Title of Educational Activity:

Cultural Diversity

Purpose / Goals:

To bring awareness of the effects of cultural differences in health care delivery.
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Content (Topics)</th>
<th>Teaching/ Learning Resources</th>
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<tr>
<td>List the educational objectives.</td>
<td>Provide an outline of the content/topic presented and indicate to which objective(s) the content/topic is related.</td>
<td>List teaching/learning resources used for each topic or content area.</td>
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</table>
| 1. Describe the cultural differences that impact values and communication. | I. Values and Communication  
   A. Communication  
   1. language / interpretation  
   2. body language  
   3. eye contact  
   4. nodding agreement  
   5. cross cultural language interpretation  
   B. Values  
   1. time and effort  
   2. respect of effort  
   3. grief  
   a. reactions based on belief systems  
   b. values  
   c. customs  
   d. ways of grieving | Media Course  
   Cultural Diversity  
   Mona Dorsonville, M.D., M.P.H., M.P.A. |
| 2. Identify cultural issues related to informed consent for health care. | II. Informed Consent (related to provision of health care)  
   A. Issues around cultural values  
   B. Language – interpretation of understanding  
   C. Issues around use of interpreters | Required Reading:  
   Notes, handouts & articles included in curriculum |
| 3. Discuss the impact of cultural differences and the speed of movement. | III. Pace – Perception of speed of movement  
   A. Body language  
   B. Cultural norms  
   C. Expectations (differences) | |
| 4. Describe the complex cultural and language issues surrounding compliance with health care directives. | IV. Non-Compliance Issues  
   A. Nodding yes when not understanding  
   B. Interpretation  
   C. Values, customs and language expectations related to instructions  
   D. Compliance may be affected  
   E. Prior experience with health care | Written Assignment:  
   Following the essay writing instructions found in the Orientation section of this curriculum, respond to all the numbered Learning Objectives found on the class outline. In addition, discuss how you would apply this information to your personal lifestyle, health and wellness. Essays must be a minimum of 1000 words in length. |
| 5. Identify the impact of culture differences on nutrition. | V. Cultural Nutrition and Folk Medicine  
   A. Cultural conditioning  
   B. Cultural healing values | |
| 6. Examine the complexities of bi-culturism and apply to the health care setting. | VI. Culture Shock and re-entry  
   A. Complexities of bicultural people  
   B. Become accustomed to new  
   C. Difficulty in re entry to old | |
The Many Faces of Diversity - Overview

Christina Cook, Ph.D., RN

Traditionally, nurses have been taught to respect the individuality of patients and to listen to their needs in terms of goals, lifestyles and culture. Nurses have been taught that individuals are psychosocial, cultural beings with their own uniqueness that must be respected. Nurse theorists, such as Leininger, have researched cultural care for decades and instilled the need for nurses to look at diversity from the perspective of the client as they practice culturally competent care. Nursing has evolved to where cultural awareness and diversity are engrained into nursing practice and the nursing consciousness.

What is diversity? There are many definitions of diversity however, most of the definitions include differences among groups or between individuals. These include, but are not limited to: gender, cultural, spiritual, biological/physical, social, environmental, moral, ethical, economical, educational, political, and ethncial differences. Many definitions include the acknowledgement that not everyone is alike and that it is imperative that differences be acknowledged for understanding and growth to occur between those who are diverse. This diversity can range from slight differences, such as those within family members, to major differences such as those between nations, religions, and geographical locations. All of these diversities affect health care practices and beliefs.

Why is it necessary to study diversity and why is it an important issue in nursing today? The world increasingly is being forced to understand and live with the differences of others. Many nations are faced with not only trying to understand the diversity of others, but are engaged in warfare in an attempt to deal with the diversities. This is very evident in tension areas such as Ireland, Israel, Bosnia, the Middle East and Baltic countries, and most recently, the War on Terrorism. The United States is also trying to accommodate the changes in ethnic/cultural makeup of the population, religious differences, and inequities in entrance into health care based on educational, social, economical, environmental, and cultural factors. As populations change and individuals become more transient, nurses are challenged everyday to incorporate the diverse needs of their clients into the provision of quality nursing care while facing the shortage in qualified staff to meet these needs. Clients are demanding individualized care considerations and research has shown us that without this attention to diversity, health care practices of clients and quality of health care diminish.

This issue of OJIN looks at these many faces of diversity in terms of health care in the United States. The focus of the articles is on cultural and racial diversity. As usual, four articles are presented addressing various aspects of this issue. In the Disparities in Health and Health Care: Focusing Efforts to Eliminate Unequal Burdens, Balwin provides an historical overview of health care in the United States. She then addresses the challenges and solutions to American health care delivery systems, especially in the area of minority health care services. Some of these include the challenge of research, health care provider’s recruitment, prevention programs, and provision of care to minority populations. Her final focus is on the patient-provider relationship and the importance of focusing on the social, cultural and economic factors of the minority population.

The article, Many Faces: Addressing Diversity In Health Care by Campinha-Bacote examines diversity beyond minority health care and looks at culture and cultural competency. She states that
nurses must go beyond just acknowledging differences, we must engage in what she refers to as the "process of becoming culturally competent." This article presents the Process of Cultural Competence in the Delivery of Healthcare Services Model as a model of cultural competence that includes the constructs of: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. This model involves life-long learning, self-examination, skill and knowledge building, and building on similarities while acknowledging differences. The author concludes that although there are many faces to cultural diversity, there is only one voice and one goal, to provide quality health care services responsive to the specific cultural group.

*Race Consciousness and the Health of African Americans* by Watts integrates the themes of the first two articles of the issue, providing culturally competent health care within the African-American culture. Watts introduces the idea that "race consciousness" must become an integral part of nursing provided to African-Americans. She provides an historical overview of oppression and inferiority toward this group in the United States. The contemporary racial injustice of the American health care system is then examined in terms of the lack of research on African-Americans, lack of preventative health care services, disparities in health care, provider-client issues, and epidemiological issues. Watts focuses on the need to assure culture competency in health care and discusses steps to attain competence and guidelines for beginning the process of incorporating race consciousness as a component of cultural competence.

The final article in this issue is entitled *Interweaving Policy and Diversity* by Milstead. This article examines the process of policy development as it connects with the concept of diversity. Policy development models are presented with particular focus on the United States political system. Milstead examines the American policy process through the four components of agenda setting, government response, implementation, and evaluation. The impact of policy on nursing and health care is highlighted, as are the values inherent in these policies. Nurses are cautioned to be aware of hidden health items on agendas that reflect values of political candidates. They are also encouraged to be active in the policy process at all stages, become aware of the interconnectedness of issues, and provide data to policy makers concerning diversity issues. Some issues examined in terms of the components of policy process include: racial concerns, human subject concerns, immigration, interstate practice, foreign nurse hiring, cultural competence, diversity in nurses, entry into practice, biological warfare, and nursing shortage.

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Why is Cultural Competence Important for Health Professionals?

