LEARNING OBJECTIVES

• Describe the main characteristics of contemporary family forms.
• Identify key factors influencing family health.
• Explain family functions that contribute to the well-being of family members and society.
• Explain family dynamics and how family dynamics contribute to accomplishing family functions.
• Compare theoretic approaches for working with childbearing families.
• Relate the impact of culture on childbearing families.
• Discuss cultural competence in relation to one’s own nursing practice.

KEY TERMS AND DEFINITIONS

acculturation Changes that occur within one group or among several groups when people from different cultures come in contact with one another
assimilation Process that occurs when a cultural group loses its identity and becomes part of the dominant culture
binuclear family Family after divorce, in which the child is a member of both the maternal and paternal nuclear households

Cultural competence Awareness, acceptance, and knowledge of cultural differences and adaptation of services to acknowledge and support the culture of the patient

cultural context Setting in which one considers the individual’s and the family’s beliefs and practices (culture)
cultural knowledge Includes beliefs and values about each facet of life and is passed from one generation to the next

cultural relativism Refers to learning about and applying the standards of another person’s culture to activities within that culture
ethnocentrism Belief in the rightness of one’s culture’s way of doing things

extended family Family that includes nuclear family and other people related by blood

family dynamics Interaction and communication among family members

family functions Affective, socialization, reproductive, economic, and health care functions that contribute to the well-being of the family
genogram Pictorial representation of family relationships and health history

homosexual (lesbian or gay) family Consists of same-sex adults and children from previous heterosexual unions, conceived through therapeutic insemination, or adopted

nuclear family Family that consists of parents and their dependent children
reconstituted family Also called blended, combined, or remarried family; includes stepparents and stepchildren

single-parent family Family in which child lives with one parent because of divorce, separation, or desertion, birth to a single parent, or adoption

subculture Group existing within a larger cultural system that retains its own characteristics

ELECTRONIC RESOURCES

Additional information related to the content in Chapter 2 can be found on the companion website at http://evolve.elsevier.com/Lowdermilk/Maternity/

• NCLEX Review Questions
• WebLinks

or on the interactive companion CD

• Critical Thinking Exercise—Cultural Health and the Family
• Plan of Care—Incorporating the Infant into the Family
• Plan of Care—The Family Newly Immigrated from a Non-English-Speaking Country
THE FAMILY IN CULTURAL AND COMMUNITY CONTEXT

The family is one of society’s most important institutions. It represents a primary social group that influences and is influenced by other people and institutions. The family assumes major responsibility for the introduction and socialization of children. It transmits its fundamental cultural background to its members. The family and its cultural context play an important role in defining the work of maternity nurses. Family structure and function, care-seeking behavior, and relationships with providers are all influenced by culturally related health beliefs and values. Ultimately all of these factors have the power to affect maternal and child health outcomes. It is therefore important to recognize these influences, discuss current trends in families, and explore nursing implications.

The family has traditionally been viewed as the primary unit of socialization, the basic structural unit within a community. Family preserves and transmits culture. Family plays a pivotal role in health care, representing the primary target of health care delivery for maternal and newborn nurses. Most models of health behavior view family as a “system” within the larger social framework of a community. These definitions and understandings affect our approaches to health and health care of individuals within the family unit.

The family assumes major responsibility for the introduction and socialization of children. It transmits its fundamental cultural background to its members. Despite modern stresses and strains, the family, through its structure and function, forms a social network that acts as a potent support system for its members. The current emphasis in working with families is on wellness and empowerment for families to achieve control over their lives (Evidence-Based Practice box). More challenging issues such as poverty, teenage pregnancy, drug addiction, incest, abuse, and violence require increasing attention.

DEFINING FAMILY

The family has traditionally been viewed as the primary unit of socialization, the basic structural unit within a community. Family preserves and transmits culture. Family plays a pivotal role in health care, representing the primary target of health care delivery for maternal and newborn nurses. Most models of health behavior view family as a “system” within the larger social framework of a community. These definitions and understandings affect our approaches to health and health care of individuals within the family unit.

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Family Organization and Structure

Census data indicate significant alterations in the definition and social configuration of families over the past several decades. The Urban Institute recognizes four categories of families: the two-parent family, the single-parent family, blended families, and no-parent families (Staveteig & Wigton, 2000). A broader view of the contemporary family is as “a group of two or more persons related by blood, marriage, adoption, or emotional commitment who have a permanent relationship and who work together to meet life goals and needs” (Brooks, 2002).

When members are gained or lost through events (e.g., marriage, divorce, birth, death, abandonment, or incarceration), the family composition is altered and roles must be redefined or redistributed. Children may belong to several different family groups during their lives.
EVIDENCE-BASED PRACTICE
Promoting Cervical Screening

BACKGROUND
Cervical cancer is the third most common cancer worldwide, with 400,000 cases and 200,000 deaths every year. Most, if not all, cervical cancers are caused by human papillomavirus (HPV). Risk factors for cervical cancer include smoking, early sexual activity, multiple lifetime sexual partners, sexually transmitted infection, and impaired immunological status. Primary prevention of cervical cancer involves avoiding the risk factors. Secondary prevention includes achieving regular cervical screening. The Papanicolaou (Pap) test can increase survival rates, depending on the skill of the clinician collecting the endocervical and ectocervical cells from the transformation zone and the skill of the cytologist evaluating the smear. Typing for HPV can also screen for the aggressive types, of which types 16 and 18 cause 80% of all cervical cancers. Cervical screening is generally recommended every 1 to 3 years for women age 20 to 65 years. Compliance ranges from 84% in England, which has a well-established national screening program, to about 5% in developing countries, where 80% of all cervical cancer cases occur. In most countries, being older, less well educated, of lower socioeconomic status, and from a rural environment is associated with the poorest screening rate. Barriers to screening include feelings of embarrassment and vulnerability; cost; lack of perceived benefit; fear of cancer; and, in the case of HPV typing, contamination of sexual promiscuity.

OBJECTIVES
The reviewers’ goal was to examine the interventions that promote both compliance with cervical screening recommendations and informed consent. The following types of interventions were sought: invitations, reminders, educational materials, positive or negative message framing, obtaining informed consent, procedures to ease the screening procedure, and economic incentives. Primary outcomes included receiving a cervical screen and obtaining informed consent about the details of the procedure and its risks and benefits. Reviewers hoped for intermediate outcomes of appointments booked, intentions to attend screening, knowledge of screening, and satisfaction with screening, as well as costs.

METHODS
Search Strategy
Reviewers searched Cochrane, MEDLINE, BIDS, CANCERLIT, DHHS data, Dissertation Abstracts, HealthStat, ASSIA, Pascal, SIGLE, CINAHL, Sociological, PsychINFO, SHARE, NHS CRD DARE, and National Research Register, as well as bibliographies, specialists, and the Journal of American Screening. Keywords included vaginal smears, Pap tests, Papanicolaou, cytology, pap smear, with attitude, accept, encourage, improve, promote, uptake, and utilization. The reviewers found 35 controlled studies, representing over 570,000 women from the United States, Australia, the United Kingdom, Canada, Italy, and Belgium. Of these trials, 27 were randomized and eight were quasi-randomized.

