experiences with nursing and medical staff by Hispanic maternity patients. The information obtained in this study can be used to assist nursing faculty in the development of a humanistic and culturally competent maternity nursing curriculum which includes Hispanic American maternity patients. A more inclusive and culturally competent curriculum is important to maintain the health and well-being of Hispanic communities within the United States.

It was evident the different aspects of the Culture Care Theory related to cultural caring in the Hispanic American maternity patients. The participants mentioned technology, family practices, the impact of language barriers upon healthcare, and religious practices, which were elements, displayed in Leininger's Sunrise Enabler Model. The findings of the study were congruent with Leininger's model and relevant to the Hispanic American maternity patient.

CHAPTER 5: DISCUSSION OF FINDINGS

Introduction

The purpose of this chapter is to review and discuss the study findings as they related to the current body of literature. In this chapter, the researcher discusses the implications, limitations, and recommendations based upon the current findings as they related to culturally sensitive education. The researcher will also present a summary of data analysis as it related to the research questions of the study, and will conclude with recommendations for future research and nursing education.

The purpose of this qualitative study was to identify culturally sensitive caring behaviors of professional nurses from the perspective of Hispanic American maternity patients 2 to 4 weeks post-discharge. The significance of this study was to identify patients' perceptions of nurse caring behaviors that emphasized culturally competent care so nursing curriculum would be enhanced.

Recent changes in the ethnic composition of the population of the U.S. have posed great challenges for healthcare institutions and healthcare providers. Seright (2012) pointed out that many healthcare providers serving formerly homogeneous populations now provide care for culturally and linguistically different groups who have different health beliefs and practices than providers' usual patients. According to Dossey et al. (2013), culture accounts for differences in behaviors such as diet and exercise, including what behaviors the client engages in to restore health and remain healthy. Seright (2012) contended that nurses and other healthcare providers needed better training in how peoples' cultural perceptions could affected their approach and

responses to healthcare. The provision of culturally competent healthcare—healthcare that takes into account issues related to the cultural context of individuals, their families, and communities—is more imperative than ever. Leonard (2010) maintained that the provision of culturally competent healthcare results in client empowerment, decreased client anxiety, better utilization of healthcare services, improvement of the health status of the client population, and increased overall client satisfaction.

Officials at OMH (2013) have recognized the need for cultural caring in minority groups. These officials believed that it was necessary to move toward a national consensus regarding cultural and linguistic caring by providing better guidance for healthcare organizations and providers on how to respond to an increasingly culturally diverse clientele. The OMH (2013) issued recommendations for 14 national standards for culturally and linguistically appropriate services (CLAS) in healthcare. Although these standards focused on organizations, they are applicable to individual providers and other groups as well. Educators from healthcare professions, training institutions, as well as legal and social services professions, needed to incorporate these standards into their curricula (OMH, 2013).

McCloskey (2014) pointed out that not only is the population changing, but so was the way that the healthcare is delivered in the U.S. More healthcare services are available in the home than in previous years. This practice called for greater understanding of the cultural background of clients and their families. Liu et al. (2011) agreed that cultural caring was imperative when nurses provided care in the home, especially since they were guests of their patients and had to adhere to the patient's values and lifestyle—in contrast to hospital settings, where patients abided by the rules of the agencies. Thus, the need for qualified, culturally competent, caring healthcare professionals has increased both in private residences and in healthcare institutions.

Researchers have emphasized caring as a critical behavior for professional nursing. The American Association of Colleges of Nursing (AACN) (2011) stated that a baccalaureate curriculum must contain content that prepares the nursing student to "engage in caring and healing techniques that promote a therapeutic nurse-patient relationship" (p. 32). The delivery of culturally sensitive care forms another component of caring nursing behaviors. Many government agencies and professional organizations began to include measures in their policies and procedures of operations to improve the interaction between the agency/organization and members of culturally diverse groups. Nursing as a profession, and nursing education in particular, began to include safeguards to ensure that patient care also included providing culturally sensitive care. In 1986, the American Nurses Association (ANA) issued its first intention to strengthen cultural diversity programs in nursing (Lowe & Archibald, 2009).

According to the U.S. Department of Health and Human Services (2010), the racial and ethnic distribution of the registered nurse (RN) population varies substantially from that of the U.S. population as a whole. Hispanics, Blacks, and American Indians/ Alaskan Natives remained underrepresented in the RN population. Seright (2012) stated that the healthcare system contained a predominantly Caucasian population of Northern European origin and philosophy, and suited the individualistic nature of American society. Thus, ideas held by the predominant number of nurses regarding how to demonstrate quality caring reside from the beliefs of the healthcare system's creators. These beliefs and values were not compatible with those of the increasingly non-European population in America. Caring for this increasingly multiethnic and multicultural clientele inevitably posed challenges for healthcare providers, and required sensitivity to the diversity of clients and the provision of care that is culturally competent. Leininger (1991), a leading specialist in cultural caring in nursing, 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).

Examination of the literature supported the need for more culturally competent healthcare providers; therefore, a gap in the literature inferred necessity for more research to improve cultural competence in nursing (Seright, 2012). Conducting research involving the lived experiences of Hispanic American maternity patients, which examined the cultural caring behaviors of professional nurses helped to close a curriculum gap in nursing education. These findings would aid nurses to become more culturally competent in their Hispanic American maternity patients' care.

There was a paucity of information regarding patients' perceptions of culturally competent care. The information gained from this study would aid in enhancing a culturally competent maternity care curriculum and patient centered design for Hispanic American maternity patients.

The main research question that guided this study was, "What are the lived experiences of Hispanic maternity patients regarding their hospital stay during the birthing process through discharge from the hospital?" The researcher discussed the specific questions asked during the semi-structured interviews in the section on the interpretation of the findings. Furthermore, the discussion of the implications of the findings included an examination of the three modalities of Leininger's Culture Care Theory as they correlated with the findings.

Interpretation of the Findings

Question 1. "How does giving birth in the United States differ from other places?"

The participants' responses resulted in several symbolic themes regarding the birthing experience in the U.S. Themes regarding the future of children in the U.S. were common in the participants, where opportunities for success for both parents and children surfaced. Other main themes

included better medical care, treatment of patients, differences in care between the U.S. and other countries, and comfort. The different themes and subthemes of Research Question 1 generally confirmed previous studies done in the medical area regarding differences in care rendered between the U.S. and other countries, although these researchers did not always address nurses and were not always qualitative.

Better future. The inclusion of expectations for the future and the importance of their children speaking English in the participants' replies were interesting, since the question focused on birthing experiences in the U.S. It served to illustrate the expectations and hopes of mothers regarding their newborn babies' future, and as such, formed a close link to the birth experience itself.

Better medical care. The participants' expression of trust in the medical staff was in contrast with the study of Stepanikova et al. (2006), who examined if racial disparities existed in patients' level of trust in their physicians. Through a survey that measured trust levels, findings revealed that minority users of healthcare services had lesser trust levels. The findings of the current study indicated that the participants trusted the medical staff.

Treatment of patients. Participants who did not speak English regularly mentioned treatment of patients as an important factor more often. In a breastfeeding project with African-American mothers in a low-income group, Cricco-Lizza (2006) found that the personal and sensitive care of the facilitators resulted in the adoption of breastfeeding by the mothers. In a study related to the personal manner (courtesy, respect, and sensitivity) of physicians, participants indicated they were more satisfied when they participated in decision making and the physician treated them in a caring manner (Cooper-Patrick et al., 1999). Although it was clear from the literature study that the treatment of patients was crucial when dealing with immigrants, studies

used different terms and descriptions for this phenomenon including personal manner in the Cooper-Patrick et al. (1999) study and interpersonal styles in the study of Cricco-Lizza (2006). This made comparisons difficult, since the authors included different aspects when describing the phenomena. The findings of the current study indicated that the participants were mostly satisfied with the manner they were treated and in agreement with other studies, the participants also rated treatment as important (Cooper-Patrick, 1999; Cricco-Lizzo, 2006).

Question 2. "How do Hispanic women define care while giving birth?" This question focused on how participants connect with their bodies, care for their bodies, and experienced bodily care. Themes fell into two categories: experiences with customs and practices and meaning of care. The themes included experiences with customs and practices and the meaning of care.

