



Cultural Competency in Nursing Research

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According to data from the U.S. Census Bureau (2010), the demographics of the United States will change dramatically in the next 50 years. Non-Caucasians will more than double from 116.2 million in 2012 to 241.3 million by 2060, representing 57% of the U.S. population (U.S. Census Bureau, 2010). The Asian population also is expected to double in the next five years and comprise 8% of the U.S. population (U.S. Census Bureau, 2012). The United States also is becoming an aging population. By 2060, about one in five residents will be aged 65 years and older (U.S. Census Bureau, 2012). Individuals aged 85 years and older will more than triple to 18.2 million and represent 4% of the U.S. population (U.S. Census Bureau, 2012).

As a result, cultural sensitivity and cultural competence in nursing will be even more critical and have dramatic implications in the practice and research setting. Cultural competency has been viewed as a means to reduce health disparities and improve access to high-quality care that is knowledgeable and respectful of the healthcare needs of diverse patients (Agency for Healthcare Research and Quality, 2014). In this article, the concept of cultural competence as it influences the research process will be discussed, with strategies to facilitate cultural awareness and competence in nursing research.

Definitions

Several terms, such as *awareness* and *sensitivity*, have been used interchangeably with cultural competence. Therefore, a brief review of the various definitions are helpful to understand this concept. *Culture* is defined as beliefs, values, and customs shared by a specific group that hold meaning for members of the group. *Cultural sensitivity* is defined as awareness and sensitivity to a group's

values and beliefs, and recognizing how these differ from one's own values and beliefs. *Cultural competence*, on the other hand, is a broad concept that not only incorporates awareness and understanding of unique characteristics of a group's social and cultural attributes, health beliefs, and values, but also encompasses interventions that reflect this awareness (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competence in research is defined as "the ability of researchers and research staff to provide high quality research that takes into account the culture and diversity of a population when developing research ideas, conducting research, and exploring applicability of research findings" (Harvard Clinical and Translational Science Center, 2010, p. 6).

Strategies to Facilitate Cultural Competency in Research

Cultural competency, first introduced in the 1980s, initially focused on education, the provider-patient interaction, and models of care. An abundance of literature focuses on cultural competence and healthcare provider education, but literature on cultural competence in research is limited. However, basic concepts and strategies from educational literature can be borrowed and applied to cultural competence in research (Seibert, Stridh-Igo, & Zimmerman, 2002). The following discussion will highlight strategies to consider when embarking on research with cultural groups.

Complete Cultural Competency Training

An initial step for any researcher interested in conducting a study involving cultural groups is the completion of cultural competency training. The goal

of this type of education program is to acquire knowledge and skills in culturally and linguistically appropriate health care and to promote self-awareness about attitudes, beliefs, biases, and behaviors. Training programs, such as the free continuing education session "Culturally Competent Nursing Care: A Cornerstone of Caring" (<https://ccnm.thinkculturalhealth.hhs.gov>), are available online. Several systematic reviews have shown beneficial effects for healthcare providers following culturally competent educational interventions. Beach et al. (2005) conducted a systematic review of healthcare provider educational interventions and found that cultural competence training improved the knowledge, attitudes, and skills of healthcare professionals, and training affected patient satisfaction. In a systematic review of interventions to improve cultural competency in healthcare providers, Truong, Paradies, and Priest (2014) found moderate evidence of improvement in healthcare providers' cultural competency knowledge, attitudes, and skills. However, the studies reviewed had considerable heterogeneity in relation to interventions used, patient populations, healthcare provider populations, and outcomes of care. The authors concluded that the concept of cultural competency as it relates to practice and research is complex and that additional research is needed.

