CHAPTER 4

TRANSCULTURAL COMMUNICATION STUMBLING BLOCKS

KEY TERMS
- Barriers
- Biased
- Cultural Blind Spot Syndrome
- Dialects
- Ethnocentrism
- Idioms
- Nursing Rituals
- Racism
- Regionalisms
- Simultaneous Dual Ethnocentrism
- Stereotype

OBJECTIVES
After completing this chapter, you should be able to:

- Identify barriers to effective transcultural communication between patients and nurses.
- Describe the process by which people from diverse cultures go from fearing each other to liking each other.
- Identify and describe the three types of racism that are found in our society.
• Define ethnocentrism and explain how this barrier blocks transcultural communication.

• Describe the different types of language barriers that can impede transcultural communication.

• Develop an awareness of the various dialects, regionalisms, and idioms that distinguish the speech of people from different races, ethnic groups, and regions.

• Identify ways in which differing perceptions and expectations can complicate communications between nurses and patients from diverse cultures.

INTRODUCTION

Communication between nurses and patients from different cultures is often complicated by different values, beliefs, traditions, expectations, and languages. As you work with patients from multicultural backgrounds, you will find that these differences raise barriers to transcultural communication. This chapter discusses communication barriers in terms of their underlying dynamics, and their impact on nurses, patients, and nursing care. Chapter 8 describes practical strategies for overcoming transcultural communication barriers in the health care arena.

BARRIERS TO TRANSCULTURAL COMMUNICATION

There are eight important barriers to transcultural communication in nursing: (1) lack of knowledge, (2) fear and distrust, (3) racism, (4) bias and ethnocentrism, (5) stereotyping, (6) ritualistic behavior, (7) language barriers, and (8) differences in perceptions and expectations.

Lack of Knowledge

The failure to understand cultural differences in values, behaviors, and communication styles is a common stumbling block for nurses who work in transcultural settings. Nurses who are not knowledgeable about cultural differences risk misinterpreting patients’ attempts to communicate. As a result, patients may not receive the proper care.

Remember that each culture dictates what is “normal” behavior when sick; for example, Japanese patients might react with silent obedience to your requests, white middle-class patients might wish to discuss their nursing care
with you, Italian patients might dramatically express their discomfort, while an inner city youth might loudly demand your attention. Nurses who are unaware of cultural differences may mistakenly expect all patients to communicate in the same way, regardless of culture.

Furthermore, nurses who have not learned about which behaviors are acceptable in different cultures may attribute a patient’s behavior (e.g., silence, withdrawal) to the wrong reason or cause—resulting in faulty assessment and intervention.

**Example:** A nurse was teaching a prenatal class to a group of white, Hispanic, and black adolescents. The nurse used some words that Bonita, a Hispanic teenager, did not understand. Bonita asked the nurse to explain what the words meant. The nurse, who wanted to cover the rest of her lesson, told Bonita that she would talk with her about the words after class. But when class was over, Bonita abruptly left the room.

The nurse, who was not knowledgeable about Hispanic culture, incorrectly assumed that Bonita had either forgotten that she was to remain after class, or had decided that she had more important things to do.

Had the nurse known more about the culture and behavioral patterns of Hispanics, she would have realized that:

- Hispanics typically view nurses and teachers as authority figures and expect them to initiate actions. Thus Bonita expected the nurse to call her name and remind her to stay after class.
- Many Hispanic children receive a great deal of close supervision and attention from adults. Bonita might have felt that she should not have been made to wait until after class to receive answers to her questions.
- Hispanic children are raised to be respectful and quiet. Bonita overcame her shyness when she asked the nurse a question. If the nurse had known more about the behavioral patterns of Hispanic children, she would have invited Bonita to ask her questions again at the end of class. As Bonita did not receive a cue from the nurse that it was all right to speak, she assumed it would be rude to raise her hand.