Customs and practices. Different studies were found that focused on immigrants that were African American (Cooper-Patrick et al., 1999; Perloff et al., 2006), Chinese (Chun et al., 2011; Ng et al., 2012), and Spanish (Fernandez et al., 2004). These studies differed not only regarding the nationality of the subject, but also in terms of methodology and primary focus (i.e., diabetes management and language proficiency of the physicians). The researcher could not find studies that focused on customs and belief systems about health practices, pregnancy, and birth of the various immigrant groups. The current study found that the 20-28 year old group especially emphasized the importance of their customs, mentioning some beliefs regarding breast feeding and extending knowledge about Hispanic American maternity patients' customs and beliefs.

Meaning of care. The care concept was widely researched, as it was crucial to the medical profession and especially to nursing. Several subthemes occurred in this study related to meaning of care. These included: physicians' level of involvement and accessibility, mitigation of safety, respect for the patients' decisions, and discussion of patient treatment. The participants referred to

patient treatment as being taken care of, being made to feel important, and providers' patience during care. When patients perceived that their healthcare providers were being insensitive to their cultures, it led to perceptions of poor quality care. It also led to decreased trust in the services they received and their service providers (Gabrysch & Campbell, 2009). Participants in the current study commented positively on the manner they were treated., which supported the findings of Gabrysch and Campbell (2009). They also found the majority of their participants trusted the medical services provided in the U.S.

Treatment of patients. The participants regarded culturally sensitive care and comfort measures as important. Leininger (2007) wrote that care was a phenomenon that needed understanding in order to guide nurses' actions. The Culture Care Theory of Leininger (2007) originated from the belief that "care is the essence of nursing and the central, dominant, and unifying focus of nursing" (Leininger, 2007, p. 35); this holistic approach focused on the care that promoted the health and well-being of people.

Question 3. "What customs, practices, beliefs, or technology helped Hispanic women give birth?" This research question aimed to examine how materials, beliefs, and technology influenced the birthing process. Themes fell into the category of customs, practices, beliefs, and technology.

Customs, practices, beliefs, and technology. Participants expressed themes about cultural competency, medical expertise, and religion. Cultural competence was essential in nursing, as nurses were at the forefront of providing care to clients at the bedside and in the community (Bau, 2007). Suh (2009) found that attributes of cultural competence in nursing included ability, openness, and flexibility. Participants in the current study also included the importance of medical expertise as well as the need for nurses to provide information to address

patient concerns. The inclusion of religious needs in the replies of the participants served as an extension of knowledge as previous studies did not include this notion.

Question 4. "How do Hispanic women experience maternity care with hospital nursing staff?" In this question, the researcher analyzed the participants' relationships with healthcare staff. Themes included experiences with staff assistance, experiences with comfort, and experiences with discomfort. The participants included assistance with the baby, explanation of medical procedures, timeliness, bedside manners, and support under the theme of staff assistance. Comfort included encouragement and positivity of the nurses, as well as attending to their well-being, whereas discomfort referred to rudeness, not spending adequate time with the patient, and impatience. Leininger (2007) indicated that nurses must understand comfort in a cultural context to provide adequate culture care.

Question 5. "How do birth experiences in Hispanic American women differ over time?" The question about birthing experiences with multiple pregnancies over time elicited two kinds of responses. These responses included either different levels of care, or that they experienced no differences.

When exploring different levels of care, participants remarked on the language barriers and availability of translator services. Some participants indicated that better availability of translation services would serve to decrease their nurses' frustration levels. Hicks et al. (2011) indicated that the satisfaction levels with the healthcare service Blacks and Hispanics received were affected by the existence and accessibility of translators, as well as the attitudes of the social workers and nursing staff who attended to them. The participants divided nurses in two categories: those who were empathetic and caring versus those who were rude and impatient.

Implications of the Findings

Question 1. The participants' experience with birth in different geographical places in comparison to the U.S. was the focus of this question. An analysis of the themes revealed that the participants perceived the U.S. experience as better. This was in terms of medical care (infrastructure of healthcare), treatment and comfort (in terms of cultural acceptance) and, interestingly, future opportunities, although this was not part of the question. The findings indicated high levels of trust in the U.S. healthcare system and expertise of the medical staff, including nurses.

According to Leininger's (2001) Culture Care Theory and Sunrise Model, congruent culture care is influenced by cultural care accommodation and/or negotiation to meet the clients' needs. The prevailing themes of better future and better medical care demonstrated the congruency of the Hispanic American maternity patients' value systems intertwining with the professional value systems in the provision of care. As nurses provided culture care in their practice, the levels of trust would continue to be positive in nature.

Question 2. The question about customs and practices during the birthing process also focused on how participants connected with their bodies, cared for their bodies, and experienced bodily care. Participants expressed concerns about safety and linked it with modernity revealing the perception that modern facilities provided more safety in terms of healthcare and medical expertise. Leininger (2007) described the need to facilitate the maintenance of health and well-being. From the participants' perspective, modern practices were able to easily facilitate and maintain health. Customs concerning recovery after childbirth and lactation were revealed, especially by the younger group of participants (20-28). These customs included beliefs on covering and staying warm, health and diet, lactation, and adequate periods of rest. These findings

pointed to the importance of in-depth knowledge of the healthcare customs and beliefs of the various immigrant groups in the U.S. to ensure satisfactory healthcare. Not only would customs and beliefs be included in curricula of nurses and other medical care providers, but office staff would also receive culturally sensitive training to ensure that the total healthcare experience of immigrants was positive. Kaplan et al. (2006) discussed the centrality of cultural knowledge and cultural respect, and found that disrespect, undervalue, stigmatization, stereotype, humiliation, and mistreatment by providers and office staff resulted in mistrust and in a reluctance to seek care.

Question 3. The question about how Hispanic American women perceived materials, beliefs, and technology influence birthing processes elicited responses regarding medical expertise and especially cultural medical expertise, including respect for cultural customs and values. Leininger claimed that if nurses were knowledgeable about the cultural beliefs and practices of clients, they could apply various cultural care modalities to make the clients satisfied with the care. If nurses were informed about the healthcare needs of the Hispanic American maternity patients, they would be able to preserve and maintain culture care, accommodate their patients' needs, or restructure their care practices depending on what their patients wanted and needed. These were the three modalities posited by Leininger (2012) under the Culture Care Theory.

Question 4. This question explored the relationship experiences of Hispanic American women with hospital staff. The findings were overall positive, resulting in positive themes about the participants' perceptions. Leininger (1991) found that the concepts of care and cultural care and comfort were related to adherence to medical treatment, recovery, and seeking healthcare. Since this study's participants' responses about their cultural care were primarily positive, they would possibly be more adherent to prescribed treatments and health teaching.

Question 5. The final question addressed experiences with multiple births over time. The

participants noted that they experienced a difference in care with different deliveries. These include differences in attentiveness, bedside manners, medical expertise, and translation problems. Leininger's model depicted the influences of care expressions as demonstrated by health practices and patterns. The repeated inclusion of these subthemes served to emphasize their importance to the participants.

The Culture Care Model was relevant to the cultural caring experience of Hispanic American maternity patients. The participants emphasized concepts such as technological factors, religious factors, and cultural values. The themes and subthemes identified by the researcher confirmed the importance of cultural caring in the provision of care in the Hispanic American maternity patient as well as demonstrated congruency between the research findings and Leininger's Sunrise Enabler Model for Culture Care.

Limitations of the Study

There were limitations to this study that future studies could address. The study focused on a small geographical area and included a small sample size, which was in keeping with the guidelines for phenomenological research. However, generalization of findings to other Hispanic American maternity patients or other groups would not be possible, thus influencing the external validity of the study. However, a strength of this study was the focus on Hispanic American maternity patients, and this type of research focusing on this population group was not included in the literature.

In describing the inclusion criteria, participants were: (a) Hispanic American females between 20 and 35 years old who participated in the WIC program, who were (b) English-speaking, (c) delivered a live baby, (d) were 2-4 weeks post discharge, and (e) were willing to participate in the study. During the analysis of the findings, it was evident that the group

was more homogeneous than anticipated. The age groups of 20-28 year olds and 30-35 year olds differed in their responses. Other differences included regular and non-regular English users, length of stay in the U.S., and being married versus single. Future researchers could keep these variables in mind when selecting participants for more focused research if the desire was to maintain more uniform or homogeneous participants.