Statistical Analysis
Similar data were pooled. Reviewers calculated relative risks for dichotomous (categorical) data, and weighted mean differences for continuous data. Results outside the 95% confidence interval were accepted as significantly different.

FINDINGS
Women were significantly more likely to use cervical screening when they received an invitation, especially when the letter was from the woman’s general practitioner health care provider and when they were provided with a fixed appointment in the letter. There was a trend toward greater participation when the letter revealed the gender of the clinician who would be taking the smear, and when using a health promotion nurse, but none of these reached the level of statistical significance. Response to telephone calls was equivocal. There was a greater response from women who received educational materials than controls. There was limited evidence of a beneficial effect of having a lay community member involved in promoting the screening.

LIMITATIONS
None of the studies were in developing countries. Invitations may not work in an area of frequent migration, illiteracy, or transportation from remote areas. Many address lists were outdated, and therefore many subjects were lost to follow-up. None of the trials examined informed consent related to risks and benefits. The assumption throughout the trials was that screening was always beneficial. The reviewers noted methodologic problems with the trial sizes, randomization, blindness of assessors, concealment of treatment allocation, and numbers lost to follow-up, as well as the way the statistical analysis of some of the data was handled.

CONCLUSIONS
Invitations and educational material appear to be effective at increasing participation in cervical screening in developed countries. Modifications of these methods may increase use of cervical screening in developing countries. Revealing the gender of the clinician and making a fixed appointment seem to be promising.

IMPLICATIONS FOR PRACTICE
To increase rates of cervical screening, health care providers can institute a program of written invitations with fixed appointments. The letter should include the gender of the health care provider. Educational materials should be distributed widely.

IMPLICATIONS FOR FURTHER RESEARCH
Trials that account for the methodologic problems of randomization, concealment, blindness of the assessors, and follow-up would strengthen the data pool. Reviewers calculated relative risks for dichotomous (categorical) data, and weighted mean differences for continuous data. Results outside the 95% confidence interval were accepted as significantly different.

network is an important resource in terms of preventive health behavior. Through its kinship network, the extended family provides role models and support to all its members. In the extended family, child-rearing is often a shared responsibility. The extended family is becoming more common as the U.S. population ages. The need to care for elderly parents within the same household often creates a “sandwich generation” in which parents of the nuclear family provide care for their children as well as for elderly grandparents or other relatives.

Single-parent family

Single-parent families are composed of an unmarried biological or adoptive parent who may or may not be living with other adults. The single-parent family may result from the loss of spouse by death, divorce, separation, or desertion; from either an unplanned or a planned pregnancy; or from the adoption of a child by an unmarried woman or man. This family structure is becoming more prevalent, with current estimates at one-fifth of Caucasian families, one-third of Hispanic families, and more than half of African-American families in the United States. Although the number of single-parent households has decreased for most groups, the number of single-parent families among African-American households has remained fairly steady at approximately 55% (Staveteg & Wigon, 2000).

Current research takes opposing perspectives on the merits and challenges of single-parent households. In many cases the single-parent family tends to be vulnerable economically and socially, creating an unstable and deprived environment for the growth potential of children. Research demonstrates the impact of single-parenthood not only in economic instability but also in relation to health status, school achievement, and high risk behaviors for affected children. Single mothers are more likely to live in poverty and have poor perinatal outcomes.

In recent years, single parenting has become a common and acceptable choice in society. Individuals for whom the single-parent family is a chosen lifestyle often enjoy a free and open system for the development of parents and children. In these families decision making and communication are seen as joint commitments between parent and child. The parent-child relationship is considered a major source of life fulfillment. The most frequently identified strength in these families is emotional closeness.

Binuclear family

A binuclear family is a family after divorce, in which the child is a member of both maternal and paternal nuclear households. In these families the degree of cooperation between parents varies. In joint custody the court assigns divorcing parents equal rights to and responsibilities for the minor child or children. These alternate family forms are efforts on the part of those concerned to view divorce as a process or reorganization and redefinition of a family rather than as a family dissolution.

Reconstituted family

Reconstituted or blended families, those formed as the result of divorce and remarriage, consist of unrelated family members (stepparents, stepchildren, and stepsiblings) who join together to create a new household. These family groups frequently involve a biological or adoptive parent whose spouse has not adopted the child.

Homosexual (lesbian and gay) family

Other family configurations that are less well documented include families in which the parents are cohabiting and an increasing number of homosexual (lesbian and gay) families, who may live together with or without children (Federal Interagency Forum on Children and Family Statistics, 2004). Children in homosexual (lesbian and gay) families may be the offspring of previous heterosexual unions, conceived by one member of a lesbian couple through therapeutic insemination, or adopted. These trends reflect the increased opportunities for alternate forms of parenthood within our society, owing both to more liberal social mores and to technologic and medical advances that offer the possibility of parenthood to single men and women. Despite increasing recognition of the biologic and psychologic needs of homosexual families, social acceptance and attitudes of health care providers often present significant barriers to quality health care.

Family Functions

Although family functions have evolved and adapted over time in response to social and economic changes (Friedman, Bowden, & Jones, 2002), the family progresses through its life cycle (Table 2-1) and continues to carry out certain functions for the well-being of family members and the wider society.

Family functions are described as affective, socialization, reproductive, economic, and health care functions (Friedman, Bowden, & Jones, 2002). The affective function is one of the most vital and focuses on meeting family members’ needs for affection and understanding. The socialization function refers to the learning experiences provided within the family to teach children their culture and how to function and assume adult social roles and is a lifelong process. The reproductive function ensures family continuity over the generations and the survival of society (Fig. 2-3). Economic functions involve the family’s provision and allocation of sufficient resources. Health care functions are met by the provision of such physical necessities as food, clothing, shelter, and health care. Some functions are emphasized more in one phase of a family’s life cycle; others are continuous for the family’s survival and progress. Many functions previously performed almost exclusively by one gender (e.g., child care and financial support) are today shared between genders. Although goals for socialization and child-rearing practices differ from culture to culture, in most societies the family appears to have three major objectives in relation to children: caregiving, nurturing, and training.
Family Dynamics
Families work cooperatively to accomplish family functions. Through family dynamics (interactions and communication), family members assume appropriate social roles. Social roles in the family are learned in pairs (e.g., mother-father, parent-child, and brother-sister). Role pairing enables social interactions to take place in an orderly, predictable manner; the roles are said to be complementary. Some families maintain a traditional pairing of roles, whereas other families change behavior patterns to suit a change in family lifestyle. Rather than mother-father and brother-sister, the roles may be mother-daughter or mother-son. Negotiation brings these pair roles into a new alignment. Negotiation is essential to maintain family equilibrium.

Ideally, the family uses its resources to provide a safe, intimate environment for the biopsychosocial development of the family members. The family provides for the nurturing of the newborn and the gradual socialization of the growing child. Children form their earliest and closest relationships with their parents or parenting persons; these affiliations continue throughout a lifetime. For better or worse, parent-child relationships influence self-worth and the ability to form later relationships. The family also influences the child’s perceptions of the outside world. The family provides the growing child with an identity that possesses both a past and a sense of the future. Cultural values and rituals are passed from one generation to the next through the family (Friedman, Bowden, & Jones, 2002).