This section will focus on strategies and practices that can enhance cultural competency for the individual health care professional. For those interested in organizational cultural competency, please see [ ] for information on organizational strategies and programs.

Lack of awareness about cultural differences can make it difficult for both providers and patients to achieve the best, most appropriate care. Despite all our similarities, fundamental differences among people arise from nationality, ethnicity, and culture, as well as from family background and individual experiences. These differences affect health beliefs, practices, and behavior on the part of both patient and provider, and also influence the expectations that patient and provider have of each other.

Often in the medical community (and the community in general) there is lack of awareness of these differences and their impact. This most likely results from a combination of factors that may include:

- **Lack of knowledge** - resulting in an inability to recognize the differences
- **Self-protection/denial** - leading to an attitude that these differences are not significant, or that our common humanity transcends our differences
- **Fear of the unknown or the new** - because it is challenging and perhaps intimidating to get to understand something that is new, that does not fit into one's world view
- **Feeling of pressure due to time constraints** - which can lead to feeling rushed and unable to look in depth at an individual patient's needs

The consequences of this lack of cultural awareness may be multiple. Patient-provider relationships are affected when understanding of each other's expectations is missing. Miscommunication results. The provider may not understand why the patient does not follow instructions: for example, why the patient takes a smaller dose of medicine than prescribed (because of a belief that Western medicine is "too strong"); or why the family, rather than the patient, makes important decisions about the patient's health care (because in the patient's culture, major decisions are made by the family as a group). Likewise, the patient may reject the provider (and the entire system) even before any one-on-one interaction occurs because of non-verbal cues that do not fit expectations. For example, "The doctor is not wearing a white coat - maybe he's not really a doctor; or, "The doctor smiles too much. Doesn't she take me seriously?"

What constitutes cultural competence is up for debate. Some use the terms cultural sensitivity and cultural awareness as synonyms, while others believe these are steps along the road to cultural competence. In this section, you will find definitions of cultural competence, discussions of how it can be achieved, and tools and resources to aid in striving for greater cultural competence.

Individual providers may want to determine where they are along the continuum of cultural competence in order to choose what steps to take next in their professional development.
Some things to consider if you work directly with patients:

1. How do you react when confronted with a "new" patient situation that does not fit your expectations? Does the situation provoke feelings of anxiety and discomfort? Are you able to assess what is going on within yourself as well as within the patient?
2. Do you have strategies to use to gain clarification of a puzzling situation, and to enhance both your own and your patient's understanding?
3. Are you able to support and help patients to understand that they are impacted by the same factors as you, regarding cultural differences in beliefs, expectations, behaviors?

Questions for the reader:

1. Is there a providers' group or faculty in your institution/area that are working on these kinds of issues?
2. What do you think providers need in order to become culturally competent?
3. What do you think patients who are recent arrivals need in order to utilize/understand the American medical system better?
Overview of Cultural Diversity and Mental Health Services

The U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations. Racial and ethnic minority groups are generally considered to be underserved by the mental health services system (Neighbors et al., 1992; Takeuchi & Uehara, 1996; Center for Mental Health Services [CMHS], 1998). A constellation of barriers deters ethnic and racial minority group members from seeking treatment, and if individual members of groups succeed in accessing services, their treatment may be inappropriate to meet their needs.

Awareness of the problem dates back to the 1960s and 1970s, with the rise of the civil rights and community mental health movements (Rogler et al., 1987) and with successive waves of immigration from Central America, the Caribbean, and Asia (Takeuchi & Uehara, 1996). These historical forces spurred greater recognition of the problems that minority groups confront in relation to mental health services.

Research documents that many members of minority groups fear, or feel ill at ease with, the mental health system (Lin et al., 1982; Sussman et al., 1987; Scheffler & Miller, 1991). These groups experience it as the product of white, European culture, shaped by research primarily on white, European populations. They may find only clinicians who represent a white middle-class orientation, with its cultural values and beliefs, as well as its biases, misconceptions, and stereotypes of other cultures.

Research and clinical practice have propelled advocates and mental health professionals to press for "linguistically and culturally competent services" to improve utilization and effectiveness of treatment for different cultures. Culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems (CMHS, 1998). Without culturally competent services, the failure to serve racial and ethnic minority groups adequately is expected to worsen, given the huge demographic growth in these populations predicted over the next decades (Takeuchi & Uehara, 1996; CMHS, 1998; Snowden, 1999).

This section of the chapter amplifies these major conclusions. It explains the confluence of clinical, cultural, organizational, and financial reasons for minority groups being underserved by the mental health system. The first task, however, is to explain which ethnic and racial groups constitute underserved populations, to describe their changing demographics, and to define the term "culture" and its consequences for the mental health system.

Introduction to Cultural Diversity and Demographics

The Federal government officially designates four major racial or ethnic minority groups in the United States: African American (black), Asian/Pacific Islander, Hispanic American (Latino), and Native American/American Indian/Alaska Native/Native Hawaiian (referred to subsequently as "American Indians") (CMHS, 1998). There are many other racial or ethnic minorities and considerable diversity within each of the four groupings listed above. The representation of the four officially designated groups in the U.S. population in 1999 is as follows: African Americans constitute the largest group, at 12.8 percent of the U.S. population; followed by Hispanics (11.4 percent), Asian/Pacific Islanders (4.0 percent), and American Indians (0.9 percent) (U.S. Census Bureau, 1999). Hispanic Americans are
among the fastest-growing groups. Because their population growth outpaces that of African Americans, they are projected to be the predominant minority group (24.5 percent of the U.S. population) by the year 2050 (CMHS, 1998).

Racial and ethnic populations differ from one another and from the larger society with respect to culture. The term “culture” is used loosely to denote a common heritage and set of beliefs, norms, and values. The cultures with which members of minority racial and ethnic groups identify often are markedly different from industrial societies of the West. The phrase “cultural identity” specifies a reference group—an identifiable social entity with whom a person identifies and to whom he or she looks for standards of behavior (Cooper & Denner, 1998). Of course, within any given group, an individual’s cultural identity may also involve language, country of origin, acculturation, gender, age, class, religious/spiritual beliefs, sexual orientation, and physical disabilities (Lu et al., 1995). Many people have multiple ethnic or cultural identities.

The historical experiences of ethnic and minority groups in the United States are reflected in differences in economic, social, and political status. The most measurable difference relates to income. Many racial and ethnic minority groups have limited financial resources. In 1994, families from these groups were at least three times as likely as white families to have incomes placing them below the Federally established poverty line. The disparity is even greater when considering extreme poverty—family incomes at a level less than half of the poverty threshold—and is also large when considering children and older persons (O’Hare, 1996). Although some Asian Americans are somewhat better off financially than other minority groups, they still are more than one and a half times more likely than whites to live in poverty. Poverty disproportionately affects minority women and their children (Miranda & Green, 1999). The effects of poverty are compounded by differences in total value of accumulated assets, or total wealth (O’Hare et al., 1991).