Since the participants frequently commented on communication style and language barriers, it was important to achieve trustworthiness and good communication by insuring that the translator was proficient in both English and Spanish. It was also crucial to utilize the same translator, as different translations and communication styles could influence the responses of the participants. The researcher was concerned that when addressing non-regular English speaking participants that their level of English proficiency would impact or restrict their responses, which would limit the richness of their responses. For future investigators conducting cultural care studies, the researcher would recommend language fluency in the participants' language to promote rich responses.

The researcher assumed that the participants provided their honest opinions during the interviews. The researcher discovered during the telephonic interviews that the participants might not have provided negative responses due to fear of immigration or their concern that their medical services would terminate as a result. The researcher inferred this assumption because the participants repeatedly asked if the researcher was associated with the department of immigration. It was therefore not clear to what degree the participants were truthful in their responses during the interviews.

Recommendation for Nursing Education

The current study confirmed the importance of respect for cultural differences, which

supported courses in cultural competency as a core aspect of nursing curriculum. The findings obtained in this study would be used to successfully assist nursing schools to develop nursing students, who were culturally competent to maintain the health and well-being of Hispanic American maternity patients within the U.S. The participants in the study expressed a need for a clear explanation of medical procedures, which emphasized the importance of language proficiency and appropriate translation services for nurses and other healthcare providers. Medical language courses included in nursing curriculum with possible cultural immersion courses was indicated due to the large Hispanic population and the need for more Spanish speaking nurses. Culturally congruent communication relied on an understanding and respect for the particular culture. Therefore, the author recommended that nursing schools included more focus on establishing therapeutic relationships with different population groups. Each nursing course would focus on cultural practice, beliefs, and the importance of culturally appropriate communication when providing care to different population groups.

Recommendations for Future Research

The research findings included beliefs and customs of Hispanic American women about delivery and lactation. Participants mentioned beliefs and customs regarding delivery and lactation more than once, leading the researcher to assume that these factors were important in the Hispanic culture. There was a need to determine culturally sensitive caring behaviors, customs of professional nurses from the perspective of Hispanic American maternity patients. This need likely existed for all immigrant groups in the United States. Based on the reviewed literature, similar culturally sensitive caring behaviors of professional nurses research is necessary for other population groups.

This study found differences between participants who spoke English regularly as opposed

to those who were non-regular English speakers. There was also a difference in the perceptions between participants who lived longer in the U.S. and those who had moved to the U.S. more recently. Future studies should address the effects of acculturation and English proficiency of different immigrant groups. Chun et al. (2011) found that acculturation influenced patients' management of diabetes. Studies on the effects of acculturation should include the whole spectrum of immigrant groups as well as different illnesses, genders, and age groups to ensure in-depth understanding of this phenomenon.

Phenomenological studies provided rich descriptive texts and were useful when studying complex issues like perceptions. A mixture of qualitative and quantitative studies would possibly provide results that the researcher could generalize to a larger population. This generalizability would better influence policy makers.

Previous research indicated a sensitive and empathetic communication style led to adoption of breastfeeding in a group of African-American mothers (Cricco-Lizza, 2006). Given the centrality of translators in the healthcare field and the important role they played in eliciting personal responses from immigrant patients, researchers could investigate the effectiveness of different communication styles with Hispanic American maternity patients.

Summary and Conclusions

The purpose of this study was to identify culturally sensitive behaviors of professional nurses from the perspective of Hispanic American maternity patients 2-4 weeks post-discharge, and to determine which cultural behaviors of the nurses needed improvement. Furthermore, the researcher intended to determine the current cultural care content needed in nurses' training to enhance culturally sensitive nursing care. Researchers could use the findings of this study to improve maternity care curricula to include more culturally competent content related to Hispanic

American maternity patients. The importance of this study was to identify patients' perceptions of nurse caring behaviors that emphasized culturally competent care. The current researcher noted that there was a paucity of information regarding patients' perceptions of culturally competent care and this study would help to fill a gap in the literature.

The results of the analysis of the one-on-one interviews indicated that the Hispanic American patients were mostly satisfied with the level of care they received from their nurses. Participants indicated that they trusted the U.S. healthcare system, the medical staff, and their nurses. This finding was important as a previous study found that patients' level of trust was associated with adherence to treatment and seeking medical advice (Thom et al., 1999).

There were some indications of dissatisfaction with bad bedside manners and comments on nurses always being in a hurry, bad-tempered, and even rude. These behaviors would erode the work done by more caring nurses with the participants. However, any patient could have similar differences in the nurses' bedside manners during their provision of care. Therefore, nursing curricula could better emphasize the importance of good bedside manners to meet all patients' needs, since this contributes to better patient adherence.

The participants revealed different customs and beliefs regarding postpartum care and lactation, as well as the need to participate in religious activities during their stay in the hospital. Hispanic American maternity patients' postpartum, lactation, and religious beliefs and customs would also be included in the training curricula of nurses. Other suggestions for nursing curriculum included language courses for Hispanic patients due to the large population and the lack of Hispanic nurses currently in the United States.

Care encompassed many behaviors including the humanistic aspects of empathy, sensitivity, cultural awareness and respect and was indicated as pivotal to nursing. Nurses formed

close relationship with patients, which aided in the speedy recovery and adherence to treatment. The already large and growing immigrant population in the U.S. necessitated increased levels of cultural sensitivity, language competency, interpersonal communication style and good bedside manners to serve these population groups adequately. Nursing curriculums must focus on cultural differences in care and beliefs to best serve all of our population groups.

As noted by the participants, the concepts in Leininger's Sunrise Enabler Model for Cultural Care were relevant to their cultural care experience as Hispanic American maternity patients. As depicted in the model, worldview concepts, which included cultural and social dimensions such as technological factors, religious factors, kinship, legal factors, educational factors, and cultural values were all mentioned in participant's interviews in the study. In addition, the families as well as the nursing care provided affected the participants' perception of cultural caring by nurses. Based on the findings of the study and the congruence with Leininger's model, nurse educators would need to recognize the importance of these concepts in providing culturally congruent nursing education for the health and well-being in the Hispanic American maternity patients.

REFERENCES

Acharya, A. S., Prakash, A., Saxena, P., & Nigam, A. (2013). Sampling: Why and how of it? *Indian Journal of Medical Specialties*, *4*(2).

Albaum, T. (1997). The Likert scale revisited: An alternate version. *Journal of the Market Research Society*, *39*(2), 331-338.

Alpers, R., & Zoucha, R. (1996). Comparison of cultural competence and cultural confidence of senior nursing students in a private southern university. *Journal of Cultural Diversity*, *3*(1), 9-15.

American Association of Colleges of Nursing (AACN) (2011). *The essentials of baccalaureate education for professional nursing practice*. Washington, D.C.: AACN.

American Association of Colleges of Nursing. (2011). *Faculty shortages in baccalaureate and graduate nursing programs: Scope of the problem and strategies for expanding the supply*. Washington, D.C.: AACN.

American Nurses Association (ANA). (1986). *Cultural diversity in nursing*. Silver Spring, MD: ANA House of Delegates.

American Nurses Association. (2013). *Today's registered nurses: Numbers and demographics.* Retrieved from http://www.nursingworld.org/readroom/fsdemogr.htm

Andrews, M. (1995). Transcultural nursing: Transforming the curriculum. *Journal of Transcultural Nursing*, *6*(2), 4-9.

Andrews, M. & Boyle, J. (1995). *Transcultural concepts in nursing care* (2nd ed.). Philadelphia, PA: J. B. Lippincott Company.

Andrews, M. & Boyle, J. (1999). *Transcultural concepts in nursing care* (3rd ed.). Philadelphia, PA: J. B. Lippincott Company.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*(1), 42-78.

Attanasio, L., & Kozhimannil, K. B. (2015). Patient-reported communication quality and perceived discrimination in maternity care. *Med Care, 53*(10), 863-71. doi:10.1097/MLR.0000000000000411.

Baker, B., & Rytina, R. (2013) *Estimates of the lawful permanent resident population in the United States: January.* Retrieved from http://www.dhs.gov/sites/default/files/publications/ois_ill_pe_2012_2.pdf

Baldonado, A., Beymer, P., Barnes, K., Starsiak, D., Nemivant, E., & Anonas-Ternate, A. (1998). Transcultural nursing practice described by registered nurses and baccalaureate nursing students. *Journal of Transcultural Nursing*, *9*(2), 15-25.