Examine the Population of Interest

Research involving cultural groups that differ from a researcher's own

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cultural background will necessitate thorough analysis and understanding of the specific patient population's beliefs and behaviors prior to the development of the actual research study. Beliefs regarding health care, perceptions about illness and treatment, designated individuals that are responsible for healthcare decisions, and financial issues may have a significant effect on care. In addition, identifying beliefs about the study intervention is important to ensure participant acceptance and willingness to participate in the research study. Without this knowledge, effective research design, implementation, and study recruitment may be jeopardized. George, Duran, and Norris (2014) conducted a systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. Shared barriers reported by all four racial and ethnic groups included mistrust and lack of access to information as a result of language barriers. Other barriers included competing demands (e.g., work schedules, child care), fear of unintended outcomes, stigma and lack of social support from family members, and issues related to health insurance coverage and legal status. Facilitators to health research participation that were reported by all four racial and ethnic groups included culturally congruent study designs with significant importance placed on having research staff that are representative of the participants' racial or ethnic group; benefits of participation that included monetary incentives, free lunches, or access to care resources; desire to help family or community; convenience of participation; and low risk of discomfort or invasiveness. The study by George et al. (2014) emphasizes the importance of acquiring knowledge about the specific cultural group represented in the research study.

Identify the Population's Preferred Method and Patterns of Communication

Communication with study participants is critical for several steps throughout the research process, including participant recruitment, informed consent, study instruments, and retention. Translators may be necessary to assist with communication or, as noted in George

et al. (2014), having a representative of the participants' racial or ethnic group on the research staff can facilitate study participation. Using a translator may be challenging when communicating with a participant, and accuracy of translated medical terminology may be a concern (O'Brien et al., 2006). Understanding a cultural group's communication should not only include preferred language, but also should consider nonverbal communication and patterns of communication specific to that group. For example, identifying topics that are taboo to the cultural group may affect survey questions and study instrument selection.

Team Approach for Instrument Selection and Translation

Appropriate instrument selection is challenging when designing research involving different cultural groups because of language barriers, different belief systems, and differences in the conceptualization and operationalization of health-related concepts (Sidani, Guruge, Miranda, Ford-Gilboe, & Varcoe, 2010). The meaning of a concept may vary across cultures and potentially can result in misinterpretation by study participants, leading to missing data. Because of the limited availability of instruments in all languages, researchers are faced with the process of adaptation and translation of research questionnaires. In addition, translated instruments will lack reliability and validity measures unless additional instrument testing has been conducted. Several different processes of instrument translation have been used. Maneesriwongul and Dixon (2004) conducted a methods review of studies involving quantitative research instrument translation. Results indicated that diverse methods of varying quality were used and included forward-only translation, forward-only translation with testing, back-translation, back-translation with monolingual test, back-translation with bilingual test, and back-translation with monolingual and bilingual tests. Sidani et al. (2010) proposed a five-phase process that includes selection of instruments, assessment of conceptual equivalence by a community advisory committee, forward translation by translators and discussion by the community advisory committee, back-translation, and pretesting of items with bicultural or

bilingual and monocultural or monolingual participants. Despite the need for additional research to achieve consensus about the most appropriate quality process for instrument translation, researchers should consider assistance from a translator and representatives from the cultural group under study to facilitate accurate conceptual and operational translation.

Application of Cultural Competency in Research

An example of cultural competency in research in this issue of the *Oncology Nursing Forum* is a validation study of the Spanish version of a mammography-specific self-efficacy scale in a population of Hispanic women to address barriers to mammogram use (Jerome-D'Emilia, Suplee, & Akincigil, 2015). Following instrument translation by two translators, women at Hispanic churches and a Hispanic community center were invited to participate, with bilingual representatives from both locations assisting with survey completion. On completion, the participants were given a monetary incentive. The authors concluded that the Spanish-translated mammogram-specific self-efficacy scale was reliable and valid and demonstrated predictive validity, which is important for valid results with translated instruments.

Conclusion

Significant changes in the population of the United States are projected in the next four decades, with an increase in aging and non-Caucasian cultural groups. Oncology nurses will need to attain knowledge and skills about different racial and ethnic groups to better provide culturally sensitive care in the practice setting. Additional research is needed to address healthcare behaviors and disparities in cultural groups through culturally competent research to ensure high-quality care.

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Methods & Meanings

Methods & Meanings comments and provides background on the methodology used in one of the studies reported in the that month's issue

of *Oncology Nursing Forum*. For more information, contact Associate Editor Diane G. Cope, PhD, ARNP, BC, AOCNP®, at dgcope@comcast.net.