Lower socioeconomic status—in terms of income, education, and occupation—has been strongly linked to mental illness. It has been known for decades that people in the lowest socioeconomic strata are about two and a half times more likely than those in the highest strata to have a mental disorder (Holzer et al., 1986; Regier et al., 1993b). The reasons for the association between lower socioeconomic status and mental illness are not well understood. It may be that a combination of greater stress in the lives of the poor and greater vulnerability to a variety of stressors leads to some mental disorders, such as depression. Poor women, for example, experience more frequent, threatening, and uncontrollable life events than do members of the population at large (Belle, 1990). It also may be that the impairments associated with mental disorders lead to lower socioeconomic status (McLeod & Kessler, 1990; Dohrenwend, 1992; Regier et al., 1993b).

Cultural identity imparts distinct patterns of beliefs and practices that have implications for the willingness to seek, and the ability to respond to, mental health services. These include coping styles and ties to family and community, discussed below.

**Coping Styles**

Cultural differences can be reflected in differences in preferred styles of coping with day-to-day problems. Consistent with a cultural emphasis on restraint, certain Asian
American groups, for example, encourage a tendency not to dwell on morbid or upsetting thoughts, believing that avoidance of troubling internal events is warranted more than recognition and outward expression (Leong & Lau, 1998). They have little willingness to behave in a fashion that might disrupt social harmony (Uba, 1994). Their emphasis on willpower is similar to the tendency documented among African Americans to minimize the significance of stress and, relatedly, to try to prevail in the face of adversity through increased striving (Broman, 1996).

Culturally rooted traditions of religious beliefs and practices carry important consequences for willingness to seek mental health services. In many traditional societies, mental health problems can be viewed as spiritual concerns and as occasions to renew one’s commitment to a religious or spiritual system of belief and to engage in prescribed religious or spiritual forms of practice. African Americans (Broman, 1996) and a number of ethnic groups (Lu et al., 1995), when faced with personal difficulties, have been shown to seek guidance from religious figures.

Many people of all racial and ethnic backgrounds believe that religion and spirituality favorably impact upon their lives and that well-being, good health, and religious commitment or faith are integrally intertwined (Taylor, 1986; Priest, 1991; Bacote, 1994; Pargament, 1997). Religion and spirituality are deemed important because they can provide comfort, joy, pleasure, and meaning to life as well as be means to deal with death, suffering, pain, injustice, tragedy, and stressful experiences in the life of an individual or family (Pargament, 1997). In the family/community-centered perception of mental illness held by Asians and Hispanics, religious organizations are viewed as an enhancement or substitute when the family is unable to cope or assist with the problem (Acosta et al., 1982; Comas-Diaz, 1989; Cook & Timberlake, 1989; Meadows, 1997).

Culture also imprints mental health by influencing whether and how individuals experience the discomfort associated with mental illness. When conveyed by tradition and sanctioned by cultural norms, characteristic modes of expressing suffering are sometimes called “idioms of distress” (Lu et al., 1995). Idioms of distress often reflect values and themes found in the societies in which they originate.

One of the most common idioms of distress is somatization, the expression of mental distress in terms of physical suffering. Somatization occurs widely and is believed to be especially prevalent among persons from a number of ethnic minority backgrounds (Lu et al., 1995). Epidemiological studies have confirmed that there are relatively high rates of somatization among African Americans (Zhang & Snowden, in press). Indeed, somatization resembles an African American folk disorder identified in ethnographic research and is linked to seeking treatment (Snowden, 1998).

A number of idioms of distress are well recognized as culture-bound syndromes and have been included in an appendix to DSM-IV. Among culture-bound syndromes found among some Latino psychiatric patients is *ataque de nervios*, a syndrome of “uncontrollable shouting, crying, trembling, and aggression typically triggered by a stressful event involving family. . . ” (Lu et al., 1995, p. 489). A Japanese culture-bound syndrome has appeared in that country’s clinical modification of ICD-10 (WHO *International Classification of Diseases*, 10th edition, 1993). *Taijin kyofusho* is an intense fear that one’s body or bodily functions give offense to others. Culture-bound syndromes sometimes reflect comprehensive systems of belief, typically emphasizing
a need for a balance between opposing forces (e.g., yin/yang, “hot-cold” theory) or the power of supernatural forces (Cheung & Snowden, 1990). Belief in indigenous disorders and adherence to culturally rooted coping practices are more common among older adults and among persons who are less acculturated. It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and culture-bound syndromes.

Family and Community as Resources

Ties to family and community, especially strong in African, Latino, Asian, and Native American communities, are forged by cultural tradition and by the current and historical need to assist arriving immigrants, to provide a sanctuary against discrimination practiced by the larger society, and to provide a sense of belonging and affirming a centrally held cultural or ethnic identity.

Among Mexican-Americans (del Pinal & Singer, 1997) and Asian Americans (Lee, 1998) relatively high rates of marriage and low rates of divorce, along with a greater tendency to live in extended family households, indicate an orientation toward family. Family solidarity has been invoked to explain relatively low rates among minority groups of placing older people in nursing homes (Short et al., 1994).

The relative economic success of Chinese, Japanese, and Korean Americans has been attributed to family and communal bonds of association (Fukuyama, 1995). Community organizations and networks established in the United States include rotating credit associations based on lineage, surname, or region of origin. These organizations and networks facilitate the startup of small businesses.

There is evidence of an African American tradition of voluntary organizations and clubs often having political, economic, and social functions and affiliation with religious organizations (Milburn & Bowman, 1991). African Americans and other racial and ethnic minority groups have drawn upon an extended family tradition in which material and emotional resources are brought to bear from a number of linked households. According to this literature, there is “(a) a high degree of geographical propinquity; (b) a strong sense of family and familial obligation; (c) fluidity of household boundaries, with greater willingness to absorb relatives, both real and fictive, adult and minor, if need arises; (d) frequent interaction with relatives; (e) frequent extended family get-togethers for special occasions and holidays; and (f) a system of mutual aid” (Hatchett & Jackson, 1993, p. 92).

Families play an important role in providing support to individuals with mental health problems. A strong sense of family loyalty means that, despite feelings of stigma and shame, families are an early and important source of assistance in efforts to cope, and that minority families may expect to continue to be involved in the treatment of a mentally ill member (Uba, 1994). Among Mexican American families, researchers have found lower levels of expressed emotion and lower levels of relapse (Karno et al., 1987). Other investigators have demonstrated an association between family warmth and a reduced likelihood of relapse (Lopez et al., in press).
Epidemiology and Utilization of Services

One of the best ways to identify whether a minority group has problems accessing mental health services is to examine their utilization of services in relation to their need for services. As noted previously, a limitation of contemporary mental health knowledge is the lack of standard measures of “need for treatment” and culturally appropriate assessment tools. Minority group members’ needs, as measured indirectly by their prevalence of mental illness in relation to the U.S. population, should be proportional to their utilization, as measured by their representation in the treatment population. These comparisons turn out to be exceedingly complicated by inadequate understanding of the prevalence of mental disorders among minority groups in the United States.\textsuperscript{24} Nationwide studies conducted many years ago overlooked institutional populations, which are disproportionately represented by minority groups. Treatment utilization information on minority groups in relation to whites is more plentiful, yet, a clear understanding of health seeking behavior in various cultures is lacking.