Through everyday interactions the family develops and uses its own patterns of verbal and nonverbal communication. These patterns give insight into the emotional exchange within a family and act as reliable indicators of interpersonal relationships.
functioning. Family members not only react to the communication or actions of other family members, but also interpret and define them.

Over time the family develops protocols for problem solving, particularly regarding important decisions such as having a baby, buying a house, or sending children to college. The criteria used in making decisions are based on family values and attitudes about the appropriateness of the behavior and the moral, social, political, and economic events of society. The power to make critical decisions is given to a family member through tradition or negotiation. This power is not always stated. Power reflects the family’s concepts of male or female dominance and cultural practices, social customs, and community norms. As a result, family members attain certain statuses or hierarchies. They play out these statuses by assuming various roles. Most families have a member who “takes charge” or “is supportive” or “can’t be expected to do anything.”

The Family in Society

The social context for the family can be viewed in relation to social and demographic trends that define the population as a whole. Current U.S. census data indicate that the racial and ethnic diversity of the population has grown dramatically in the last three decades. This increased diversity—first manifested among children, and soon to be evident in the older population—is projected to increase in the future.

Each family sets up boundaries between itself and society. People are conscious of the difference between “family members” and “outsiders,” or people without kinship status. Some families isolate themselves from the outside community; others have a wide community network to help in times of stress. Although boundaries exist for every family, family members set up channels through which they interact with society. These channels also ensure that the family receives its share of social resources.

THEORETIC APPROACHES TO UNDERSTANDING FAMILIES

A family theory can be used to describe families and how the family unit responds to events both within and outside the family. Each family theory makes certain assumptions about the family and has inherent strengths and limitations. Most nurses use a combination of theories in their work with families. A brief discussion of a theory commonly used with families, systems theory, and the implications of this theory for maternal-child nursing is presented. A brief synopsis of several other theories useful in working with families is included in Table 2-2.

Family Systems Theory

Among the caring disciplines, a systems approach to understanding the family is almost universally applied. Many systems concepts are central to the delivery of holistic nursing care. These include recognition that changes occurring in one member affect the entire family, and an appreciation that nurses who work with families also enter into a systemic relationship with them. This is especially true for nurses who provide perinatal nursing care through community- or home-based agencies. Understanding how family members influence and interact with one another can help the nurse develop empathy with and respect for different ways of functioning.

When applied to families, the systems theory allows nurses to “view the family as a unit and thus focus on observing the interaction among family members rather than studying family members individually” (Wright & Leahey, 2000). Within a systems framework, the individual takes on several roles as a unique and important person in his or her own system and as part of one or more subsystems within the larger family. For example, an individual may belong to one of several subsystems, such as a child subsystem or a parental subsystem. When considering more than one generation of a family, a married woman may belong to a parental subsystem in her own home and to a subsystem of children when considered in relationship to her own parents.

Wright and Leahey (2000) outlined the key characteristics of family systems theory:

- A family system is part of a larger suprasystem and is composed of many subsystems.
The family as a whole is greater than the sum of its individual members.

A change in one family member affects all family members.

The family is able to create a balance between change and stability.

Family members’ behaviors are best understood from a view of circular rather than linear causality—that is, an individual’s behavior affects and is affected by the behavior of others.

The family systems theory encourages nurses to view individual family members as part of a larger family system influenced by and influencing others. Application of these concepts can guide assessment and interventions for the family. For example, the childbearing family interacts as a system with many elements in the environmental supersystem, including the health care community. The extent to which this supersystem influences the family in matters such as prenatal care, childbirth education, and infant care depends on the family’s boundary permeability. A relatively closed family may want instructions only from others within the family, whereas a relatively open family may be more receptive to instructions from health care providers.

Using Theories to Guide Practice

People interact effectively with each other in many ways. The nurse must understand that countless factors influence ways in which family members relate among themselves and with others.
the health care community. Some of these factors include the natural history of the family, culture, roles, values, beliefs, and traditional customs. Because so many variables affect ways of relating, the nurse must be aware that most family members will interact and communicate with each other in ways that are very different from those of the nurse’s own family of origin. Most families will hold at least some beliefs about health that are very different from those of the nurse. In some instances these beliefs will conflict with principles of health care management predominant in the Western health care system. Therefore, to be effective in working with families, the nurse must possess a degree of personal openness and acceptance and be willing to work with families in a way that is respectful and adapts to their ways of learning and communicating.

Because family relationships are always complex, viewing the interaction of the whole family helps nurses to understand more fully the functioning of individual family members. A family that has recently immigrated to this country may want to receive health information only from others within the family or the immediate cultural community, whereas a family that has more experience in dealing with the American health care system may be more receptive to nurses who are culturally different. When interacting with family members, the nurse becomes part of a system with them. The behaviors and interaction style of the nurse affect not just the individual who is identified as the “patient” but also contribute to family members’ responses to each other. Finally, the quality of the nurse-family system strongly influences how the family will interact with the greater health care community in the future.

Knowing about the phases of the life cycle can assist nurses in providing anticipatory guidance for families. For example, helping childbearing families prepare for the birth of a newborn may minimize the development of crises (Plan of Care—Incorporating the Infant into the Family). By using developmental theory, a nurse can anticipate that a family who has a child with a serious anomaly might experience a crisis or state of disequilibrium because the birth of an ill child is not a normative event. Because such a family may revert to a state of dependence, the nurse will realize that their need for extra support and nurturing from the nurse is a natural response to stress.

Because today’s families experience a great deal of pressure, they must develop effective stress-management strategies. Maternity nurses working in community settings may care for families in a full range of situations including healthy but highly stressed families and families coping with the extraordinary stress of ill infants or mothers who have recently had major surgical procedures such as cesarean birth. Nurses can assist families in changing their stress levels by helping families control internal and external context factors. The

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<tr>
<th>PLAN OF CARE</th>
<th>Incorporating the Infant into the Family</th>
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<tbody>
<tr>
<td><strong>NURSING DIAGNOSIS</strong></td>
<td>Readiness for enhanced family coping related to adaptation of family to new infant</td>
</tr>
<tr>
<td>Expected outcome</td>
<td>Family members will verbalize that individual and family goals are met during a smooth transition of new family member into the home.</td>
</tr>
<tr>
<td>Nursing Interventions/Rationales</td>
<td></td>
</tr>
<tr>
<td>• Assess type and amount of support available to family on a daily basis during the postpartum period to facilitate adaptation of the family to situation of a new member.</td>
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<tr>
<td>• Encourage family to use past successful coping mechanisms to enhance ability to cope with new situation and promote self-esteem.</td>
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<tr>
<td>• Encourage mother to use family and other support or services to carry out daily household tasks to permit her to focus on herself and infant.</td>
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<tr>
<td>• Suggest that woman take time to rest when infant sleeps to conserve energy for healing and limit responsibility to herself and infant.</td>
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<tr>
<td>• Assess family structure and relationships, including culture, to evaluate if longer period of adjustment may be expected.</td>
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<tr>
<td>• Teach family about sensory needs and capabilities of infant to motivate family to meet infant’s needs and set realistic expectations for infant’s capabilities.</td>
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<tr>
<td>• Refer to parent support group or community agencies, as needed, to facilitate and validate ongoing positive adjustment of family to new family member.</td>
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| **NURSING DIAGNOSIS** | Ineffective role performance related to developmental challenge of addition of new family member |
| Expected outcome | Each family member will verbalize realistic expectations regarding his or her role in the family and formulate a plan to incorporate role into overall family goals. |
| Nursing Interventions/Rationales | 
| • Assess family structure, roles, and each member’s perception of his or her role in the family to evaluate the impact of the new member on the structure and roles of the family as perceived by the members. |
| • Evaluate individual’s perception of goals and new roles during this transition to promote early intervention and correct any misinterpretation. |
| • Encourage discussion of family members’ thoughts and feelings regarding this transition to promote open communication and trust. |
| • Provide positive reinforcement for family members’ actions that promote a positive environment for the infant to increase self-esteem and provide encouragement. |
| • Refer to community support groups to provide group reinforcement and further assistance. |
| • Give information about sibling and grandparent classes and support groups available to promote empowerment and self-esteem for significant others in the family. |
nurse can intervene through educational strategies to correct misconceptions and reduce stress. Explaining normal infant growth and development (maturation) may reduce the stress of parenting.