Thus, this nurse-instructor incorrectly attributed Bonita’s behavior to forgetfulness or disrespect. Because the nurse did not understand the culturally-based reasons for Bonita’s behavior, she missed a valuable opportunity to expand Bonita’s grasp of prenatal care.
Fear and Distrust

Fear, dislike, and distrust are emotions that all too often erupt when people from diverse cultures first meet. Rothenburger (1990) has identified seven stages of adjustment that individuals pass through during their initial encounters with people of different cultures that they do not know or understand. These stages are:

1. **Fear**: When first meeting someone from a different culture, many people feel threatened. Each person perceives the other person as different and, therefore, dangerous. Usually as people become better acquainted with each other, the fear gradually dissipates, only to be replaced by dislike.

2. **Dislike**: Dislike is a much milder emotion than fear. Group members have a tendency to dislike people who behave or communicate differently from what is considered “the norm” in that culture or group. For example, a working class black person might dislike a middle-class white person because white people tend to be less vocal and expressive than many black people, and thus appear insincere and weak.

3. **Distrust**: People from different cultures are often suspicious of each others’ actions and motives because they lack information. For example, a white nurse who does not realize the importance of family in Vietnam, may be suspicious of the new Vietnamese nurse who allows family members to participate in a patient’s care instead of providing all of the care herself. Unfortunately, unless there is pressure to change their attitudes, some people never do progress beyond fear, dislike, and distrust to the next stage of acceptance.

4. **Acceptance**: Usually if two people from different cultures share enough good experiences over a period of time, they will begin to accept each other rather than resent each other.

5. **Respect**: If individuals from diverse cultures are open minded, they will allow themselves to see and admire qualities in one another. For example, a Japanese nurse who has been trained to defer to authority might admire the white American nurse who challenges authority. Acceptance and admiration, in turn, foster respect.

6. **Trust**: Once people from diverse cultures have spent enough quality time together, they usually are able to trust each other. For example, a white American nurse will eventually trust the foreign-born nurse who consistently provides good patient care and finishes
assignments on time. Once people trust each other, they may finally learn to genuinely like each other.

7. **Like:** For people to like each other, they must share many things in common. To reach this final stage, individuals from diverse cultures must be able to concentrate on the human qualities that bind people together, rather than the differences that pull people apart.

This evolution of a relationship from fear to trust has been dramatized in films. For instance *The Defiant Ones* starring Tony Curtis and Sidney Poitier is the story of two escaped convicts—one white and one black—who are chained together. At first the two men dislike and distrust each other. However the men are forced to work together in order to survive. By the time the film ends, the men have established a mutual trust and respect.

**Racism**

*Racism* in American nursing is a formidable barrier that strangles transcultural communication between nurses and patients, and between nurses and other health care providers. Because nursing is regarded as a “caring profession,” nurses find it difficult to acknowledge that racism exists in the health care workplace. Indeed, for most Euro-American nurses, discussions of racism in American nursing are taboo (Barbee, 1993).

Barbee’s article points out that there are three types of racism:

1. **Individual racism:** Individuals are discriminated against because of their visible biological characteristics; for example, black skin or the epicanthic fold of the eyelid in Asians.

2. **Cultural racism:** An individual or institution claims that its cultural heritage is superior to that of other individuals or institutions. For example, during World War II, the Nazis claimed that their Aryan genetic and cultural heritage was superior to the Jewish heritage. They justified persecution of the Jews by convincing themselves that the Jews were an inferior people.

3. **Institutional racism:** Institutions (universities, businesses, hospitals, schools of nursing) manipulate or tolerate policies that unfairly restrict the opportunities of certain races, cultures, or groups. For example, at one time, black nurses were not allowed to join the American Nurses Association (ANA). This policy prevented black nurses from having a voice in the regulation of nursing practice and policies.
Because nurses perceive themselves as individuals who regard all people as equal, most nurses (black and white) will talk about cultural diversity, but avoid the word racism. Nevertheless, racism exists. For example, in a classic study by Morgan in 1984, researchers found that Euro-American nursing students perceived black patients more favorably than black people, and Euro-American patients as more favorable than any other group.