Bau, I. (2007). Nurses are vital providers of culturally-competent care. *Journal of Transcultural Nursing, 18*(1), 5S-6S.

Bednarz, H., Schim, S., & Doorenbos, A. (2010). Cultural diversity in nursing education: Perils, pitfalls, and pearls. *Journal of Nursing Education*, *49*(5), 253-260.

Berger, L. K., Zane, N., & Hwang, W. C. (2014). Therapist ethnicity and treatment orientation differences in multicultural counseling competencies. *Asian American Journal of Psychology, 5*(1), 53.

Bernal, H., & Froman, R. (1987). The confidence of community health nurses in caring for ethnically-diverse populations. *Journal of Nursing Scholarship*, *19,* 201-203.

Betancourt, J., Green, A., Carrillo, E., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Reports, 118*, 293-302.

Boerleider, A. W., Francke, A. L., Van de Reep, M., Manniën, J., Wiegers, T. A., & Deville, W. L. (2014). Being flexible and creative: A qualitative study on maternity care assistants' experiences with non-Western immigrant women. *PloS ONE, 9*(3), e91843.

Bond, M., Kardong-Edgren, S., Jones, M. (2010). Assessment of professional knowledge and attitudes about patients of diverse cultures. *Journal of Professional Nursing*, *17*(6), 305-312.

Brick, J. M. (2011). The future of survey sampling. *Public Opinion Quarterly, 75*(5), 872-888.

Brown-Krimsley, V. (2004). Lessons learned: Providing culturally-competent care in a nurse-managed center. *The American Black Nursing Foundation Journal*, *15*(2), 71-73.

Burchum, J. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum, 37*(4), 5-15.

Byrne, M., Weddle, C., Davis, E., & McGinnis, P. (2011). The Byrne guide for inclusionary cultural content. *Journal of Nursing Education*, *42*(6), 277-281.

Camacho, A. V., Castro, M. D., & Kaufman, R. (2006). Cultural aspects related to the health of Andean women in Latin America: A key issue for progress toward the attainment of the

Millennium Development Goals. *International Journal of Gynecology & Maternity, 94*(3), 357-363.

Campinha-Bacote, I. (1999). A model and instrument for addressing cultural competence in healthcare. *Journal of Nursing Education*, *38,* 203-207.

Campinha-Bacote, J. (1994). Cultural competence in psychiatric mental health nursing: A conceptual model. *Nursing Clinics of North America, 29*(1), 1-8.

Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery of healthcare services: A culturally-competent model of care* (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.

Campinha-Bacote, J. (2003). The process of cultural competence in the delivery of healthcare services: A culturally-competent model of care. *Transcultural C.A.R.E Associates.*

Campinha-Bacote, J., Yahle, T., & Langencamp, M. (1996). The challenge of cultural diversity for nurse educators. *Journal of Nursing Education, 27*, 59-64.

Carpenito, L. (1989). *Nursing diagnosis: Application to clinical practice* (3rd ed.). Philadelphia, PA: J.B. Lippincott Company.

Chrisman, N. (1998). Faculty infrastructure for cultural competence education. *Journal of Nursing Education*, *37*(1), 45-47.

Chun, K., Chesla, C., & Kwan, C. (2011). So we adapt step by step: Acculturation experiences affecting diabetes management and perceived health for Chinese American immigrants. *Social Science & Medicine, 72,* 256-264.

Cioffi, J. (2011). Communicating with culturally and linguistically diverse patients in an acute care setting: Nurses' experiences. *International Journal of Nursing Studies*, *40(3)*, 299-306.

Coast, E., Jones, E., Portela, A., & Lattof, S. R. (2014). Maternity care services and culture: A systematic global mapping of interventions. *PLoS ONE, 9*(9), e108130. doi:10.1371/journal.pone.0108130

Coleman, J. (2012). Culture care meanings of African-American parents related to infant mortality and healthcare. *Journal of Cultural Diversity, 16*(3), 109-119.

Cooper Brathwaite, A. (2005). Evaluation of a cultural competence course. *Journal of Transcultural Nursing, 16*(4), 361-369.

Cooper Brathwaite, A. (2006). Influence of nurse characteristics on the acquisition of cultural competence. *International Journal of Nursing Education Scholarship, 3*(1), 1-16.

Cooper-Patrick, L., Gallo, J., Gonzales, J., Vu, H., Powe, N., Nelson, C., & Ford, D. (1999). Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association, 282*(6), 583-589.

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Los Angeles, CA: Sage.

Creswell, J. (2012). *Qualitative inquiry & research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.

Cricco-Lizza, R. (2006). Black Non-Hispanic mothers' perceptions about the promotion of infant-feeding methods by nurses and physicians. *Journal of Maternity, Gynecological and Neonatal Nursing, 35*(2), 173-180.

Cross, T. (1998). Services to minority populations: Cultural competence continuum. *Focal Point*, *3*(1), 1-4.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Toward a culturally-competent system of care: Vol. 1. A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Dana, R. (1995a). Cultural competence in school psychology: An assessment perspective. *The School Psychologist, 49*(4), 87-90.

Dana, R. (1995b). Cultural competent MMPI assessment of Hispanic populations. *Hispanic Journal of Behavioral Sciences*, *17,* 305-319.

Dana, R. (1996). Culturally-competent assessment practice in the United States. *Journal of Personality Assessment, 66,* 472-487.

Day, J. (1996). Population projections of the United States by age, sex, race, and Hispanic origin: 1995 to 2050. *U.S. Bureau of the Census [Electronic version] Current Population Reports, 25,* 1130.

DeSantis, L., & Ugarriza, D. (2013). The concepts of theme as used in qualitative nursing research. *Western Journal of Nursing Research, 22*(3), 351-372.

Doorenbos, A., & Schim, S. (2004). Cultural competence in hospice. *American Journal of Hospice & Palliative Care, 21*(1), 28-32.

Doorenbos, A., Schim, S., Benkert, R., & Borse, N. (2005). Psychometric evaluation of the Cultural Competence Assessment instrument among healthcare providers. *Nursing Research, 54*(5), 324-331.

Dossey, B., Keegan, L. & Gazette. C. (2013). *Holistic nursing: A handbook for practice* (3rd ed). Gaithersburg, MD: Aspen Publishers, Inc.

Duffy, M. (2010). A critique of cultural education in nursing. *Journal of Advanced Nursing*, *36*, 487-495.
Examination for Registered Nurses. Retrieved from www.ncsbn.org.

Fadiman, A. (1997). *The spirit catches you and you fall down*. New York, NY: Farrar, Straus, and Giroux.

Fernandez, A., Schillinger, D., Grumbach, D., Rosenthal, A., Stewart, A., Wang, F., & Pérez-Stable, E.J. (2004). Physician language ability and cultural competence. *Journal of General Internal Medicine, 19*, 167-174.

Gabrysch, S., & Campbell, O. M. (2009). Still too far to walk: Literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth, 9*(1), 34.

Giger, J., Davidhizar, R., Purnell, L., Harden, J., Phillips, J., & Strickland, O. (2007). AAN expert panel report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing, 18*(2), 95-102.

Glei, D. A., Goldman, N., & Rodríguez, G. (2003). Utilization of care during pregnancy in rural Guatemala: Does obstetrical need matter? *Social Science & Medicine, 57*(12), 2447-2463.

Goode, T. (2013). *Promoting cultural and linguistic competency: Self-assessment checklist for personnel providing healthcare services*. Washington DC: Georgetown University Child Development Center.

Grossman, D., Massey, P., Blais, K., Geiger, E., Lowe, J., … Pereira, O. (1998). Cultural diversity in Florida nursing programs: A survey of deans and directors. *Journal of Nursing Education, 37*, 22-26.

Hicks, L., Tovar, D., Orav, E., & Johnson, P. (2011). Experiences with hospital care: Perspectives of Black and Hispanic patients. *Journal of General Internal Medicine*, *23*(8), 1234-1240.

Holland, K., & Hogg, C. (2010). *Cultural awareness in nursing and healthcare: An introductory text*. London, England: Hodder Arnold.