In planning the care of a family or an individual family member, the nurse may find it useful to view the family at a developmental phase in the life cycle, facing stressful life events, and operating as a system. A family assessment tool such as the one outlined by Friedman (1998) (Fig. 2-4) can be used as a guide for assessing aspects of the family discussed in this chapter. A family genogram (family tree format depicting relationships of family members over at least three generations) (Fig. 2-5) provides valuable information about a family and can be placed in the nursing care plan for easy access by care providers.

By using the Health Belief Model as a guide to assessment, nurses can better address concerns specific to an individual from a different cultural group, motivating the individual to take action on his or her own behalf. Understanding a woman’s concerns from her own point of view can help the nurse to provide interventions that will place women at ease in the health care setting. For example, the nurse can modify or adjust care in assessing uterine involution as part of postpartum care for a woman who holds traditional Mexican beliefs and fears of having cold enter her uterus during a normal examination. The culturally competent nurse can close the door to the room, pull curtains to minimize air flow around the woman, position the woman so that the perineum is facing away from the door or air vents, and keep the perineum draped so that the examination takes place with a minimum of exposure.

Within the larger society, individuals and families have a variety of stressors that affect their ability to function and to engage consistently in behaviors that will promote health and wellness. These individuals and families fall into high risk or vulnerable populations. The stressors relate to many aspects of life: ethnic and cultural minority status, immigration status, poverty, challenges with English language fluency and literacy, malnutrition, and limited access to housing. Some families have multiple stressors, placing them at especially high risk for poor health outcomes. It should be noted, however, that not only low-income or minority groups are at high risk for morbidity and mortality. Some stressors affect families in all strata of society. Those who are well educated and in a higher socioeconomic class can also have life stressors that make them highly vulnerable to health problems. These antecedents to vulnerability include mental illness; substance use; domestic violence; and reduced access to medical care because of unemployment, loss of medical insurance, or inadequate insurance coverage. Nurses cannot make the assumption that a family is immune to vulnerability because its members live in an exclusive neighborhood, are well educated, and are fully employed. The concepts of high risk and vulnerability potentially apply to everyone.

CULTURAL FACTORS RELATED TO FAMILY HEALTH

Cultural Context of the Family

Culture has many definitions. Thomas (2001) defined culture as “a unified set of values, ideas, beliefs, and standards of behavior shared by a group of people; it is the way a person accepts, orders, interprets, and understands experiences throughout the life course.” Culture includes values, beliefs and practices that are acquired over a lifetime through interactions with others from that culture. Culture gives meaning to what people do in their everyday lives. The political, social, and economic context of people’s lives also is part of the cultural experience and helps shape a person’s interpretation of every life experience.

Culture is influenced by religion, environment, and historical events, and plays a powerful role in the individual’s behavior and patterns of human interaction. Culture is not static; it is an ongoing process that influences people throughout their entire life, from birth to death. Culture is an essential element of what defines us as people. Cultural knowledge includes beliefs and values about each facet of life and is passed from one generation to the next. Cultural beliefs and traditions relate to food, language, religion, art, health and healing practices, kinship relationships, and all other aspects of community, family, and individual life. Culture also has been shown to have a direct effect on health behaviors. Values, attitudes, and beliefs that are culturally acquired may influence perceptions of illness, as well as health care-seeking behavior and response to treatment (National Academy Press, 2002). The impact of these influences must be assessed by health professionals in providing health care and developing effective intervention strategies (Cultural Considerations).

Many subcultures may be found within each culture. Subculture refers to a group existing within a larger cultural system that retains its own characteristics. A subculture may be an ethnic group or a group organized in other ways. In the United States, there are many ethnic subcultures (e.g., African-Americans, Asian-Americans, Hispanics), as well as subcultures within these groups. In addition, the Caucasian population in America has diverse and multiple subcultures (e.g., Italian, Russian, German). Because every identified cultural group has subcultures, and because it is impossible to study every subculture in depth, greater differences may exist among and between groups than is generally acknowledged.

Each subculture holds rich and complex traditions, including health practices that have proved effective over time. These traditions vary from group to group. In a multicultural society, many groups can influence traditions and practices. As cultural groups come in contact with one another, acculturation and assimilation may occur.

Acculturation refers to changes that occur within one group or among several groups when people from different
UNIT ONE
INTRODUCTION TO MATERNITY NURSING

The Friedman Family Assessment Model (Short Form)

**Identifying Data**
1. Family name
2. Address and phone
3. Family composition
4. Type of family form
5. Cultural (ethnic) background
6. Religious identification
7. Social class status
8. Family’s recreational or leisure-time activities

**Developmental Stage and History of Family**
9. Family’s present developmental stage
10. Extent of family developmental tasks fulfillment
11. Nuclear family history
12. History of family of origin of both parents

**Environmental Data**
13. Characteristics of home
14. Characteristics of neighborhood and larger community
15. Family’s geographic mobility
16. Family’s associations and transactions with community
17. Family’s social support system or network

**Family Structure**
18. Communication patterns
   - Extent of functional and dysfunctional communication
   - Extent of emotional (affective) messages and how expressed
   - Extent of congruent and incongruent messages
   - Extent of functional and dysfunctional communication processes within family subsystems
19. Power structure
   - Power outcomes
   - Decision-making process
   - Power bases
   - Variables affecting family power
   - Overall family system and subsystem power
20. Role structure
   - Formal role structure
   - Informal role structure
   - Analysis of role models (optional)
   - Variables affecting role structure
21. Family values
   - Compare the family to American or family’s reference group values and/or identify important family values and their importance (priority) in family
   - Congruence between the family’s values and their family’s reference group or wider community
   - Congruence between the family’s values and family member’s values
   - Variables influencing family values
   - Values consciously or unconsciously held
   - Presence of value conflicts in family
   - Effect of the above values and value conflicts on health status of family