At the institutional level, white students have been admitted more readily to schools of nursing than black students. Racism is also a factor in the low enrollment numbers of black students in baccalaureate nursing programs compared to 2-year programs. Within the workforce, black nurses have complained about not being promoted as readily as white nurses (see Chapter 14). Also, black nurses have had difficulty publishing in Euro-American nursing journals.

Racism will undermine the nursing profession for as long as nurses deny its existence and refuse to talk about it openly and honestly. In the words of Evelyn Barbee (1993):

One of the flaws in the profession is an unwillingness to recognize that racism is endemic in nursing and health care. This unwillingness results in a lack of discussion about racism and leads to responses that exacerbate the problem.

**Bias and Ethnocentrism**

Whatever their cultural background, people have a tendency to be biased toward their own cultural values, and to feel that their values are right and the values of others are wrong or not as good. Many people are surprised to discover that the values and actions they so admire in their own culture may be looked upon with suspicion by people from other cultures, who are equally biased.

**Communication Considerations**

The belief that one's own culture or traditions are better than those of other cultures is called ethnocentrism. The person who is ethnocentric tends to antagonize and alienate people from other cultures.

**Simultaneous dual ethnocentrism** is a component of every nurse-patient relationship. Nurses are assessing, judging, evaluating, and reacting to
patients on the basis of their own cultural values, medicocentric points of view, and expectations. Simultaneously, patients are using their cultural values to judge and evaluate their nurses and the Western health care system. As Lydia DeSantis (1994) points out:

The concept of a simultaneous dual ethnocentrism makes nurses keenly aware that they, their patients, their colleagues, and everyone else in the clinical setting are operating under the influence of personal cultural rules, some of which are shared and some of which are not.

Attitudes towards Western medicine constitute one of the biggest barriers to transcultural communication between American nurses and patients. American nurses tend to be heavily biased toward the Western biomedical health care system because most of them have been educated in this system. Indeed, many nurses feel that the biomedical system is the best (and even the only) approach to patient care. They may view other health belief systems with suspicion and even contempt, refusing to acknowledge that another approach might have some merit. This ethnocentric attitude can alienate patients from other cultures, who fully believe that their therapeutic interventions also have merit. Here is an example of how simultaneous dual ethnocentrism can severely damage the nurse-patient relationship.

**Example:** Juan Perez, a Mexican immigrant, was hospitalized with a fever of unknown origin. A major conflict developed between the head nurse and Mr. Perez’s family when the family insisted that a curandero or folk healer visit the patient. When the curandero appeared on the ward with various healing paraphernalia, the head nurse demanded that the healer leave the patient’s room at once. The nurse’s attitude so upset Mr. Perez that his family signed him out of the hospital against consent. Had the nurse been willing to at least acknowledge Mr. Perez’s health care beliefs, he would have been more willing to accept her biomedical beliefs.

When white American nurses care for people from other cultures, they may be biased not only toward their own health care system, but toward other learned values—such as cleanliness—as well.

**Example:** During a clinic visit, a Caucasian nurse assessed that a Native American child had severe impetigo. The nurse observed that the child appeared dirty, and that the mother had not thoroughly washed her hands. The nurse concluded that because the child was dirty, the mother was not taking adequate care of her child.
The nurse’s assessment was based on a value she learned while studying nursing, that is, that cleanliness is essential and basic to good health. Her observations translated into a value judgment based on Western bias: “Cleanliness is good. Therefore, a good mother always keeps her child clean.”

The mother perceived correctly from the nurse’s demeanor and tone of voice that this authority figure from the dominant white culture disapproved of her and her parenting skills. She also suspected that the nurse was planning to impose her expectations concerning cleanliness and child-rearing.

