

# DPC Tips on Cultural Awareness



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America has long been called the “Melting Pot” of the world. This is truer today than ever in the general population as well as the dialysis population. Prevailing attitudes, past behaviors, customs and traditions comprise culture. Culture is learned and shared in families, in ethnic and gender groups, in geographic regions, by social class and even in universities. Behaviors that seem rude and obnoxious in one culture may be perfectly normal in another. So it is not uncommon for misunderstandings to arise between people of very different cultures. When cultural expectations of staff and patients differ significantly, conflict is likely to occur.

Sometimes, just enhancing sensitivity to these differences can reduce conflict. While this tip sheet cannot address the many components of Cultural Competency, highlights are provided with resources for more in-depth information that can be obtained to suit the diversity of your unit.

## Immigrants and Refugees

The reason a person came to the U.S. may be important in understanding how they will adjust to their illness and the dialysis setting. Sensitivity about immigration status may create tensions when in-depth assessments are performed. Fears of deportation or reporting may drive refusal to provide information or raise suspicion of the staff’s asking questions. The Immigration and Naturalization Service (INS) defines the following: Immigrant -a nonresident alien admitted for permanent residence; Refugee -a person who is admitted outside of official quota restrictions based on a well founded fear of persecution because of race, religion, nationality, social group, or political opinion; Asylum-seeker- a person who comes to the U.S. applying for refugee status; Undocumented Persons -entrants who do not possess documents allowing them to legally reside in the U.S. This group is commonly referred to as "illegal aliens" or “illegals,” and people may take great offense to this term.

## Ethnic and Racial Groups

Sometimes these two terms are confused, creating misunderstandings. Race was originally about biological differences. The most common races were Caucasian, African-American, and Mongoloid. Because there has been extensive racial mixing, there are now many more categories, and the biological differences are not as distinct. In a discussion about cultural differences, race has an impact mainly because of sensitivities and perceptions about racism, which is defined as “an oppressive system of racial relations, justified by ideology, in which one racial group benefits from dominating another.” (Krieger, et al 1993). Being called racist is very offensive, perhaps more so when a patient makes that accusation of the caregiver. Of course the feeling of being discriminated against because of race can create serious distrust that will undermine the caregiver- patient relationship.

Ethnicity relates to the grouping of people by social, cultural, and political characteristics. This may be based on ancestry, language or religion for instance. People may differ in how closely they relate to their ethnic group. Patients within the same culture may differ. These differences may be observed in each succeeding generation from the original immigrants, or even when religions modernize.

## Social Class and Socioeconomic Status

Social class and economic status are related to income, education, occupation and even geographic region. This factor may be more important in health status than any other. For a chronically ill person, economic status may well determine many quality of life issues i.e. how well a patient will be able to adhere to the prescribed dialysis regime due to

transportation issues, financial ability to purchase medications, and most certainly, diet. Staff or other patients that have never faced these challenges may not be able to comprehend why others simply will not do what the doctor says.

### **Sexual Orientation**

Several high profile cases of violence to homosexuals and the debate about gay marriage highlight the many societal differences that we all face. Matters of sexual orientation cross all racial and ethnic groups. This is a good example of how geography can impact cultural acceptance or stigmatism of different groups; inner city San Francisco is very accepting of the gay lifestyle in contrast to a rural middle American city.

### **Areas of Common Cultural Differences**

**Conversational Style:** We have all interacted with people who seem abrupt, almost rude in their conversational style, and when we get to know them, we realize that nothing negative was intended; it is just their “way.” Initially, however, these differences can be very upsetting, especially if coupled with other cultural differences. In certain cultures silence may indicate respect, while in others it may mean “no” and in another culture it may be perceived as giving “the silent treatment.” Some cultures use loud voices for emphasis while others only raise their voice in anger. Conflicts that arise from conversational style differences may escalate quickly unless the caregiver can follow the conflict resolution steps like creating a calm environment and using a non judgmental approach until understanding can be reached.

**Personal Space:** Most people have had the experience of having a person get too close for comfort. Commonly this behavior is not malevolent rather it just a difference in culture about personal space. Often there are differences in generations concerning personal space, with older persons being more sensitive. These differences are heightened in the dialysis environment with staff leaning over patients, sometimes touching them in a personal area, for instance high on the inner arm or the thigh or assisting a patient that is unsteady to the scale. Care should be taken to ensure that staff is sensitive to these differences.

**Eye Contact:** Perception of eye contact varies dramatically between cultures. While direct eye contact is presumptuous and rude to some, avoiding it is suspicious behavior to others. There are important cultural differences regarding eye contact between men and women and young and old that may be easily misinterpreted as negative personality characteristics.

**Touch:** It may seem obvious to some that touching is a particularly sensitive area; however, as caregivers we may forget how easily upset persons of particular cultures or religions may be regarding touching. There are prohibitions in some cultures regarding touching one part of the body before the other. Touching the genitals or discussing a sexual issue may be taboo in many cultures.

**Time Orientation:** Time perception varies between people of the same family. These perceptions are magnified between cultures. While one person is tapping his/her foot waiting for the another person that is only two minutes late, someone else may not even notice that another is late until a half hour has passed. Matters regarding time can disrupt the dialysis facility schedule and create tremendous conflict. Time orientation problems must be recognized and addressed early on.

## **Conclusion**

Sometimes we all just need to be reminded of these differences and nudged to understand that the way we perceive certain behaviors and actions may be very different to the way others perceive them. This tip sheet can be handed out to staff, or it can be discussed in an open meeting. It is highly recommended that some research be done into cultures of patients whose cultures are very different from the culture of the staff, and then have discussions about those differences. If conflicts arise that may be related to cultural differences, suggest this as a possibility to staff and then ask the Social Worker or another staff member to do some research using the following resources.

## **References**

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Office of Minority Health, Health Resources and Services Administration. *Cultural Competence in Cancer Care: A Health Care Professionals Passport*.

Salimbene, S. (2000). What Language Does Your Patient Hurt In?: A Practical Guide to Caring for Patients from Other Cultures. *Inter-Face International*. Available at <http://www.interfaceinter.com>.

Spector, RE. (2000). *Cultural Diversity in Health and Illness*. 5th ed.

## **Websites**

### **Health Resources & Services Administration**

<http://erc.msh.org/mainpage.cfm?file=5.4.0.htm&module=provider&language=English>.

This site has sections on the following cultural groups: African Americans, Arab Americans, Asian Americans, Central Asians, Hispanics/Latinos, Muslims, Native Americans, Pacific Islanders, South Asians.

### **Trans-cultural Nursing: Basic Concepts and Case Studies**

<http://www.culturediversity.org/mide.htm>.

This site offers information on treating patients of the Islamic faith, using real-life examples to illustrate key points.

### **Institute of Druze Studies**

<http://www.druzestudies.org/druzes.html>.

This site provides a background and demographics of the Druze minority in the Middle East.

### **Harborview Medical Center**

<http://ethnomed.org/ethnomed/cultures>.

This site provides a cultural profile on the Ethiopian, Eritrean and Somali people.