**Family Functions**
22. Affective function
   - Family’s need–response patterns
   - Mutual nurturance, closeness, and identification
   - Separateness and connectedness
23. Socialization function
   - Family child-rearing practices
   - Adaptability of child-rearing practices for family form and family’s situation
   - Who is (and socializing agents) for children?
   - Value of children in family
   - Cultural beliefs that influence family’s child-rearing patterns
   - Social class influence on child-rearing patterns
   - Estimation about whether family is at risk for child-rearing problems and if so, indication of high risk factors
   - Adequacy of home environment for children’s need to play
24. Health care function
   - Family’s health beliefs, values, and behavior
   - Family’s definitions of health–illness and their level of knowledge
   - Family’s personal health status and illness susceptibility
   - Family’s dietary practices
   - Adequacy of family diet (recommended: 3-day food history record)
   - Function of mealness and attitudes toward food and mealtimes
   - Shopping (and its planning) practices
   - Parent(s) responsible for planning, shopping, and preparation of meals
   - Sleep and rest habits
   - Physical activity and recreation practices (not covered earlier)
   - Family’s sleep habits
   - Family’s role in self-care practices
   - Medically based preventive measures (physicals, eye and hearing tests, and immunizations)
   - Dental health practices
   - Family’s health history (both general and specific diseases—environmentally and genetically related)
   - Health care services received
   - Feelings and perceptions regarding health services
   - Emergency health services
   - Source of payments for health and other services
   - Logistics of receiving care

**Family Stress and Coping**
25. Short- and long-term familial stressors and strengths
26. Extent of family’s ability to respond, based on objective appraisal of stress-producing situations
27. Coping strategies utilized (present/past)
   - Differences in family members’ ways of coping
   - Family’s short-term coping strategies
   - Family’s long-term coping strategies
28. Dysfunctional adaptive strategies utilized (present/past; extent of usage)

**Family Composition Form**

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Relationship</th>
<th>Date/place of birth</th>
<th>Occupation</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Father)</td>
<td></td>
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<tr>
<td>(Mother)</td>
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<tr>
<td>(Oldest child)</td>
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</table>

Fig. 2-4 The Friedman Family Assessment Model (Short Form). (From Friedman, M. [1998]. Family nursing theory and assessment [4th ed.]. New York: Appleton & Lange.)
Cultural Considerations

Questions to Elicit Cultural Expectations about Childbearing

1. What do you and your family think you should do to remain healthy during pregnancy?
2. What are the things you can do or cannot do to improve your health and the health of your baby?
3. Who do you want with you during labor?
4. What actions are important for you and your family to do after the baby’s birth?
5. What do you and your family expect from the nurse(s) caring for you?
6. How will family members participate in your pregnancy, childbirth, and parenting?

especially show differences among cultural groups. In the United States, acculturation is generally thought to take three generations. An adult grandchild of an immigrant is usually fully Americanized. An example of acculturation is the adoption of ethnic food practices in the United States.

Assimilation, on the other hand, occurs when a cultural group loses its identity and becomes part of the dominant culture. According to Friedman, Bowden, and Jones (2002), “assimilation denotes the more complete and one-way process of one culture being absorbed into the other.” Assimilation is the process by which groups “melt” into the mainstream, thus accounting for the notion of a “melting pot,” a phenomenon that has been said to occur in the United States. This is illustrated by individuals who identify themselves as being of “Irish” or “German” descent, without having any remaining cultural practices or values linked specifically to that culture, such as food preparation techniques, style of dress, or proficiency in the language associated with their reported cultural heritage. Spector (2004) asserts that in the United States the melting pot, with its dream of a common culture, is a myth. Instead, a mosaic phenomenon exists in which we must both accept and appreciate the differences among people.

The family process within its cultural context is a central concern in nursing, especially when the nurse is providing care to the childbearing family. A critical life experience, such as childbearing, is often bound by traditional beliefs and practices. A culture’s beliefs and practices regarding childbearing are embedded in its economic, religious, kinship, and political structures. All cultures have behavioral norms and expectations for each stage of the perinatal cycle. These norms and expectations relate to each culture’s view of how people stay healthy and prevent illness. Patients have the right to expect that their physiologic and psychologic health care needs will be met and that their cultural beliefs will be respected. Cultural sensitivity, compassion, and a critical awareness of family dynamics and social stressors that will affect health-related decision making are critical components in developing an effective plan of care (Plan of Care—The Family Newly Immigrated from a Non-English-Speaking Country).

Understanding the concepts of ethnocentrism and cultural relativism may be helpful to nurses caring for families in a multicultural society.

Ethnocentrism is a belief in the rightness of one’s culture’s way of doing things. Essentially, ethnocentrism supports the notion that “my group is the best.” Although the United States is a culturally diverse nation, the prevailing practice of health care is based on beliefs and practices held by members of the dominant culture, primarily Caucasians.
Communication

Communication often creates the most challenging obstacle for nurses working with patients from diverse cultural groups. This is because communication is not merely the exchange of words. Instead it involves (1) understanding the individual’s language, including subtle variations in meaning and distinctive dialects; (2) appreciation of individual differences in interpersonal style; and (3) accurate interpretation of the volume of speech, as well as the meanings of touch and gestures. For example, members of some cultural groups tend to speak more loudly, with great emotion, and with vigorous and animated gestures when they are excited; this is true whether their excitement is related to positive or negative events or emotions. It is important, therefore, for the nurse to avoid rushing to judgment regarding a patient’s intent when the patient is speaking, especially in a language not understood by the nurse. In such situations it is critical that the nurse avoid instantaneous responses that may well be based on an incorrect interpretation of the patient’s gestures and meaning. Instead, the nurse should withhold an interpretation of what has been communicated until it is possible to clarify the patient’s intent. The nurse needs to enlist the assistance of a person who can help and verify with the patient the true intent and meaning of the communication.

Use of interpreters

Inconsistencies between the language of providers present a significant barrier to effective health care. Because of the diversity of cultures
and languages within the U.S. and Canadian populations, health care agencies are increasingly seeking the services of interpreters (of oral communication from one language to another) or translators (of written words from one language to another) to bridge these gaps and fulfill their obligation for culturally and linguistically appropriate health care (Box 2-1).

Finding the best possible interpreter in the circumstance also is critically important. A number of personal attributes and qualifications contribute to an interpreter’s potential to be effective. Ideally, interpreters should have the same native language and be of the same religion or have the same country of origin as the patient. Interpreters should have specific health-related language skills and experience and help bridge the language and cultural barriers between the patient and the health care provider. The person interpreting also should be mature enough to be trusted with private information.

However, because the nature of nursing care is not always predictable and because nursing care that is provided in a home or community setting does not always allow expert, experienced, or mature adult interpreters, ideal interpretive services sometimes are impossible to find when they are needed. In crisis or emergency situations, or when family members are having extreme stress or emotional upset, it may be necessary to use relatives, neighbors, or children as interpreters. If this situation occurs, the nurse must ensure that the patient is in agreement and comfortable with using the available interpreter to assist.

When using an interpreter, the nurse respects the family by creating an atmosphere of respect and privacy. Questions should be addressed to the woman and not to the interpreter. Even though an interpreter will of necessity be exposed to sensitive and privileged information about the family, the nurse should take care to ensure that confidentiality

**BOX 2-1**

**Working with an Interpreter**

**STEP 1: BEFORE THE INTERVIEW**

A Outline your statements and questions. List the key pieces of information you want or need to know.