The Native American mother found herself nodding yes, but tuning out the disapproving nurse’s instructions. The young mother would have been much more inclined to listen had the nurse been sensitive in her approach rather than dictatorial. The nurse could have said: “I’m sure that you’ve noticed that your baby has a problem with his skin. When did the problem start? What have you done thus far for the itching? Has it helped? Let’s think about this problem together and see what we can do.”

By admitting and overcoming her own rigid bias toward cleanliness, the nurse would have conveyed that the child needed attention without appearing to judge the mother’s standard of cleanliness or her child care skills. As a result, the mother would have been more inclined to listen to the nurse and follow through on her suggestions.

COMMUNICATION CONSIDERATIONS

Cultural biases can distort your perception of other people’s values and behavior, and thus damage your ability to communicate. To overcome your biases, you must first acknowledge that they exist.

Stereotyping

A cultural stereotype is the unsubstantiated assumption that all people of a certain racial and ethnic group are alike. For example: All Eskimos are reserved, deliberate, and noncommittal. Certainly, some or even the majority of Eskimos may be reserved, deliberate, and noncommittal, but it is cultural
stereotyping to state that all Eskimos have these traits. Stereotyping is particularly destructive when negative traits or characteristics are imposed on all members of a cultural group. For example, *All Native Americans are at risk for alcoholism.*

While you must avoid negatively stereotyping patients from different cultural groups, it is nevertheless important to learn about the representative characteristics of different groups. This knowledge will help to smooth and ease your interactions with patients from other cultures.

For example, if you know that Eskimos are raised to be reserved and non-committal, you will not be offended when Eskimo patients respond to your assessment questions with silence or monosyllables. Conversely, if you are aware that Italian patients tend to be more flamboyant as a group, you will not be surprised when your Italian patients respond to their problems with dramatic gestures and tears.

**COMMUNICATION CONSIDERATION**

To avoid stereotyping, remember that patients are individuals with unique experiences, and thus may not conform to many (or any) of the characteristics ascribed to their cultural group. Thus, some Eskimos may be outgoing and some Italians may be reserved.

*Cultural blind spot syndrome* is a form of stereotyping that is a problem for many nurses and physicians. Cultural blind spot syndrome is the belief that “Just because the client looks and behaves much the way you do, you assume that there are no cultural differences or potential barriers to care” (Buchwald, 1994). For example, white American nurses may assume that white American patients believe in the same cultural values as they do. This assumption is false. As you learned in Chapter 2, white Americans come from many different ethnocultural backgrounds—Irish, Russian, German, Jewish, and English to name but a few. In addition, white nurses and patients may also belong to different subcultures that have different values. For example, a white male patient of Italian descent who is gay will probably have somewhat different values than a white Irish-American nurse who is married with 3 children. The negative impact of cultural blind spot syndrome on patient care is discussed further in Chapter 10.
Ritualistic Behavior

A ritual is a set procedure for performing a task. In the past, students in nurse's training were taught to perform their duties in a ritualistic manner. Even today, nursing rituals persist. Many nursing rituals are beneficial, such as always performing certain safety checks when preparing and administering medications. However, other rituals, such as always excluding family from the bedside during treatments, are unnecessary and may upset patients and their families. Unfortunately, many nurses are so in the habit of performing certain rituals that they become deeply disturbed when these rituals are challenged.

COMMUNICATION CONSIDERATION

As you care for patients, ask yourself which nursing rituals are really necessary and which rituals are outdated. If there is no scientific or logical reason to follow a ritual, try to create a new routine that will benefit you and your patient.

Language Barriers

Language provides the tools (words) that allow people to express their thoughts and feelings. Thus, language barriers present a grave threat to transcultural communication between nurses and patients. There are several types of language barriers that impede communication in the United States. These barriers include:

a. foreign languages,
b. different dialects and regionalisms, and
c. idioms and “street talk.”