The following paragraphs reveal that disparities abound in treatment utilization: some minority groups are underrepresented in the outpatient treatment population while, at the same time, overrepresented in the inpatient population. Possible explanations for the differences in utilization are discussed in a later section.

African Americans

The prevalence of mental disorders is estimated to be higher among African Americans than among whites (Regier et al., 1993a). This difference does not appear to be due to intrinsic differences between the races; rather, it appears to be due to socioeconomic differences. When socioeconomic factors are taken into account, the prevalence difference disappears. That is, the socioeconomic status-adjusted rates of mental disorder among African Americans turn out to be the same as those of whites. In other words, it is the lower socioeconomic status of African Americans that places them at higher risk for mental disorders (Regier et al., 1993a).

African Americans are underrepresented in some outpatient treatment populations, but overrepresented in public inpatient psychiatric care in relation to whites (Snowden & Cheung, 1990; Snowden, in press-b). Their underrepresentation in outpatient treatment varies according to setting, type of provider, and source of payment. The racial gap between African Americans and whites in utilization is smallest, if not nonexistent, in community-based programs and in treatment financed by public sources, especially Medicaid (Snowden, 1998) and among older people (Padgett et al., 1995). The underrepresentation is largest in privately financed care, especially individual outpatient practice, paid for either by fee-for-service arrangements or managed care. As a result, underrepresentation in the outpatient setting occurs more among working and middle-class African Americans, who are privately insured, than among the poor. This suggests that socioeconomic standing alone cannot explain the problem of underutilization (Snowden, 1998).

African Americans are, as noted above, overrepresented in inpatient psychiatric care (Snowden, in press-b). Their rate of utilization of psychiatric inpatient care is about double that of whites (Snowden & Cheung, 1990). This difference is even higher than would be expected on the basis of prevalence estimates. Overrepresentation is found in hospitals of all types except private psychiatric hospitals.\textsuperscript{25} While difficult to
explain definitively, the problem of overrepresentation in psychiatric hospitals appears more rooted in poverty, attitudes about seeking help, and a lack of community support than in clinician bias in diagnosis and overt racism, which also have been implicated (Snowden, in press-b). This line of reasoning posits that poverty, disinclination to seek help, and lack of health and mental health services deemed appropriate, and responsive, as well as community support, are major contributors to delays by African Americans in seeking treatment until symptoms become so severe that they warrant inpatient care.

Finally, African Americans are more likely than whites to use the emergency room for mental health problems (Snowden, in press-a). Their overreliance on emergency care for mental health problems is an extension of their overreliance on emergency care for other health problems. The practice of using the emergency room for routine care is generally attributed to a lack of health care providers in the community willing to offer routine treatment to people without insurance (Snowden, in press-a).

**Asian Americans/Pacific Islanders**

The prevalence of mental illness among Asian Americans is difficult to determine for methodological reasons (i.e., population sampling). Although some studies suggest higher rates of mental illness, there is wide variance across different groups of Asian Americans (Takeuchi & Uehara, 1996). It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and culture-bound syndromes. With respect to treatment-seeking behavior, Asian Americans are distinguished by extremely low levels at which specialty treatment is sought for mental health problems (Leong & Lau, 1998). Asian Americans have proven less likely than whites, African Americans, and Hispanic Americans to seek care. One national sample revealed that Asian Americans were only a quarter as likely as whites, and half as likely as African Americans and Hispanic Americans, to have sought outpatient treatment (Snowden, in press-a). Asian Americans/Pacific Islanders are less likely than whites to be psychiatric inpatients (Snowden & Cheung, 1990). The reasons for the underutilization of services include the stigma and loss of face over mental health problems, limited English proficiency among some Asian immigrants, different cultural explanations for the problems, and the inability to find culturally competent services. These phenomena are more pronounced for recent immigrants (Sue et al., 1994).

**Hispanic Americans**

Several epidemiological studies revealed few differences between Hispanic Americans and whites in lifetime rates of mental illness (Robins & Regier, 1991; Vega & Kolody, 1998). A recent study of Mexican Americans in Fresno County, California, found that Mexican Americans born in the United States had rates of mental disorders similar to those of other U.S. citizens, whereas immigrants born in Mexico had lower rates (Vega et al., 1998a). A large study conducted in Puerto Rico reported similar rates of mental disorders among residents of that island, compared with those of citizens of the mainland United States (Canino et al., 1987).

Although rates of mental illness may be similar to whites in general, the prevalence of particular mental health problems, the manifestation of symptoms, and help-seeking behaviors within Hispanic subgroups need attention and further research. For instance, the prevalence of depressive symptomatology is higher in Hispanic
women (46%) than men (almost 20%); yet, the known risk factors do not totally explain the gender difference (Vega et al., 1998a; Zunzunegui et al., 1998). Several studies indicate that Puerto Rican and Mexican American women with depressive symptomatology are underrepresented in mental health services and overrepresented in general medical services (Hough et al., 1987; Sue et al., 1991, 1994; Duran, 1995; Jimenez et al., 1997).

**Native Americans**

American Indians/Alaska Natives have, like Asian Americans and Pacific Islanders, been studied in few epidemiological surveys of mental health and mental disorders. The indications are that depression is a significant problem in many American Indian/Alaska Native communities (Nelson et al., 1992). One study of a Northwest Indian village found rates of DSM-III-R affective disorder that were notably higher than rates reported from national epidemiological studies (Kinzie et al., 1992). Alcohol abuse and dependence appear also to be especially problematic, occurring at perhaps twice the rate of occurrence found in any other population group. Relatedly, suicide occurs at alarmingly high levels. (Indian Health Service, 1997). Among Native American veterans, post-traumatic stress disorder has been identified as especially prevalent in relation to whites (Manson, 1998). In terms of patterns of utilization, Native Americans are overrepresented in psychiatric inpatient care in relation to whites, with the exception of private psychiatric hospitals (Snowden & Cheung, 1990; Snowden, in press-b).

**Barriers to the Receipt of Treatment**

The underrepresentation in outpatient treatment of racial and ethnic minority groups appears to be the result of cultural differences as well as financial, organizational, and diagnostic factors. The service system has not been designed to respond to the cultural and linguistic needs presented by many racial and ethnic minorities. What is unresolved are the relative contribution and significance of each factor for distinct minority groups.

**Help-Seeking Behavior**

Among adults, the evidence is considerable that persons from minority backgrounds are less likely than are whites to seek outpatient treatment in the specialty mental health sector (Sussman et al., 1987; Gallo et al., 1995; Leong & Lau, 1998; Snowden, 1998; Vega et al., 1998a, 1998b; Zhang et al., 1998). This is not the case for emergency department care, from which African Americans are more likely than whites to seek care for mental health problems, as noted above. Language, like economic and accessibility differences, can play an important role in why people from other cultures do not seek treatment (Hunt, 1984; Comas-Diaz, 1989; Cook & Timberlake, 1989; Taylor, 1989).