B Learn something about the culture so that you can converse informally with the interpreter.

**STEP 2: MEETING WITH THE INTERPRETER**

A Introduce yourself to the interpreter and converse informally. This is the time to find out how well he or she speaks English. No matter how proficient or what age the interpreter is, be respectful. Some ways to show respect are to ask a cultural question to acknowledge that you can learn from the interpreter, or you could learn one word or phrase from the interpreter.

B Emphasize that you do want the patient to ask questions because some cultures consider this inappropriate behavior.

C Make sure the interpreter is comfortable with the technical terms you need to use. If not, take some time to explain them.

**STEP 3: DURING THE INTERVIEW**

A Ask your questions and explain your statements (see Step 1).

B Make sure that the interpreter understands which parts of the interview are most important. You usually have limited time with the interpreter, and you want to have adequate time at the end for patient questions.

C Try to get a “feel” for how much is “getting through.” No matter what the language is, if in relating information to the patient the interpreter uses far fewer or far more words than you do, “something else” is going on.

D Stop every now and then and ask the interpreter, “How is it going?” You may not get a totally accurate answer, but you will have emphasized to the interpreter your strong desire to focus on the task at hand. If there are language problems: (1) speak slowly; (2) use gestures (e.g., fingers to count or point to body parts); and (3) use pictures.

E Ask the interpreter to elicit questions. This may be difficult, but it is worth the effort.

F Identify cultural issues that may conflict with your requests or instructions.

G Use the interpreter to help problem solve or at least give insight into possibilities for solutions.

**STEP 4: AFTER THE INTERVIEW**

A Speak to the interpreter and try to get an idea of what went well and what could be improved. This will help you to be more effective with this or another interpreter.

B Make notes on what you learned for your future reference or to help a colleague.

**Remember**

Your interview is a collaboration between you and the interpreter. Listen as well as speak.

**Notes**

1 The interpreter may be a child, grandchild, or sibling of the patient. Be sensitive to the fact that the child is playing an adult role.

2 Be sensitive to cultural and situational differences (e.g., an interview with someone from urban Germany will likely be different from an interview with someone from a transitional refugee camp).

3 Younger females telling older males what to do may be a problem for both a female nurse and a female interpreter. This is not the time to pioneer new gender relations. Be aware that in some cultures it is difficult for a woman to talk about some topics with a husband or a father present.

Courtesy Elizabeth Whalley, PhD, San Francisco State University, San Francisco, CA.
is maintained. A quiet location free from interruptions is the ideal place for interpretive services to take place. In addition, culturally and linguistically appropriate educational materials that are easy to read, with appropriate text and graphics, should be available to assist the woman and her family in understanding health care information. When using interpretive services, the nurse demonstrates respect for the woman and helps her maintain a sense of dignity by taking care to do all of the following:

- Respect the woman’s wishes
- Involve her in the decision about who will be the most appropriate person to interpret under the circumstances
- Provide as much privacy as possible
- Use culturally appropriate learning aids

**Personal space**

Cultural traditions define the appropriate personal space for various social interactions. Although the need for personal space varies from person to person and with the situation, the actual physical dimensions of comfort zones differ from culture to culture. Actions such as touching, placing the woman in proximity to others, taking away personal possessions, and making decisions for the woman can decrease personal security and heighten anxiety. Conversely, if nurses respect the need for distance, they allow the woman to maintain control over personal space and support personal autonomy, thereby increasing her sense of security. For example, many Asian groups have reserved attitudes about physical contact, and touching a woman may at times create anxiety when health care is delivered. To provide care, nurses must touch patients. However, they frequently do so without any awareness of the emotional distress they may be causing their patients.

**Time orientation**

Time orientation also is a fundamental way in which culture affects health behaviors. People in cultural groups may be relatively more oriented to past, present, or future. Those who focus on the past strive to maintain tradition or the status quo and have little motivation for formulating future goals. In contrast, individuals who focus primarily on the present neither plan for the future nor consider the experiences of the past. These individuals do not necessarily adhere to strict schedules and are often described as “living for the moment” or “marching to the beat of their own drummer.” Individuals oriented to the future maintain a focus on achieving long-term goals.

The time orientation of the childbearing family may affect nursing care. For example, talking to a family about bringing the infant to the clinic for follow-up examinations (events in the future) may be difficult for the family that is focused on the present concerns of day-to-day survival. Because a family with a future-oriented sense of time plans far in advance, thinking about the long-term consequences of present actions, they may be more likely to return as scheduled for follow-up visits. Despite the differences in time orientation, each family may be equally concerned for the well-being of its newborn.

**Family roles**

Family roles involve the expectations and behaviors associated with a member’s position in the family (e.g., mother, father, grandparent). Social class and cultural norms also affect these roles, with distinct expectations for men and women clearly determined by social norms. For example, culture may influence whether a man actively participates in pregnancy and childbirth, yet maternity care practitioners working in the Western health care system expect fathers to be involved. This can create a significant conflict between the nurse and the role expectations of very traditional Mexican or Arab families, who usually view the birthing experience as a female affair. The way that health care practitioners manage such a family’s care molds its experience and perception of the Western health care system.

In maternity nursing the nurse supports and nurtures the beliefs that promote physical or emotional adaptation to childbirth. However, if certain beliefs might be harmful, the nurse should carefully explore them with the woman and use them in the reeducation and modification process. Strategies for care delivery and providing appropriate care are presented in Box 2-2.

Table 2-3 provides examples of some cultural beliefs and practices surrounding childbirth. The cultural beliefs and customs in this table are categorized based on distinct cultural traditions and are not practiced by all members of the cultural group in every part of the country. Women

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**BOX 2-2**

**Strategies for Care Delivery and Providing Appropriate Care**

**STRATEGIES FOR CARE DELIVERY**

- Break down the language barriers
- Explain your rationale and reasons for suggestions
- Integrate folk and Western treatments
- Enlist the family caretaker and others
- Get consent from the right person
- Provide language-appropriate materials

**PROVIDING APPROPRIATE CARE**

- Ask about traditional beliefs, such as the role of hot and cold
- Be sensitive regarding interpreters and language barriers
- Ask about important dietary practices, particularly related to events such as childbirth
- Ask about group practices and beliefs
- Ask about a woman’s fears, and those of her family, regarding an unfamiliar care setting

from these cultural and ethnic groups may adhere to some, all, or none of the practices listed. In using Table 2-3 as a guide, the nurse should use caution to avoid making stereotypic assumptions about any person based on sociocultural-spiritual affiliations. Nurses should exercise sensitivity in working with every family, being careful to assess the ways in which they apply their own mixture of cultural traditions.

**DEVELOPING CULTURAL COMPETENCE**

Cultural competence has many names and definitions, all of which have subtle shades of difference, but which are essentially the same: multiculturalism, cultural sensitivity, and intercultural effectiveness. The culturally competent person thinks, feels, and acts in ways that acknowledge, respect and build upon ethnic, [socio]cultural, and linguistic diversity. Culturally competent professionals act to meet the needs of the patient and are respectful of ways and traditions that may be very different from their own. In today’s society it is of critical importance that nurses develop more than technical skill. Nurses at every level of preparation, and throughout their professional lives, must engage in a continual process of developing and refining attitudes and behaviors that will promote culturally competent care.