Foreign Languages, Dialects, and Regionalisms. Even when nurses and patients speak the same language, misunderstandings can arise. But when patients come from countries or households where English is not the native tongue, the resulting language barrier can bring communication to a halt, producing frustration and conflict.

Unfortunately, it is not possible to be familiar with the hundreds of languages and dialects spoken by patients from different countries and cultures. As noted in Chapter 1, over 6,000 different languages and dialects are spoken today. In addition, the number of people in the United States (all potential patients) who speak languages other than English is growing.
Based on the 1990 census, individuals who spoke languages other than English constituted approximately 10% of the population, or 25 million people. According to a U.S. Education Department report on languages during the 1980s, the number of Spanish speakers increased 65% and speakers of Asian languages rose 98%. The number of people 5 years old and older who spoke languages other than English at home rose approximately 40% (Gannet, 1994). These statistics will be updated in the 2000 census.

Large communities of people who speak languages other than English are flourishing in Southern California, Texas, New Mexico, and Arizona. In Los Angeles alone, over 100 languages other than English are spoken. These languages range from the familiar Spanish tongue to the more exotic language of Gujarati, which is spoken in western India (Compton’s, 1995). Moreover, there are many more communities throughout the country where different languages and traditions are common.

As if coping with people who speak different languages is not enough, nurses must also be aware that there are hundreds of dialects and regionalisms. Webster’s Dictionary defines a **dialect** as the distinctive way a language is spoken or written in a given locality or by a given group of individuals. A **regionalism** is a word, phrase, pronunciation, or custom peculiar to a given region. For example:

- There are three major Chinese dialects: Mandarin, Cantonese, and Shanghainese.
- There are 600 Filipino languages and dialects, among which the most common are Tagalog, Ilocano, Ilonggo, and Cebuano.
- Spanish is not divided into dialects, but there are some regional differences in the use of particular words and phrases. The most recent influx of migrant workers in California speak Mixtec, not Spanish.
- Ebonics, or African-American English, was first discussed in 1975 in *Ebonics: The True Language of Black Folks*, a book by psychology professor Robert L. Williams. Williams derived the word *Ebonics* from *ebony* (for black) and *phonics* for “the scientific study of speech sounds.” Williams pointed out that black people are often accused of using bad English when actually they are speaking their own language or dialect, which is based on standard English. In December of 1996, the Oakland School Board in California officially recognized Ebonics as a language or dialect. Concerned that the majority of black students who spoke Ebonics were not doing well in school, the Board passed a resolution calling for improved instruction in standard English (Barnhart and Metcalf, 1997).
To communicate effectively with patients who are not proficient in English, you will need an interpreter. A skilled interpreter can help you, your patient, and your patient's family overcome the anxiety and frustration produced by language barriers. Chapter 9 describes methods for communicating with patients with limited English proficiency, both with and without an interpreter.

**Idioms, Slang, and Street Talk.** Sometimes the language barrier—and the type of interpreter needed—may not fit the conventional mold just discussed. For example, if you are from a white middle-class background, you may find yourself at a loss to understand the characteristic terms, idioms, or expressions used by patients from English-speaking subcultures, be they ghetto blacks, Appalachian hillfolk, or teenagers fluent only in the latest street slang. For example, a nursing student from an upper class background failed to understand the adolescent girls in a clinic until another nurse explained that *poppers, fizzers,* and *wa-was* referred to prescribed medicines.

Black American speech is particularly rich in idioms. In her book *Black Talk: Words and Phrases From the Hood to the Amen Corner,* Geneva Smitherman (1994) explains that the word *hood* means the neighborhood where a person has grown up and feels comfortable. The phrase *Amen Corner* refers to the corner in a traditional black church where the older church members (usually women) sit. These women, regarded as the *watch dogs of Christ* lead the congregation in Amens.