Jones, M., Bond, M., & Mancini, M. (1998). Developing a culturally-competent workforce: An opportunity for collaboration. *Journal of Professional Nursing, 14,* 280-287.

Kaplan, S., Calman, N., Golub, M., Davis, J., Ruddock, C., & Billings, J. (2006). Racial and ethnic disparities in health: A view from the South Bronx. *Journal of Healthcare for the Poor and Underserved, 17*, 116-127.

Kelly, K. (1991). Healthcare providers and ethnically-diverse clients. *Dissertation Abstracts International, 52*(06), 2994.

Kim-Godwin, Y., Alexander, J., Felton, G., Mackeu, M., & Kasakoff, A. (2009). Prerequisites to providing culturally-competent care to Mexican migrant farmworkers: A Delphi study. *Journal of Cultural Diversity*, *13*(1), 27-33.

Kim-Godwin, Y., Clarke, P., & Barton, L. (2001). A model for the delivery of culturally-competent community care. *Journal of Advanced Nursing, 35*(6), 918-925.

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, *29*(2), 312-317.

Kudzma, E. (1999). Culturally-competent drug administration. *American Journal of Nursing*, *99*(8), 46-52.

Kulwicki, A., & Bolonik, B. (1996). Assessment of level of comfort providing multicultural nursing care by baccalaureate nursing students. *Journal of Cultural Diversity*, *3*(2), 40-45.

Lancellotti, K. (2011). Culture care theory: A framework for expanding awareness of diversity and racism in nursing education. *Journal of Professional Nursing, 24*(3), 179-183.

Leach, S., Wojnar, D. M., & Pettinato, M. (2014). Lived Experience of Miscarriage for Nine Latina Immigrant Women. *Journal of Theory Construction & Testing*, *18*(1), 11.

Leininger, M (1995). Teaching transcultural nursing undergraduate and graduate programs. *Journal of Transcultural Nursing, 6*(2), 10-26.

Leininger, M. (1978). *Transcultural nursing: Concepts, theories and practice.* New York, NY: Wiley.

Leininger, M. (1991). *Culture care diversity & universality: A theory of nursing.* New York, NY: National League for Nursing Press.

Leininger, M. (2007). Theoretical questions and concerns: Response from the theory of culture care diversity and universality perspective. *Nursing Science Quarterly*, *20*(1), 9-15.

Leininger, M. (2012). The phenomenon of caring, part V: Caring, the essence and central focus of nursing. *International Journal for Human Caring*, *16*(2), 57.

Leininger, M., & McFarland, M. (2002). *Transcultural nursing: Concepts, theories & practice* (3rd ed.). New York, NY: McGraw Hill.

Leininger, M., & McFarland, M. (2006). *Culture care diversity and universality: A world wide nursing theory*. Toronto, Canada: Jones and Bartlett Publishers.

Leininger, M., & Reynolds, C. (1993). *Madeleine Leininger: Culture care diversity and universality theory.* Newbury Park, CA: Sage.

Li, Y., Yin, J., Cai, X., Temkin-Greener, H., & Mukamel, D. B. (2011). Association of race and sites of care with pressure ulcers in high-risk nursing home residents. *Jama*, *306*(2), 179-186.

Lipson, J., Weinstein, H., Gladstone, E., & Sarnoff, R. (2003). Bosnian and Soviet refugee's experiences with healthcare. *Western Journal of Nursing Research*, *25*(7), 854-871.

Liu, J., Mok, E., & Wong, T. (2011). Caring in nursing: Investigating the meaning of caring from the perspective of cancer patients in Beijing, China. *Cancer and Palliative Care, 15*(2), 188-196.

Lockhart, J. S., & Resnick, L. (1997). Teaching cultural competence. *Nurse Educator*, *22*(3), 27-31.

Lowdermilk, D., Perry, S., & Bobak, J. (2013). *Maternity and women's health* (7th ed.). St. Louis, MO: Mosby.

Lowe, J., & Archibald, C. (2009). Cultural diversity: The intention of nursing. *Nursing Forum, 44*(1), 11-18.

Lujan, J. (2010). Meeting Religious Needs of Hispanic Clients to Provide Culturally Competent Care. *Internet Journal of Allied Health Sciences and Practice*, *8*(2), 4.

Mareno, N., & Hart, P. L. (2014). Cultural competency among nurses with undergraduate and graduate degrees: Implications for nursing education. *Nursing Education Perspectives, 35*(2), 83-88.

Mason, J. (1994). Developing culturally-competent organizations. *Focal Point, 8*(2), 1-8.

Mason, J. (1995). *Cultural competence self-assessment questionnaire: A manual for users.* Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

Mason, J., Cross, T., Rider, M., & Friesen, B. (1988). Services to Minority Populations: What does it mean to be a culturally-competent professional? *Focal Point, 2*(4), 1-2, 4-5.

McCloskey, D. J. (2014). Cultural sensitivity and health information resources and services. *The Medical Library Association Guide to Providing Consumer and Patient Health Information*, *173*.

McFarland, M. R., Mixer, S. J., Lewis, A. E., & Easley, C. E. (2006). *Use of the culture care theory as a framework for the recruitment, engagement, and retention of culturally diverse students in a traditionally European American baccalaureate nursing program*. M. M. Leininger and M. R. McFarland (Eds.), Sudbury, MA: Jones and Bartlett Publishers.

McFarland, M. R., & Wehbe-Alamah, H. (2015). *Leininger's sunrise enabler to discover culture care, modified by McFarland and Wehbe-Alamah (2015).* Retrieved from: http://www.madeleine-leininger.com/cc/sunrise2015.pdf.

Meleis, A. (1996). Culturally-competent scholarship: Substance and rigor. *Advances in Nursing Science, 19*(2), 1-16.

Meleis, A. (1999). Culturally-competent care. *Journal of Transcultural Nursing, 10*(1), 12.

Meleis, A. (Ed.). (1995). *Diversity, marginalization, and culturally-competent healthcare: Issues in knowledge development* [Monograph]. Washington, DC: American Academy of Nursing.

Melo, L. P. D. (2013). The Sunrise Model: a Contribution to the Teaching of Nursing Consultation in Collective Health. *American Journal of Nursing Research*, 1(1), 20-23.

Morse, J. (2013). Determining sample size. *Qualitative Health Research, 10*(3), 3-5.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage Publications.

Napholz, L. (1999). A comparison of self-reported cultural competency skills among two groups of nursing students: Implications for nursing education. *Journal of Nursing Education, 38*(2), 81-83.

National Association of Hispanic Nurses (2016). Hispanics in Nursing. Retrieved from https://www.nahnnet.org/NAHN_NIH_Project.html

NCLEX-RN Examination (2016). Detailed test plan for the National Council Licensure.

Nelson, J. (2006). Culture care theory: The theory of culture care diversity and universality. *International Journal for Human Caring, 10*(4), 50-54.

Ng, J., Popova, S., Yau, M., & Sulman, J. (2012). Do culturally sensitive services for Chinese in-patients make a difference? *Social Work in Healthcare*, *44*(3), 129-143.

Nightingale, F. (1859). *Notes on nursing: What it is and what it is not*. Philadelphia, PA: Lippincott, Williams, and Wilkins.

Owens, A., & Randhawa, G. (2004). 'It's different from my culture; they're very different': Providing community-based, 'culturally-competent' palliative care for South Asian people in the UK. *Health and Social Care in the Community*, *12*(5), 414-421.

Papadopoulos, I., & Omeri, A. (2008). Transcultural nursing theory models: The challenges of application. *Contemporary Nurse*, *28*, 45-47.

Perloff, R., Bonder, B., Ray, G., Ray, E., & Siminoff, L. (2006). Doctor-patient communication, cultural competence, and minority health: Theoretical and empirical perspectives. *American Behavioral Scientist, 49*, 835-852.

Polit, D., & Beck, C. (2011). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott.

Purnell, L., & Paulanka, B. (1998). *Transcultural healthcare: A culturally-competent approach.* Philadelphia, PA: F. A. Davis Company.

Reitmanova, S., & Gustafson, D. (2011). "They can't understand it": Maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Maternal Child Health Journal*, *12*, 101-111.

Reynolds, C., & Leininger, M. (1993). *Culture care diversity universality theory*. London, England: Sage.

Rudestam, K., & Newton, R. (2012). *Surviving your dissertation: A comprehensive guide to content and process*. Los Angeles, CA: Sage.