**Mistrust**

The reasons why racial and ethnic minority groups are less apt to seek help appear to be best studied among African Americans. By comparison with whites, African Americans are more likely to give the following reasons for not seeking professional help in the face of depression: lack of time, fear of hospitalization, and fear of
treatment (Sussman et al., 1987). Mistrust among African Americans may stem from their experiences of segregation, racism, and discrimination (Primm et al., 1996; Priest, 1991). African Americans have experienced racist slights in their contacts with the mental health system, called “microinsults” by Pierce (1992). Some of these concerns are justified on the basis of research, cited below, revealing clinician bias in overdiagnosis of schizophrenia and underdiagnosis of depression among African Americans.

Lack of trust is likely to operate among other minority groups, according to research about their attitudes toward government-operated institutions rather than toward mental health treatment per se. This is particularly pronounced for immigrant families with relatives who may be undocumented, and hence they are less likely to trust authorities for fear of being reported and having the family member deported. People from El Salvador and Argentina who have experienced imprisonment or watched the government murder family members and engage in other atrocities may have an especially strong mistrust of any governmental authority (Garcia & Rodriguez, 1989). Within the Asian community, previous refugee experiences of groups such as Vietnamese, Indochinese, and Cambodian immigrants parallel those experienced by Salvadoran and Argentine immigrants. They, too, experienced imprisonment, death of family members or friends, physical abuse, and assault, as well as new stresses upon arriving in the United States (Cook & Timberlake, 1989; Mollica, 1989).

American Indians’ past experience in this country also imparted lack of trust of government. Those living on Indian reservations are particularly fearful of sharing any information with white clinicians employed by the government. As with African Americans, the historical relationship of forced control, segregation, racism, and discrimination has affected their ability to trust a white majority population (Herring, 1994; Thompson, 1997).

**Stigma**

The stigma of mental illness is another factor preventing African Americans from seeking treatment, but not at a rate significantly different from that of whites. Both African American and white groups report that embarrassment hinders them from seeking treatment (Sussman et al., 1987). In general, African Americans tend to deny the threat of mental illness and strive to overcome mental health problems through self-reliance and determination (Snowden, 1998). Stigma, denial, and self-reliance are likely explanations why other minority groups do not seek treatment, but their contribution has not been evaluated empirically, owing in part to the difficulty of conducting this type of research. One of the few studies of Asian Americans identified the barriers of stigma, suspiciousness, and a lack of awareness about the availability of services (Uba, 1994). Cultural factors tend to encourage the use of family, traditional healers, and informal sources of care rather than treatment-seeking behavior, as noted earlier.

**Cost**

Cost is yet another factor discouraging utilization of mental health services (Chapter 6). Minority persons are less likely than whites to have private health insurance, but this factor alone may have little bearing on access. Public sources of insurance and publicly supported treatment programs fill some of the gap. Even among working
class and middle-class African Americans who have private health insurance, there is underrepresentation of African Americans in outpatient treatment (Snowden, 1998). Yet studies focusing only on poor women, most of whom were members of minority groups, have found cost and lack of insurance to be barriers to treatment (Miranda & Green, 1999). The discrepancies in findings suggest that much research remains to be performed on the relative importance of cost, cultural, and organizational barriers, and poverty and income limitations across the spectrum of racial and ethnic and minority groups.

Clinician Bias

Advocates and experts alike have asserted that bias in clinician judgment is one of the reasons for overutilization of inpatient treatment by African Americans. Bias in clinician judgment is thought to be reflected in overdiagnosis or misdiagnosis of mental disorders. Since diagnosis is heavily reliant on behavioral signs and patients’ reporting of the symptoms, rather than on laboratory tests, clinician judgment plays an enormous role in the diagnosis of mental disorders. The strongest evidence of clinician bias is apparent for African Americans with schizophrenia and depression. Several studies found that African Americans were more likely than were whites to be diagnosed with schizophrenia, yet less likely to be diagnosed with depression (Snowden & Cheung, 1990; Hu et al., 1991; Lawson et al., 1994).

In addition to problems of over diagnosis or misdiagnosis, there may well be a problem of under diagnosis among minority groups, such as Asian Americans, who are seen as “problem-free” (Takeuchi & Uehara, 1996). The presence and extent of this type of clinician bias are not known and need to be investigated.

Improving Treatment for Minority Groups

The previous paragraphs have documented underutilization of treatment, less help-seeking behavior, inappropriate diagnosis, and other problems that have beset racial and ethnic minority groups with respect to mental health treatment. This kind of evidence has fueled the widespread perception of mental health treatment as being uninviting, inappropriate, or not as effective for minority groups as for whites. The Schizophrenia Patient Outcome Research Team demonstrated that African Americans were less likely than others to have received treatment that conformed to recommended practices (Lehman & Steinwachs, 1998). Inferior treatment outcomes are widely assumed but are difficult to prove, especially because of sampling, questionnaire, and other design issues, as well as problems in studying patients who drop out of treatment after one session or who otherwise terminate prematurely. In a classic study, 50 percent of Asian Americans versus 30 percent of whites dropped out of treatment early (Sue & McKinney, 1975). However, the disparity in dropout rates may have abated more recently (O’Sullivan et al., 1989; Snowden et al., 1989). One of the few studies of clinical outcomes, a pre- versus post-treatment study, found that African Americans fared more poorly than did other minority groups treated as outpatients in the Los Angeles area (Sue et al., 1991). Earlier studies from the 1970s and 1980s had given inconsistent results (Sue et al., 1991).

Ethnopsychopharmacology

There is mounting awareness that ethnic and cultural influences can alter an individual’s responses to medications (pharmaco-therapies). The relatively new field
of ethno-psychopharmacology investigates cultural variations and differences that influence the effectiveness of pharmaco-therapies used in the mental health field. These differences are both genetic and psychosocial in nature. They range from genetic variations in drug metabolism to cultural practices that affect diet, medication adherence, placebo effect, and simultaneous use of traditional and alternative healing methods (Lin et al., 1997). Just a few examples are provided to illustrate ethnic and racial differences.

Pharmaco-therapies given by mouth usually enter the circulation after absorption from the stomach. From the circulation they are distributed throughout the body (including the brain for psychoactive drugs) and then metabolized, usually in the liver, before they are cleared and eliminated from the body (Brody, 1994). The rate of metabolism affects the amount of the drug in the circulation. A slow rate of metabolism leaves more drug in the circulation. Too much drug in the circulation typically leads to heightened side effects. A fast rate of metabolism, on the other hand, leaves less drug in the circulation. Too little drug in the circulation reduces its effectiveness.

There is wide racial and ethnic variation in drug metabolism. This is due to genetic variations in drug-metabolizing enzymes (which are responsible for breaking down drugs in the liver). These genetic variations alter the activity of several drug-metabolizing enzymes. Each drug-metabolizing enzyme normally breaks down not just one type of pharmacotherapy, but usually several types. Since most of the ethnic variation comes in the form of inactivation or reduction in activity in the enzymes, the result is higher amounts of medication in the blood, triggering untoward side effects.