Pathways to the Development of Cultural Competence

Cultural competence proceeds along a continuum. Programs that promote values important to the cultural identity of the community build on the values of mutual support, cohesiveness, and self-sufficiency and therefore result in better health outcomes for community members. The use of community advocates most effectively reaches underserved populations through a network of existing social relationships. This can be especially true in isolated communities such as those that exist in remote or rural areas. Using local health workers builds on preexisting trust relationships. Moreover, local health workers are in a position to reinforce health teaching and best practices in health maintenance even when nurses or other health professionals are absent.

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**TABLE 2-3**

Traditional* Cultural Beliefs and Practices: Childbearing and Parenting

<table>
<thead>
<tr>
<th></th>
<th>PREGNANCY</th>
<th>CHILDBIRTH</th>
<th>PARENTING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HISPANIC</strong> (Based primarily on knowledge of Mexican-Americans; members of the Hispanic community have their origins in Spain, Cuba, Central and South America, Mexico, Puerto Rico, and other Spanish-speaking countries.)</td>
<td></td>
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<tr>
<td>Pregnancy</td>
<td>Pregnancy desired soon after marriage</td>
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<td></td>
<td>Late prenatal care</td>
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<td></td>
<td>Expectant mother influenced strongly by mother or mother-in-law</td>
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<td></td>
<td>Cool air in motion considered dangerous during pregnancy</td>
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<td></td>
<td>Unsatisfied food cravings thought to cause a birthmark</td>
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<td></td>
<td>Some pica observed in the eating of ashes or dirt (not common)</td>
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<td></td>
<td>Milk avoided because it causes large babies and difficult births</td>
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<td></td>
<td>Many predictions about sex of baby</td>
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<td></td>
<td>May be unacceptable and frightening to have pelvic examination by male health care provider</td>
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<td></td>
<td>Use of herbs to treat common complaints of pregnancy</td>
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<td></td>
<td>Drinking chamomile tea thought to ensure effective labor</td>
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<tr>
<td>Labor</td>
<td>Use of “partera” or lay midwife preferred in some places; may prefer presence of mother rather than husband</td>
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<td></td>
<td>After birth of baby, mother’s legs brought together to prevent air from entering uterus</td>
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<td>Loud behavior in labor</td>
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<td>Postpartum</td>
<td>Diet may be restricted after birth; for first 2 days only boiled milk and toasted tortillas permitted (special foods to restore warmth to body)</td>
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<td></td>
<td>Bed rest for 3 days after birth</td>
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<td></td>
<td>Keep warm</td>
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<td></td>
<td>Delay bathing</td>
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<td></td>
<td>Mother’s head and feet protected from cold air; bathing permitted after 14 days</td>
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<td></td>
<td>Mother often cared for by her own mother</td>
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<td></td>
<td>Forty-day restriction on sexual intercourse</td>
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<tr>
<td>Novoborn</td>
<td>Breastfeeding begun after third day; colostrum may be considered “filthy” or “spoiled”</td>
<td>Olive oil or castor oil given to stimulate passage of meconium</td>
<td>Male infant not circumcised</td>
</tr>
</tbody>
</table>

*Variations in some beliefs and practices exist within subcultures of each group.  

Continued
<table>
<thead>
<tr>
<th>PREGNANCY</th>
<th>CHILDBIRTH</th>
<th>PARENTING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFRICAN-AMERICAN</strong>&lt;br&gt;(Members of the African-American community, many of whom are descendants of slaves, have different origins. Today a number of black Americans have emigrated from Africa, the West Indian Islands, the Dominican Republic, Haiti, and Jamaica.)</td>
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<tr>
<td>Acceptance of pregnancy depends on economic status</td>
<td>Use of “Granny midwife” in certain parts of United States</td>
<td>Feeding very important; “Good” baby thought to eat well</td>
</tr>
<tr>
<td>Pregnancy thought to be state of “wellness,” which is often the reason for delay in seeking prenatal care, especially by lower-income African-Americans</td>
<td>Varied emotional responses: some cry out, some display stoic behavior to avoid calling attention to selves</td>
<td>Early introduction of solid foods</td>
</tr>
<tr>
<td>“Old wives’ tales” include beliefs that having a picture taken during pregnancy will cause stillbirth and reaching up will cause cord to tangle baby</td>
<td>Woman may arrive at hospital in far-advanced labor</td>
<td>May breastfeed or bottle-feed; breastfeeding may be considered embarrassing</td>
</tr>
<tr>
<td>Craving for certain foods, including chicken, greens, clay, starch, and dirt</td>
<td>Emotional support often provided by other women, especially the woman’s own mother</td>
<td>Parents fearful of spoiling baby</td>
</tr>
<tr>
<td>Pregnancy may be viewed by African-American men as a sign of their virility</td>
<td>Vaginal bleeding seen as sign of sickness; tub baths and shampooing of hair prohibited</td>
<td>Commonly call baby by nicknames</td>
</tr>
<tr>
<td>Self-treatment for various discomforts of pregnancy, including constipation, nausea, vomiting, headache, and heartburn</td>
<td>Sassafras tea thought to have healing power</td>
<td>May use excessive clothing to keep baby warm</td>
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<td></td>
<td>Eating liver thought to cause heavier vaginal bleeding because of its high “blood” content</td>
<td>Strong feeling of family, community, and religion</td>
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<td><strong>ASIAN-AMERICANS</strong>&lt;br&gt;(Typically refers to groups from China, Korea, the Philippines, Japan, Southeast Asia [particularly Thailand], Indochina, and Vietnam.)</td>
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<tr>
<td>Pregnancy considered time when mother “has happiness in her body”</td>
<td>Mother attended by other women, especially her own mother</td>
<td>Concept of family important and valued</td>
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<td>Pregnancy seen as natural process</td>
<td>Father does not actively participate</td>
<td>Father is head of household; wife plays a subordinate role</td>
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<td>Strong preference for female health care provider</td>
<td>Labor in silence</td>
<td>Birth of boy preferred</td>
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<tr>
<td>Belief in theory of hot and cold</td>
<td>Cesarean birth not desired</td>
<td>May delay naming child</td>
</tr>
<tr>
<td>May omit soy sauce in diet to prevent dark-skinned baby</td>
<td>Postpartum</td>
<td>Some groups (e.g., Vietnamese) believe colostrum is dirty; therefore they may delay breastfeeding until milk comes in</td>
</tr>
<tr>
<td>Prefer soup made with ginseng root as general strength tonic</td>
<td>Must protect self from yin (cold forces) for 30 days</td>
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<tr>
<td>Milk usually excluded from diet because it causes stomach distress</td>
<td>Ambulation limited</td>
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<td>Inactivity or sleeping late may cause difficult delivery</td>
<td>Warm room</td>
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<td></td>
<td>Diet:</td>
<td></td>
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<td></td>
<td>Warm fluids</td>
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<td></td>
<td>Some women are vegetarians</td>
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<td></td>
<td>Korean mother served seaweed soup with rice</td>
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<td>Chinese diet high in hot foods</td>
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<td></td>
<td>Chinese mother avoids fruits and vegetables</td>
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Integrating Cultural Competence
with the Nursing Care Plan

In many cultures, family members make most of the decisions for the patient, and therefore the central relationship between the nurse and patient is mediated directly by the family. The nurse must recognize the cultural importance of family in supporting the patient, guiding decision making, and preserving cultural integrity in the health care interaction.