Ryan, M., Twibell, R., Brigham, C., & Bennett, P. (2013). Learning to care for clients in their world, not mine. *Journal of Nursing Education*, *39,* 401-408.

Ryan, M., Twibell, R., Miller, A., & Brigham, C. (1996). Cross cultural communication: A report of faculty collaboration through regional networking. *Nurse Educator*, *21*(6), 28-32.

Saha, S., Arbelaez, J., & Cooper, L. (2003). Patient-physician relationships and racial disparities in the quality of healthcare. *American Journal of Public Health, 93*(10), 1713-1719.

Salimbene, S. (1999). Cultural competence: A priority for performance improvement action. *Journal of Nursing Care Quality, 13*(3), 23-35.

Sanner, S., Baldwin, D., Cannella, K., Charles, J., & Parker, L. (2010). The impact of cultural diversity forum on students' openness to diversity. *Journal of Cultural Diversity*, *17*(2), 56-61.

Satir, V. (1972). *People making: Because you want to be a better parent*. Palo Alto, CA: Science and Behavior Books, Inc.

Schim, S., Doorenbos, A., & Borse, N. (2006). Cultural competence among hospice nurses. *Journal of Hospice and Palliative Nursing, 8*(5), 302-307.

Schmidley, A., & Gibson, C. (1999). *Profile of the foreign-born population in the United States: 1997.* Washington, DC: U.S. Government Printing Office.

Seright, T. (2012). Perspectives of registered nurse cultural competence in a rural state, Part II. *Online Journal of Rural Nursing and Healthcare*, *7*(1), 57-69.

Sheppard, V., Zambrana, R., & O'Malley, A. (2004). Providing healthcare to low- income women: A matter of trust. *Family Practice, 21*(5), 484-491.

Sitzman, K. (2007). Teaching-learning professional caring based on Jean Watson's theory of human caring. *International Journal for Human Caring, 11*(4), 8-16.

Small, R., Roth, C., Raval, M., Shafiei, T., Korfker, D., Heaman, M., ... Gagnon, A. (2014). Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy and Childbirth, 14*(1), 152.

Smith, J., & Dunworth, F. (2003). Qualitative methodology. *Handbook of Developmental Psychology*, 603-621.

Smith, L. (1998). Concept analysis: Cultural competence. *Journal of Cultural Diversity*, *5*(1), 4-10.

Spector, R. (2013). *Cultural diversity in health and illness* (8th ed.). Stamford, CT: Appleton & Lange.

Stanley, M. J. C., Hayes, J., & Silverman, F. L. R. (2014). Examining student nurses' perceptions of diverse populations: Are student nurses prepared to care for culturally diverse patients? *Journal of Nursing Education and Practice, 4*(7), 148.

Starks, H., & Trinidad, S. (2012). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380.

Stepanikova, I., Mollborn, K., Thom, D., & Kramer, R. (2006). Patients' race, ethnicity, language, and trust in a physician. *Journal of Health and Social Behavior, 47*(4), 390-405.

Stewart, A. L., Nápoles□Springer, A. M., Gregorich, S. E., & Santoyo Olsson, J. (2007). Interpersonal processes of care survey: Patient-reported measures for diverse groups. *Health Services Research*, *42*(3), 1235-1256.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*(4), 477-486.

Sue, S., Fujino, D., Hu, L., Takeuchi, D., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting & Clinical Psychology, 59*(4), 533-540.

Suh, E. (2004). The model of cultural competence through an evolutionary concept analysis. *The Journal of Transcultural Nursing, 15*(2), 93-102.

Suliman, W., Welmann, E., Omer, T., & Thomas, L. (2009). Applying Watson's nursing theory to assess patient perceptions of being cared for in a multicultural environment. *Journal of Nursing Research, 17*(4), 293-300.

Swanson, K. M. (2012). What is known about caring in nursing science? *Caring in Nursing Classics: An Essential Resource*, 59.

Tanner, C. (1996). Cultural diversity in nursing education. *Journal of Nursing Education, 35,* 291-292.

Thom, David H., Ribisl, Kurt M., Stewart, Anita L., Luke, Douglas A. (1999). Further Validation and Reliability Testing of the Trust in Physician Scale. *Medical Care, 37(5),* 510-517.

Transcultural Nursing Society. (2002). *Mission statement.* Retrieved from http://www.tcns.org/society/about

U.S. Department of Health and Human Services (2010). *Health Resources and Services Administration. Bureau of Health Professions. The registered nurse population: Findings from the 2008 National Sample Survey of Registered Nurses. Table 2-2 and Appendix A, Table 5*. Retrieved from http://bhpr.hrsa.gov/healthworkforce/rnsurvey/2008/nssrn2008.pdf

UNFPA (2005). *Cultural Programming: Reproductive health challenges and strategies in East and South-East Asia*. Bangkok, Thailand: UNFPA.

UVA Today (2014). *UVA student finds Hispanic women opt for labor pain relief less often than others.* Retrieved from https://news.virginia.edu/content/uva-student-finds-hispanic-women-opt-labor-pain-relief-less-often-others

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany: SUNY Press.

Vandall-Walker, V., Jensen, L., & Oberle, K. (2012). Nursing support for family members of critically ill adults. *Qualitative Health Research, 17*(9), 1207-1218.

Watson, J. (2012). Caring science and human caring theory: Transforming personal and professional practices of nursing and healthcare. *Journal of Health and Human Services Administration, 31*(4), 466-482.

World Health Organization (WHO). (2003). *Working with individuals, families, and communities to improve MNH.* Geneva, Switzerland: WHO.

World Health Organization. (2007). *Maternal mortality in 2005: Estimates developed by WHO UNICEF, UNFPA, and the World Bank*. Geneva, Switzerland: WHO.

Yoder, M. K. (1996). Instructional responses to ethnically-diverse nursing students. *Journal of Nursing Education, 35*(7), 315-321.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., … Lowe, S. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33*(5), 569-585.

APPENDIX A

UNIVERSITY OF ALABAMA
HUMAN RESEARCH PROTECTION PROGRAM

UNIVERSITY OF ALABAMA
Individual's Consent to be in a Research Study

Your participation in a research study, called "Understanding the Lived Experiences of the Hispanic Maternity Patient" is requested. This study is conducted by Andraa' Perrin, MSN, RN. She is a doctoral student in the College of Education and the Capstone College of Nursing at The University of Alabama. She is supervised by Dr. Melondie Carter.

What is this study about?
Nursing as a profession and nursing education in particular have begun to include safeguards to ensure that patient care also includes providing care that is sensitive to issues of racial, cultural, religious, age, and/or sexuality minority groups. In this study, the researcher is seeking to understand the nature of this experience for those patients. Specifically, the investigator would like to know whether the patient thinks that they received culturally sensitive nursing care.

Why is this study important and what good will the results do?
The findings will help nurse educators understand the issues that surround educating future nurses regarding racial, cultural, religious, age, and/or sexuality minority sensitive nursing care. This will help them to deliver more patient centered care sensitive of race, culture, religion, age, and sexuality.

Why have I been asked to take part in this study?
You responded to a letter presented to you upon visiting the WIC Program at the county health department in Northeast Georgia. You told us that you were a member of a Hispanic ethnic group who was discharged from a Mother/Baby Unit within the past 2-4 weeks with a minimum stay of 2 days. You gave us your contact information.

How many other people will be in this study?
The investigator hopes to interview 15-20 people from Northeast Georgia within the next 6 months.

What will I be asked to do in this study?
If you agree to be in this study, Andraa' Perrin will interview you at the health department regarding your experience with nursing care while you were hospitalized. The interviewer would like to audiotape the interview to ensure that all your words remain accurately captured. However, if you do not want to be taped, simply tell the interviewer, who will take handwritten

notes. The interviewee will also be asked to complete a brief demographic questionnaire and participate in a second follow-up interview.

How much time will I spend being in this study?
The interview should last about 30-45 minutes, depending on how much information about your experiences you choose to share. It should take less than 10 minutes to complete the questionnaire, so your total time in the study should be about 1 hour. If you decide to participate in the second follow-up interview, this will require an additional 30-45 minutes.

Will being in this study cost me anything?
The only cost to you from this study is your time.