For example, 33 percent of African Americans and 37 percent of Asians are slow metabolizers of several antipsychotic medications and antidepressants (such as tricyclic antidepressants and selective serotonin reuptake inhibitors) (Lin et al., 1997). This awareness should lead to more cautious prescribing practices, which usually entail starting patients at lower doses in the beginning of treatment. Unfortunately, just the opposite typically had been the case with African American patients and antipsychotic drugs. Clinicians in psychiatric emergency services prescribed more oral doses and more injections of antipsychotic medications to African American patients (Segel et al., 1996). The combination of slow metabolism and overmedication of antipsychotic drugs in African Americans can yield very uncomfortable extra pyramidal side effects (Lin et al., 1997). These are the kinds of experiences that likely contribute to the mistrust of mental health services reported among African Americans (Sussman et al., 1987).

Psychosocial factors also can play an important role in ethnic variation. Compliance with dosing may be hindered by communication difficulties; side effects can be misinterpreted or carry different connotations; some groups may be more responsive to placebo treatment; and reliance on psychoactive traditional and alternative healing methods (such as medicinal plants and herbs) may result in interactions with prescribed pharmaco-therapies. The result could be greater side effects and enhanced or reduced effectiveness of the pharmacotherapy, depending on the agents involved and their concentrations (Lin et al., 1997). Greater awareness of ethno-psychopharmacology is expected to improve treatment effectiveness for racial and ethnic minorities. More research is needed on this topic across racial and ethnic groups.
20 The term “Latino(a)” refers to all persons of Mexican, Puerto Rican, Cuban, or other Central and South American or Spanish origin (CMHS, 1998).

21 Acculturation refers to the “social distance” separating members of an ethnic or racial group from the wider society in areas of beliefs and values and primary group relations (work, social clubs, family, friends) (Gordon, 1964). Greater acculturation thus reflects greater adoption of mainstream beliefs and practices and entry into primary group relations.

22 Research is emerging on the importance of tailoring services to the special needs of gay, lesbian, and bisexual mental health service users (Cabaj & Stein, 1996).

23 Of the 15 percent of the U.S. population that use mental health services in a given year, about 2.8 percent receive care only from members of the clergy (Larson et al., 1988).

24 In spring 2000, survey field work begins on an NIMH-funded study of the prevalence of mental disorders, mental health symptoms, and related functional impairments in African Americans, Caribbean blacks, and non-Hispanic whites. The study will examine the effects of psychosocial factors and race-associated stress on mental health, and how coping resources and strategies influence that impact. The study will provide a database on mental health, mental disorders, and ethnicity and race. James Jackson, Ph.D., University of Michigan, is principal investigator.

25 African Americans are overrepresented among persons undergoing involuntary civil commitment (Snowden, in press-b).

26 Dystonia (brief or prolonged contraction of muscles), akathisia (an urge to move about constantly), or parkinsonism (tremor and rigidity) (Perry et al., 1997).
As the number of foreign-born nurses climbs, executives look for ways to bridge cultural gap

Just like the nation as a whole, America's hospitals are an ever-expanding mixing bowl of cultures and ethnicities. Need proof? Look no further than your nursing staff. It's estimated that foreign-born nurses make up 12 percent of the workforce, up from 9 percent in the mid-1990s.

With the demand for nurses growing, that number is likely to climb even higher. As a result, hospital executives face a critical personnel challenge: integrating foreign-born nurses into the workplace. Problems most typically arise around cultural differences, which influence people's beliefs and expectations, says Georgianna Donadio, director, New England School of Whole Health Education, Wellesley, Mass., a provider of continuing education for nurses.

"Culture impacts how nurses communicate with each other. For example, in many cultures, keeping eyes downcast is a sign of respect. In the U.S., this can make it seem like the person is hiding something," Donadio explains. "Some cultures are open, some are reticent. What one person says, or how they behave, in one culture doesn't necessarily translate to another, and it's important people [recognize] this. Otherwise, there can be misunderstandings and conflict."

There are additional issues, says Shawn Feinstein, CEO of Absolut Global Healthcare, a Boca Raton, Fla., health care recruiting firm. Although overseas hires generally have good command of English, they're often unfamiliar with the advanced technology found in U.S. hospitals, and with hospital protocols. Consequently, more training is needed to help them assimilate. This isn't just a critical staff issue, she says, but a critical patient care one as well.
Laura Fortin, chief nursing executive and chief operating officer of Christus St. Joseph Hospital in Houston agrees. Christus hires "a lot" of foreign-born nurses, about 95 percent of which are from the Philippines.

"We have to acculturate them to the hospital--it's not unusual for nurses from the Philippines to never have worked in a hospital--and to the community," Fortin says. "The program we have in place minimizes the cultural conflict that we may otherwise experience."

They rely on their veteran Filipino nurses, who serve on a volunteer welcome committee, to buddy with the new hires and show them the ropes both inside and outside of the hospital. New arrivals and their families are also housed on the hospital campus for two months, free of charge.

"The U.S.-born staff has no problem acculturating to the Filipino nurses; we've had them on staff for so long. But if we didn't have something in place for the [new nurses] they'd really struggle, and I suspect some of them would go home," Fortin says. "Given all that's required to get them here, this would be unfortunate."

Christus is developing programs to educate staff about diversity issues overall, having done a yearlong study last summer.

"We're focusing on this at the systems level," Fortin says. "We feel you have to understand staff diversity before you can understand patient diversity."

*This article 1st appeared in the April 2005 issue of HHN Magazine.*
Cultural Diversity: Eating in America

Middle Eastern

Jill Eversole Nolan

The countries of the Middle East include Egypt, Iran, Iraq, Israel, Jordan, Lebanon, Saudi Arabia, Syria, and Turkey. Although the cuisines of Middle Eastern countries are similar, each culture has distinctly different eating practices, food preferences, and food preparation techniques.

Thousands of Middle Easterners live in the United States. Middle Easterners emigrate for political reasons, advanced schooling, and because of the prior emigration of other family members. The many students and professionals who emigrate from these countries often come from affluent families and are cosmopolitan in their food habits. As with other immigrant groups, the length of stay in the United States correlates with the degree of Americanization of the diet. Traditional dishes tend to be prepared and eaten for special occasions.

Food Habits and Their Relationship to Dietary Guidelines

Foods common among all of the Middle Eastern cuisines include dates, olives, wheat, rice, legumes, and lamb. Bread typically accompanies each meal.

Common food consumption includes the following:

- **Dairy Products**
  
  Most dairy products are eaten in fermented forms, such as yogurt and cheese. Whole milk is used in desserts and puddings. Feta cheese is the most commonly consumed cheese.