Some black expressions that you may hear as you work with some black patients in neighborhood clinics or hospitals have the following meanings (Smitherman, 1994):

- *Bad* means excellent or good.
- *BMT* means black man talking. This term is used to express authority.
- *Can't kill nothing and won't nothing die* means having a difficult time.
- *Get on the good foot* means to correct what needs improving.
- *Git out my face* means stop confronting me.
- *Glass house* is a drug house.
- *Come out of a bag* means to behave differently than expected.
- *Hard headed* is a person who refuses to listen to reason.
Conflicting Perceptions and Expectations

When people from different cultures try to communicate, their best efforts may be thwarted by misunderstandings and even serious conflicts. In health care situations, misunderstandings often arise when the nurse and patient have different perceptions and expectations, and consequently misinterpret each others’ messages.

Misunderstandings due to cultural differences commonly arise in situations involving food and drink. Imagine that you are taking care of a postoperative Vietnamese female patient who, as her culture dictates, is almost constantly attended by her family. You want to clearly instruct family members that they are not to give the patient anything to drink. As the family speaks only Vietnamese, you motion that the patient is not to drink, and you explain via an interpreter that the patient must not drink.

When you return from your lunch break you find your patient vomiting, and you observe an empty bowl of soup on her table. Obviously the family has ignored your instructions and fed the patient soup. If you angrily say “I told you not to give her anything to drink!” your reaction would be that of many nurses in this situation.

However, you later learn from the interpreter that the family knew that they should not give the patient water, but they assumed that broth would be beneficial. Vietnamese believe that the sick need to drink broth to rebuild energy. Your intended message (do not drink anything) was not understood by the patient’s family, and you failed to grasp the family’s perception of your instructions (broth is not water, and therefore all right to drink). As a result, the patient’s family gave her broth and you became frustrated.
COMMUNICATION CONSIDERATION

When there are cultural, behavioral, and language differences between nurses, patients, and patient’s families, there is a greater probability that patients will misunderstand nursing care instructions. To prevent conflicts and misunderstandings, make sure that the message you send the patient is the same message that the patient receives. When there is a language barrier, you will need to work closely with an interpreter.

Another common area of conflict between nurses and patients from diverse cultures involves the perception of health promotion and disease prevention. For example, Hispanics—whose culture is based on honor and pride—may be taught from childhood to bravely accept illness and pain as an inevitable part of human existence. For this reason, traditional Hispanics may see no reason to submit to mammograms or vaccinations (Sabatino, 1993). In the words of the former Surgeon General, Antonia Novello:

Hispanics are fatalistic. We’ve been taught that you live, you suffer, you die. That’s the way life is. The idea has never been presented that if you take care of your health, if you go to the doctor early, you won’t have to suffer pain or discomfort.

Expectations that patients have of nurses and physicians may also lead to transcultural communication problems. For example, Japanese patients generally look to their family members for the majority of their care, rather than to nurses. Even physicians are not in charge; instead they are thought of as skilled and sympathetic technicians whose job it is to help families cure the patient (Rothenburger, 1990). Nurses or physicians need to recognize the importance of the Japanese patient’s family as caregiver, and always communicate with the family before making any important decisions concerning the patient’s care.
TESTING YOUR KNOWLEDGE

Circle the correct answer.

1. Racism can be classified as
   a. institutional.
   b. individual.
   c. cultural.
   d. all of the above.

2. The belief that one’s culture and value system is better than that of another culture is called
   a. bias.
   b. pride.
   c. ethnocentrism.
   d. stereotyping.

3. The statement: “All Asians honor the past” is an example of
   a. ethnocentrism.
   b. stereotyping.
   c. racism.
   d. Cultural Blind Spot Syndrome.

4. A nurse who fails to culturally assess a patient from the same culture is guilty of
   a. ethnocentrism.
   b. stereotyping.
   c. Cultural Blind Spot Syndrome.
   d. lack of knowledge.

5. The nurse who always excludes the patient’s family from the bedside when giving care is
   a. protective of the patient.
   b. ethnocentric.
   c. ritualistic.
   d. biased.

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