Will I be compensated for being in this study?
You will be compensated with a $10.00 Wal-Mart gift card for your time and participation in this study.

What are the risks (problems or dangers) from being in this study?
No potential risks are involved in this study beyond minimal risk that does not exceed the risks associated with normal daily activities. If you find the discussion of your experiences to be sad or stressful, you can control this possibility by refusing to answer a particular question, or by not telling things you find to be sad or stressful. At any time, the interviewee begins to experience any discomfort with the interview process the interview will be discontinued immediately. A counselor can be recommended to you if you seem to be upset or depressed. Seeing the counselor would be at your own expense.

What are the benefits of being in this study?
There are no direct benefits to you unless you find it pleasant or helpful to describe your experience regarding your nursing care while hospitalized. You may also feel good knowing that you have helped nurse educators learn how to help nursing students provide better racial, cultural, religious, age, and/or sexuality sensitive care.

How will my privacy be protected?
The interview will be conducted in a private room in the WIC clinic so we can talk without being overheard. If you consent to a second follow-up interview, it may be conducted via phone or in one of the private rooms at the WIC clinic. You will decide how much or how little information about yourself and your experiences to share with the researcher. If you do not feel comfortable answering a particular question, feel free to decline it. You will not be forced to answer any question for the interview or questionnaire. If you become too upset during the interview, we can stop for a break or you may quit at any time.

How will my confidentiality be protected?
The only place where your name appears in connection with this study is on this informed consent. The consent forms will be kept in a locked file drawer in Andraa' Perrin's office. There is not a name-number list so there is no way to link a consent form to an interview. When the interview is audiotaped, your name will not be used, so no one will know who you are on the tape. When the interviews have been typed, the audiotapes will be destroyed. This should occur within one month

of the interview. You may refuse to be audio taped, in which case the interviewer will take handwritten notes. Any records that would identify you as a participant in this study, such as informed consent forms, will be destroyed by shredding approximately 3 years after the study is completed.

Research articles will be written on this study but participants will be identified only as "persons from 10 counties in Northeast Georgia". No one will be able to recognize you.

What are the alternatives to being in this study?
The only alternative is not to participate.

What are my rights as a participant?
Being in this study remains voluntary. It is your free choice. You may choose not to be in it at all. If you start the study, you can stop at any time. Not participating or stopping participation will have no effect on services you receive through the WIC Program or health department.

The University of Alabama Institutional Review Board is a committee that looks out for the ethical treatment of people in research studies. They may review the study records if they wish. This is to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?
If you have questions about this study right now, please ask them. If you have questions later on, please call Andraa' Perrin at 706-255-0420 or her faculty supervisor, Dr. Melondie Carter at 205-348-1022. If you have questions or complaints about your rights as a research participant, call Ms. Carpantato Myles, the Research Compliance Officer of the University at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make a suggestion, or file complaints and concerns through the Institutional Review Board (IRB) Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. After you participate, you are encouraged to complete the survey for research participants that is online there, or you may ask Andraa' Perrin for a copy of it. You may also e-mail us at participantoutreach@bama.ua.edu.

Two copies of this informed consent form have been provided. Please sign both, indicating you have read, understood, and agree to participate in this research. Return one to the researcher and keep the other for your files. The IRB of The University of Alabama retains access to all signed informed consent forms.

I have read this consent form. I have had a chance to ask questions.

The researcher would like permission to audio record the interview. If you would rather not be recorded, the researcher will take handwritten notes instead.

_____You may audio record my interview.

_____ I do not wish to be audio recorded.

Signature of Research Participant_____ Date_____

Signature of Investigator_____ Date_____

APPENDIX B

Interview Protocol

First Interview

Research Question

How can the lived experiences of Hispanic American maternity patients enhance the pedagogical approaches to teaching culturally sensitive nursing care in maternity courses?

Additional Questions to Support Research Questions

1. Tell me about yourself. What is it like to be a Hispanic giving birth here in the U.S.?
2. What customs, values, beliefs, and/or health practices do you use as a Hispanic when giving birth?
3. What customs, values, beliefs, and/or health practices would you like your doctors and nurses to know more about?
4. What does it mean to be cared for when you are giving birth?
5. In what ways did the nursing staff help you as you gave birth?
6. What types of things did the nurses do that made you feel comfortable or cared for?
7. What types of things did the nurses do that made you feel uncomfortable or not cared for?
8. If this was not your first pregnancy, were there differences in how the nurses cared for you with your previous birth?

APPENDIX C

Interview Protocol

d Interview

Research Question

How can the lived experiences of Hispanic American maternity patients enhance the pedagogical approaches to teaching culturally sensitive nursing care in maternity courses?

Additional Questions to Support Research Questions

1) I have revealed the study findings to you. What are the differences in your birthing experiences and the study findings?
2) What are the similarities in your birthing experiences and the study findings?
3) Based on the findings of this study, what additional information would you like to include to help nurses providing care for Hispanic women during child birth?

APPENDIX D

Cover Letter

Understanding the Lived Experiences of the Hispanic Maternity Patient

I am currently involved in a research project addressing the identification of culturally sensitive caring behaviors of nurses. The project examines the relationship between nurses and patients from the patients' point of view. In examining this relationship, the patient will be asked to identify those behaviors they believe demonstrate caring. The study is performed as a partial fulfillment of the requirements for my Ed. D. degree in instructional leadership at The University of Alabama under the supervision of Dr. Melondie Carter.

Your participation in this project will provide useful information on this topic. You qualify for participation if you are between the ages of 20 and 35 years and are 2-4 weeks post-discharge from a mother/baby unit of a hospital. You will be asked to participate in a 7-question interview that will take about 45 minutes and a second interview that will take about 30-45 minutes. You will also be asked to fill out a background questionnaire that will take approximately 10 minutes.

Participation in this study is strictly voluntary. You may withdraw from the study at any point without penalty. Participation is not associated with your services from the WIC Program. All data from this project is confidential and will be used for research purposes only. Data from your questionnaire and interview is anonymous. Names of participants will not be connected to the information.

Although there are no foreseeable risks to the participant, the questions require the participant to reveal and recall lived experiences that may be upsetting. If you feel questions of this type would upset you, please feel free to decline from participation at any point in this project. A counselor can be recommended to you if you seem to be upset or depressed. Seeing the counselor would be at your own expense.

Thank you for your assistance.

(Signature)

Andraa' Perrin

706-255-0420

APPENDIX E

Demographic Questionnaire
Understanding the Lived Experiences of Hispanic Maternity Women

1) **What is your age? _____**
2) **How do you describe yourself?** (please circle the one option that best describes you)
   American Indian or Alaska Native
   Hawaiian or Other Pacific Islander
   Asian or Asian American
   Black or African American
   Hispanic or Latino
   Non-Hispanic White
3) **How long have you lived in the U.S.?**
   _____years
   _____months
4) **What languages are spoken in your home?** (Mark all that apply.)
   _____English
   _____Spanish
   _____Other (explain)_____
5) **Marital status. Are You…** (please circle the one option that best describes you)
   Married
   Divorced
   Widowed
   Separated
   Never been married
   A member of an unmarried couple
6) **What is the highest grade or year of school you completed?** (please circle the one option that best describes you)
   Never attended school or only attended kindergarten
   Grades 1 through 8(Elementary-Middle School)
   Grades 9 through 11 (Some high school)
   Grade 12 or GED (High school graduate)
   College 1 year to 3 years (Some college of technical school
   College 4 years (College graduate)
   Graduate School(Advance Degree)
7) **How many children live in your household who are...**
   Less than 5 years old? _____
   5 through 12 years old? _____
   13 through 17 years old?_____

8) Are you willing to participate in a second interview?