- **Meats**

  Lamb is the most widely eaten meat. Pork is eaten only by Christians and not by Muslims or Jews. Many Middle Easterners will not combine dairy products or shellfish with the meal. Kosher beef, kosher poultry, herring, lox, and sardines are also common foods. Legumes such as black beans, chick peas (garbanzo beans), lentils, navy beans, and red beans are used in many dishes.
• **Breads and Cereals**

Some form of wheat or rice accompanies each meal. Matzoh, unleavened bread, and pita bread are common and readily available in American food markets. Filo dough, which is used to make baklava, is also used in many dishes.

• **Fruits**

Fruits tend to be eaten as dessert or as snacks. Fresh fruit is preferred. Fruits made into jams and compotes are eaten if fresh is not available. Lemons commonly are used for flavoring.

• **Vegetables**

Eggplant is the most commonly consumed vegetable. Fruit and vegetables are preferred raw or mixed in a salad. Many times vegetables are stuffed with rice or meats. Green and black olives are present in many dishes, and olive oil is most frequently used in food preparation.

**Eating Practices, Food Preferences and Food Preparation Techniques**

Grilling, frying, grinding, and stewing are the most common ways of preparing meats. A whole, roasted lamb, or leg of lamb is a special dish prepared for festive gatherings. Spices and seasonings are essential in the preparation of Middle Eastern dishes. Common spices and herbs include dill, garlic, mint, cinnamon, oregano, parsley, and pepper. Olive oil is preferred in food preparation.

While Americanized Middle Easterners prefer an American-type breakfast and lunch, dinner is more traditional. Recipes have been altered to require less preparation time, less fat, and fewer spices.

**Teaching Implications**

The ability to work effectively with persons from culturally diverse backgrounds, such as those from the Middle East, is important. Many people from these cultures observe Muslim and Eastern Orthodox religions, which influences the kinds of food chosen and/or how the foods are combined. Muslims do not eat any form of pork or meat that has been slaughtered without mentioning God's name. Muslims cannot drink alcoholic beverages or foods flavored with alcohol. Middle Easterners have a high incidence of lactose intolerance, and therefore fresh milk is not widely consumed. The wide use of olive oil in food preparation attributes to a diet high in monounsaturated fatty acids and a culture commonly known for lower blood pressures.
Customs and Family Traditions

The Middle Eastern culture centers around a strong patriarchal family. This has lessened since their emigration to the United States but family ties are still strong.

Food is an integral part of family celebrations, special days of honor, and festivals. The Kosher dietary laws concerning selection, preparation, and eating of food remains influential in the Jewish religious and family life. The Jewish laws of Kashrut, or keeping Kosher, determine which foods are Kosher and non-Kosher.

Many ancient practices and rituals, handed down from generation to generation, are observed. Fasting from sunrise to sunset is a Muslim religious obligation practiced during Ramadan.

Body movement such as touch is allowed only between the same sex. Body language and eye contact remain an important tool in effective communication.

Cultural Diversity: Eating in America

Cultural diversity is a major issue in American eating. To fully understand the impact cultures play in American nutrition, one must study both food and culture.

This fact sheet on the Middle Eastern culture is one of a series of nine developed to address cultural diversity in American eating.

This fact sheet is designed as an awareness tool for a novice working with a cultural group previously unknown to them. Given the nature of the variations that exist in each cultural group (i.e. socio-economic status, religion, age, education, social class, location, length of time in the United States, and location of origin) caution needs to be taken not to generalize or imply that these characteristics apply to all individuals of a cultural group. This fact sheet was designed primarily for use in Northeastern Ohio, but may stimulate awareness of differences in these cultural groups in other parts of the country. The goal of this fact sheet is to assist a novice educator in reducing any cultural barriers that may inhibit education. The author strongly recommends continued reading and additional research into the cultural groups in which you work.
References


Additional resources addressing cultural diversity in nutrition education:


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Cultural Diversity: Eating in America

Puerto Rican

Cheryle Jones Syracuse

The Puerto Rican culture includes people whose ancestors and possibly current extended family members are from the Caribbean island of Puerto Rico. Their original language is Spanish. Under Spanish rule and then under American rule, Puerto Rico has never been an independent nation. Puerto Ricans are American citizens and can legally enter and leave the mainland. Migration flows circularly between the island of Puerto Rico and the mainland. Because of this circular migration, elements of both cultures thrive in both places, and a specific Puerto Rican "cultural type" is difficult to describe.

Food Habits and Their Relationship to Dietary Guidelines

The typical Puerto Rican diet has many positive aspects. This diet is high in complex carbohydrates such as breads, cereals, soda crackers, rice, and corn meal.

A typical diet also includes some calcium and milk products. Adult women will drink milk in cafe con leche (coffee with milk) and consume calcium in flan (custard).

Incomplete proteins, such as those as found in legumes, rice, and beans, are often eaten. Meats eaten include chicken, pork sausage, turkey, beef, pork chops, spare ribs, and marinated pork. Fish is eaten, but in quantities smaller than other meats.

When available, viandas (starchy vegetables) are also included in the Puerto Rican diet. Viandas include plantains, green bananas, taniers, white and yellow sweet potatoes, and chayote squash. Lettuce salads with tomato are popular.

Increasing the calcium intake and the varieties of vegetables would improve the typical Puerto Rican diet. The diet is generally high in calories, complex carbohydrates, fats, and sodium.

Almost 70 percent of the food on the island of Puerto Rico is imported from the United States. Because of this the Puerto Rican diet - particularly the diets of younger generations - has become very Americanized. Favorite foods include pizza, hot dogs, canned spaghetti, cold cereal, and canned soups. Fast food restaurants are also popular. Some Puerto Rican families living on the mainland shift away from traditional dietary patterns. Others maintain their ethnic food patterns after living on the mainland several decades. Bilingual children can play a major role in promoting dietary changes and modifications.
The population has a tendency toward high blood pressure, heart disease, diabetes (three to five times higher than the general population), cancer, arthritis, gastrointestinal disorders, and obesity.

Nutritional objectives should involve: encouraging selection of foods from all food groups; drinking plenty of water; maintaining ideal body weight; encouraging the use of low-fat dairy products; encouraging the consumption of unsugared fruit juices; teaching a greater variety of preparation styles; and introducing a greater variety of vegetables. The population should also be discouraged from eating sugar and simple carbohydrates, and using excessive fats in cooking.

Eating Practices, Food Preferences and Food Preparation Techniques

Puerto Rican foods are not spicy like Mexican foods, but they do have a mild, distinctive taste. They frequently use a seasoning called Sazon, which is mostly MSG. Other common seasonings are annato (a yellow coloring similar to saffron), cilantro, and sofrito (a seasoning sauce used in cooking made from lean cured ham, onion, green pepper, cilantro, and garlic sauteed in oil).

Teaching Implications

Teachers may benefit from developing a trust relationship and engaging learners on a personal level. For example, when passing out papers, hand them to each individual rather than passing them down the row. This will show that "personal touch." Also, do not be offended if you are asked personal questions. Puerto Ricans typically like to touch and feel close (both physically and emotionally) to those around them.