All nursing care is delivered in multiple cultural contexts. These contexts include the cultures of the patient, of the nurse, and of the health care system, as well as the larger culture of the society in which health care is delivered. If any of these cultural groups is excluded from the nurse’s assessment and consideration, nursing care may fail to achieve its goals and may be culturally insensitive.

Implications for Nursing

To provide culturally competent care, nurses must develop awareness of various cultures and sensitivity to differences; gain knowledge of values, beliefs, and lifeways of other groups; develop skills in cultural assessment as a basis for intervention; and engage in direct cultural encounters or immersion in cultural experiences. These approaches build

<table>
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<tr>
<th>TABLE 2-3</th>
<th>Traditional Cultural Beliefs and Practices: Childbearing and Parenting—cont’d</th>
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<tbody>
<tr>
<td><strong>PREGNANCY</strong></td>
<td><strong>CHILDBIRTH</strong></td>
</tr>
<tr>
<td><strong>EUROPEAN-AMERICAN</strong></td>
<td>Pregnancy viewed as a condition that requires medical attention to ensure health</td>
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<td></td>
<td>Emphasis on early prenatal care</td>
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<td></td>
<td>Variety of childbirth education programs available, and participation encouraged</td>
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<tr>
<td></td>
<td>Technology driven</td>
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<td>Emphasis on nutritional science</td>
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<td>Involvement of the father valued</td>
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<td>Self-care valued</td>
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Critical Thinking Exercise

Family Roles and Functions

Marta is a 23-year-old married woman. She is having a protracted labor with fetal distress, and the obstetrician has recommended a cesarean birth. The obstetrician talked with Marta and her husband, Cesar, and coming out of her room, asked the nurse to get the operative permit signed. When the nurse approached Marta for her signature, Cesar said, “Here, I will sign it.” Marta explained that “Cesar makes all the decisions in our family.” The nurse responded that, “Oh, no. Marta has to sign it. Just sign right here.” Was the nurse’s response appropriate?

1 Evidence—Is there sufficient evidence to draw conclusions about the appropriateness of the nurse’s response?
2 Assumptions—What assumptions can be made about the appropriateness of the response in relation to:
   a. Legal requirements for informed consent
   b. Who is the decision maker in the family
   c. The patient’s preferences
   d. Culture of the patient and family
   e. Values of the patient
3 What implications and priorities for nursing care can be drawn at this time?
4 Does the evidence objectively support your conclusion?
5 Are there alternative perspectives to your conclusion?

Expected Outcomes of Care

Examples of expected outcomes for perinatal patients include that the woman and/or family will do the following:

- Verbalize understanding of treatments
- Report decreased anxiety about procedures she will perform (e.g., insulin injection)
- Perform procedures accurately (e.g., blood glucose monitoring), as evidenced by return demonstration
- Use support systems to cope effectively with problems (e.g., pregnancy complications, newborn complications or treatments)
- Verbalize decreased role strain

Plan of Care and Interventions

The nursing plan of care is developed in collaboration with the patient, based on the health care needs of the individual.

Evaluation

Evaluation is based on the expected outcomes of care. The plan is revised as necessary.

Community Activity

In a prenatal clinic, interview families from at least two different cultural backgrounds.

- What do they believe will keep them healthy in pregnancy?
- What are the roles of men and women in childbirth? Who should be present at birth?
- What is the role of technology in the childbirth process?
- Are there restrictions on activity and diet in the postpartum period?
- What is the preferred method of infant feeding?
- How soon after birth should breastfeeding begin?
- Are there special foods that should be eaten during pregnancy or after childbirth?
- What will keep the infant healthy after birth?
- Did the responses to these questions differ significantly between the two families? Did the responses differ from what you have learned as the “correct way” to keep healthy? How can you use this information?
The Family and Culture

Key Points

- Contemporary American society recognizes and accepts a variety of family forms.
- The family is a social network that acts as an important support system for its members.
- Ideally, the family provides a safe, intimate environment for the biopsychosocial development of its children and adult members.
- Family theories provide nurses with useful guidelines for understanding family function.
- Family socioeconomics, response to stress, and culture are key factors influencing family health.
- The reproductive beliefs and practices of a culture are embedded in its economic, religious, kinship, and political structures.
- To provide quality care to women in their childbearing years and beyond, nurses should be aware of the cultural beliefs and practices important to individual families.
- Nurses must develop cultural competence and integrate it into the nursing plan of care.

Answer Guidelines to Critical Thinking Exercise

Family Roles and Functions

1. Yes. The nurse’s response is not appropriate. Legally in the United States the patient must sign the consent for her surgery (unless she is unconscious or incapacitated). However, in some cultures and some families, the decision maker may be another person such as the husband or parent. The obstetrician should explain the situation to Marta and Cesar, obtain Cesar’s consent, and then have Marta sign the consent form.

2. a. Legal requirements for obtaining informed consent must be met.
   b. The patient may not always be the decision maker.
   c. The wishes of the patient must be ascertained.
   d. To provide culturally competent care, the family’s culture, roles, and responsibilities must be respected.
   e. Patients may have values that do not fit with the Western biomedical model of care.

3. To protect the mother and the fetus, the fetus must be delivered. This requires informed consent for the procedure. The priority for the nurse is to ensure that Marta and Cesar have a clear understanding of the need for the procedure and that a written consent is obtained. (A physician is responsible for obtaining informed consent; a nurse can obtain a signature on a consent form.)

4. Yes, the evidence supports this conclusion.

5. The values of patients and their families may differ from those of health care providers. Ultimately, the patient has the right to consent to or refuse treatment even if health care providers believe that the decision is wrong or may result in harm. In some situations, health care providers have sought a court order for a cesarean in the belief that it is their responsibility to save the life of the fetus. This drastic step should be avoided if at all possible.

Resources

Child and Family Policy Center
218 6th Ave., Suite 1021
Des Moines, IA 50309-4013
515-280-9027
515-284-8997 (fax)
www.cfpcowa.org

Federal Interagency Forum on Children and Family Statistics
www.childtrend.gov

The Harriet and Robert Heilbrunn Department of Population and Family Health
http://cpmcnet.columbia.edu/dept/ohil/pophfam/

Health Literacy Toolbox

Indian Health Services
www.irs.gov

Institute for the Support of Latino Families and Communities
www.uiowa.edu/~nrcfcp/latino

Institute for Urban Family Health
16 East 16th St.
New York, NY 10003
212-633-0800
212-691-4610 (fax)
www.institute2000.org/

Kaiser Family Foundation
www.kff.org/

Maternal and Child Health Bureau
http://mchb.hrsa.gov/

Maternal and Neonatal Health Resources
www.jhuccp.org

National Alliance for Hispanic Health
1501 Sixteenth St., NW
Washington, DC 20036
202-387-5000
www.hispanichealth.org
References