_____Yes (If yes, please provide contact information below.)

_____No

Contact Information:_____

_____

APPENDIX F

Proposed Timeline

January – May 2011	Development of Dissertation Prospectus
June 2011	Meetings with Dissertation Chair to prepare Prospectus for presentation to committee
July 2011	Present Prospectus to Dissertation Committee
August – December 2013	Develop Proposal
July 22, 2015	Present Proposal to Dissertation Committee (Chapters 1-3)
September 1, 2015 – November 1, 2015	Data Collection and Analysis
November 1, 2015 – May 1, 2016	Write Chapters 4-5 of Dissertation
June 21, 2016	Defend Dissertation

APPENDIX G

DPH IRB Approval Letter

Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor
Atlanta, Georgia 30303-3142
www.health.state.ga.us

September 4, 2015

Andraa Perrin
MSN, RN
109 Tyrus Lane
Royston, GA 30662

Project: 150805 - Understanding the Lived Experiences of the Hispanic Maternity Patient

Project Status: Approved Until 09/04/2016

Dear Researcher,

The above-refereneced project was reviewed by the DPH Institutional Review Board in accordance with expedited review procedures outlined in 45 CFR 46.110(b)(1), category(ies) **7**
The Board has **approved** this study until **09/04/2016**

If you wish to continue this project beyond the current approval period, please submit a "Continuing Review Application" before the above expiration date. If you do not submit a renewal application before the expiration date, the approval of your project will automatically terminate. Any involvement with human subjects must cease on the above date unless you have received approval from the Board to continue the project. It is the investigators responsibility to track the deadline.

This approval applies only to the protocol described in your application. IRB review and approval is required before implementing any changes in this project except where necessary to eliminate apparent immediate hazards to human subjects.

If you have any questions regarding this letter or general procedures, please contact the DPH IRB at irb@dhr.state.ga.us. Please reference the project # in your communication.

Best wishes in your research endeavors,

[redacted]

APPENDIX H

University of Alabama IRB Approval Letter

Office for Research

Institutional Review Board for the Protection of Human Subjects

THE UNIVERSITY OF ALABAMA RESEARCH

August 25, 2015

Andraa' Perrin
109 Tyrus Lane
Royston, GA 30662

Re: IRB # 15-OR-254: "Understanding the Lived Experiences of the Hispanic Maternity Patient"

Dear Ms. Perrin,

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your approval will expire on August 24, 2016. If the study continues beyond that date, you must complete the IRB Renewal Form within e-Protocol. If you modify the application, please complete the IRB Revision Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Final Report Form.

Please use reproductions of the IRB-stamped consent form.

Should you need to submit any further correspondence regarding this application, please include the assigned IRB approval number.

Good luck with your research.

Sincerely,

[redacted]

358 Rose Administration Building
Box 870127
Tuscaloosa, Alabama 35487-0127
(205) 348-8461
FAX (205) 348-7189
TOLL FREE (877) 820-3066

UNIVERSITY OF ALABAMA
HUMAN RESEARCH PROTECTION PROGRAM

UNIVERSITY OF ALABAMA
Individual's Consent to be in a Research Study

You are being asked to be in a research study. This study is called "Understanding the Lived Experiences of the Hispanic Maternity Patient". This study is being done by Andraa' Perrin, MSN, RN. She is a doctoral student in the College of Education and the Capstone College of Nursing at The University of Alabama. She will be supervised by Dr. Melondie Carter.

What is this study about?
Nursing as a profession and nursing education in particular have begun to include safeguards to ensure that patient care also includes providing care that is sensitive to issues of racial, cultural, religious, age, and/or sexuality minority groups. In this study, the researcher is seeking to understand the nature of this experience for those patients. Specifically, the investigator would like to know whether the patient thinks that they received culturally sensitive nursing care.

Why is this study important-What good will the results do?
The findings will help nurse educators understand the issues that surround educating future nurses regarding racial, cultural, religious, age, and/or sexuality minority sensitive nursing care. This will help them to deliver more realistic care that is patient centered and sensitive of race, culture, religion, age, and sexuality.

Why have I been asked to take part in this study?
You responded to a letter presented to you upon visiting the WIC Program at the county health department in Northeast Georgia. You told us that you are a member of a Hispanic ethnic group that was discharged from a Mother/Baby Unit within the past two-four weeks with a minimum stay of two days. You gave us your contact information.

How many other people will be in this study?
The investigator hopes to interview 15- 20 people from Northeast Georgia within the next six months.

What will I be asked to do in this study?
If you agree to be in this study, Andraa' Perrin will interview you at the health department regarding your experience with nursing care while you were hospitalized. The interviewer would like to audiotape the interview to be sure that all your words are captured accurately. However, if you do not want to be taped, simply tell the interviewer, who will take handwritten notes. The interviewee will also be asked to complete a brief demographic questionnaire and participate in a second follow-up interview.

How much time will I spend being in this study?
The interview should last about 30-45 minutes, depending on how much information about your experiences you choose to share. It should take less than 10 minutes to complete the questionnaire, so your total time in the study should be about 1 hour. If you decide to participate in the second follow-up interview, this will require an additional 30-45 minutes.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 8/25/2015
EXPIRATION DATE: 8/24/2016

Will being in this study cost me anything?
The only cost to you from this study is your time.

Will I be compensated for being in this study?
You will be compensated with a $10.00 Wal-Mart gift card for your time and participation in this study.

What are the risks (problems or dangers) from being in this study?
No potential risks are involved in this study beyond minimal risk that does not exceed the risks associated with normal daily activities. If you find the discussion of your experiences to be sad or stressful, you can control this possibility by refusing to answer a particular question, or by not telling things you find to be sad or stressful. At any time, the interviewee begins to experience any discomfort with the interview process the interview will be discontinued immediately. A counselor can be recommended to you if you seem to be upset or depressed. Seeing the counselor would be at your own expense.

What are the benefits of being in this study?
There are no direct benefits to you unless you find it pleasant or helpful to describe your experience regarding your nursing care while hospitalized. You may also feel good about knowing that you have helped nurse educators learn how to help nursing students provide better racial, cultural, religious, age, and/or sexuality sensitive care.

How will my privacy be protected?
The interview will be conducted in a private room in the WIC clinic so we can talk without being overheard. If you consent to a second follow-up interview, it may be conducted via phone or in one of the private rooms at the WIC clinic. You will decide how much or how little information about yourself and your experiences to share with the researcher. If you do not feel comfortable answering a particular question, feel free to decline it. You will not be forced to answer any question for the interview or questionnaire. If you become too upset during the interview, we can stop for a break or you may quit at any time.

How will my confidentiality be protected?
The only place where your name appears in connection with this study is on this informed consent. The consent forms will be kept in a locked file drawer in Andraa' Perrin's office, which is locked when she is not there. We are not using a name-number list so there is no way to link a consent form to an interview. When we audiotape the interview, we will not use your name, so no one will know who you are on the tape. Once back in my office, I will type out the interview. When the interviews have been typed, the audiotapes will be destroyed. This should occur within one month of the interview. You may refuse to be audio taped, in which case the interviewer will take handwritten notes. Any records that would identify you as a participant in this study, such as informed consent forms, will be destroyed by shredding approximately 3 years after the study is completed.
We will write research articles on this study but participants will be identified only as "persons from 10 counties in Northeast Georgia". No one will be able to recognize you.

What are the alternatives to being in this study?
The only alternative is not to participate.

What are my rights as a participant?
Being in this study is totally voluntary. It is your free choice. You may choose not to be in it at all. If you start the study, you can stop at any time. Not participating or stopping participation will have no effect on services you receive through the WIC Program or health department.

The University of Alabama Institutional Review Board is a committee that looks out for the ethical treatment of people in research studies. They may review the study records if they wish. This is to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?
If you have questions about this study right now, please ask them. If you have questions later on, please call Andraa' Perrin at 706-255-0420 or her faculty supervisor, Dr. Melondie Carter at 205-348-1022. If you have questions or complaints about your rights as a research participant, call Ms. Carpantato Myles, the Research Compliance Officer of the University at 205-348-8461 or toll-free at 1-877-820-3066..

You may also ask questions, make a suggestion, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. After you participate, you are encouraged to complete the survey for research participants that is online there, or you may ask Andraa' Perrin for a copy of it. You may also e-mail us at participantoutreach@bama.ua.edu.

Two copies of this informed consent form have been provided. Please sign both, indicating you have read, understood, and agree to participate in this research. Return one to the researcher and keep the other for your files. The Institutional Review Board of The University of Alabama retains access to all signed informed consent forms.

I have read this consent form. I have had a chance to ask questions.

The researcher would like permission to audio record the interview. If you would rather not be recorded, the researcher will take handwritten notes instead.

_____You may audio record my interview.

_____ I do not wish to be audio recorded.

Signature of Research Participant_____ Date_____

Signature of Investigator_____ Date_____

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 8/25/2015
EXPIRATION DATE: 8/24/2016