Enlisting the help of a member of the community - such as an elder or older woman, both of whom are well-respected - may benefit your presentations. An indigenous educator that speaks the language is also beneficial. When using written materials remember that many people cannot read English or Spanish.

Possible meeting places may include the church or English-as-a-Second Language classes. Teaching the women may be easier. Frequently, however, the men's support is needed before the women will listen.

Custom Religions and Family Traditions

Respect for family is critical in the Puerto Rican culture. Mothers and elders are adored and duty to the family, including the extended family, is essential. Family ties are strong. Families often gather for holidays, birthdays, and weddings. Machismo is a critical element of the society. Women usually make decisions on foods purchased and served. Traditionally meals are served when the entire family is together.

Breastfeeding is frequently practiced. Puerto Ricans believe breastfeeding is nourishing and creates bonding between mother and child.
Cultural Diversity: Eating in America

Cultural diversity is a major issue in American eating. To fully understand the impact cultures play in American nutrition, one must study both food and culture.

This fact sheet on the Puerto Rican culture is one of a series of nine developed to address cultural diversity in American eating.

This fact sheet is designed as an awareness tool for a novice working with a cultural group previously unknown to them. Given the nature of the variations that exist in each cultural group (i.e. socio-economic status, religion, age, education, social class, location, length of time in the United States, and location of origin) caution needs to be taken not to generalize or imply that these characteristics apply to all individuals of a cultural group. This fact sheet was designed primarily for use in Northeastern Ohio, but may stimulate awareness of differences in these cultural groups in other parts of the country. The goal of this fact sheet is to assist a novice educator in reducing any cultural barriers that may inhibit education. The author strongly recommends continued reading and additional research into the cultural groups in which you work.

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Cultural Diversity: Eating in America

Mexican-American

Marisa Warrix

In the United States Mexican-Americans comprise 60 percent of the Hispanic/Latino population. Mexicans live predominantly in California, Texas, Arizona, New Mexico, and Colorado. The difference between Mexican, Puerto Rican, and other Latin American countries includes 500 years of separate history, as well as entirely different native populations that were present when the Spaniards arrived. Thus, the Mexican, Puerto Rican, and Latin American cultures each have a completely different concept of what foods are appropriate and what these foods are called.

Food Habits and Their Relationship to Dietary Guidelines

The Mexican diet of today is rich in a variety of foods and dishes that represent a blend of pre-Columbian, Spanish, French, and more recently, American culture. The typical Mexican diet is rich in complex carbohydrates, which are provided mainly by corn and corn products, beans, rice, and breads. The typical Mexican diet contains an adequate amount of protein in the forms of beans, eggs, fish and shellfish, and a variety of meats, including beef, pork, poultry, and goat. Because of the extensive use of frying as a cooking method, the Mexican diet is also high in fat. The nutrients most likely to be inadequately provided are calcium, iron, vitamin A, folacin, and vitamin C.

Eating Practices, Food Preferences and Food Preparation Techniques

Traditionally, Mexicans ate four or five meals daily. The foods eaten varied with factors such as income, education, urbanization, geographic region, and family customs. The extent to which the traditional Mexican meal pattern continues among Mexicans in the United States has not been systematically studied. The three-meal pattern prevails, although whether or not the major meal of the day occurs in mid-afternoon is unclear. The daily meal pattern in the typical Mexican-American home varies according to the availability of traditional foods and the degree of assimilation into American society.

With emigration to the United States, major changes occur in the Mexican-American's diet. Healthy changes include a moderate increase in the consumption of milk, vegetables, and fruits, and a large decrease in the consumption of lard and Mexican cream. The introduction of salads and cooked vegetables has increased the use of fats, such as salad dressings, margarine, and butter. Other less healthy changes include a severe decline in the consumption of traditional fruit-based beverages in favor of high-sugar drinks. Consumption of inexpensive sources of complex carbohydrates, such as beans and rice, also has decreased as a result of acculturation. In addition to the negative impact on the health of this population, these dietary changes also may adversely affect the family's budget when low-priced foods are replaced with more expensive ones.
Clinical studies have consistently reported a high prevalence of obesity, cardiovascular disease, diabetes, dental caries, and over/under nutrition in the Mexican-American population. Overweight and obesity are higher in Hispanic women and children. Research also indicates that Mexicans in the United States eat more meat and saturated fats than Anglos, and use fewer low-fat dairy products. Mexicans also are less likely to recognize high-fat foods. Approximately 10 to 12 percent of Mexican-American adults have diabetes, with 95 percent of those having the non-insulin-dependent type.

**Teaching Implications**

Health care providers need to understand Hispanic culture, beliefs, norms, food practices, and terminology to assist clients. Providers need to support and stimulate the preservation of healthy cultural food practices among Mexican-American clientele. When appropriate, suggest modifications of traditional dishes that are high in sodium, fat, and sugar. Increase clients' knowledge of healthy food selections from typical American fare. Gain support from clients' families to enhance their acceptability of the diet.

The diets of pregnant Mexican-American women of marginal social and economic standing are deficient in dietary iron, vitamin A, and calcium. Encourage the consumption of low-fat cheeses, lean red meat, fresh fruits, and vegetables. Monitor beverage intake, as carbonated soft drinks and presweetened drinks are widely consumed. Breastfeeding is widely practiced in Mexico, although most Mexican-Americans use infant formula. Weaning children from the bottle at one year of age is not widely practiced. Baby bottle tooth decay is common in toddlers, suggesting that the child is put to bed with a bottle.

**Customs and Family Traditions**

The family unit is the single most important social unit in the life of Hispanics. Family responsibilities come before all other responsibilities. Gender differentiation and male dominance are issues to consider while working with Hispanic families. The father is the leader of the family, and the mother runs the household, shops, and prepares the food. The traditional concepts of manhood and womanhood, however, appear to be changing toward a more egalitarian model with increased exposure to American society. The majority of Mexicans are Roman Catholic. Evangelical Protestantism is a fast-growing religion, especially among immigrants.

**Summary**

The health care provider may intervene with Hispanic clients and communities in culturally sensitive ways, which includes viewing culture as an enabler rather than a resistant force, incorporating cultural beliefs into the plans of care, stressing familialism, and taking time for pleasant conversation.

Cultural diversity is a major issue in American eating. To fully understand the impact cultures play in American nutrition, one must study both food and culture.

This fact sheet on the Mexican-American culture is one of a series of nine developed to address cultural diversity in American eating.
This fact sheet is designed as an awareness tool for a novice working with a cultural group previously unknown to them. Given the nature of the variations that exist in each cultural group (i.e. socio-economic status, religion, age, education, social class, location, length of time in the United States, and location of origin) caution needs to be taken not to generalize or imply that these characteristics apply to all individuals of a cultural group. This fact sheet was designed primarily for use in Northeastern Ohio, but may stimulate awareness of differences in these cultural groups in other parts of the country. The goal of this fact sheet is to assist a novice educator in reducing any cultural barriers that may inhibit education. The author strongly recommends continued reading and additional research into the cultural groups in which you work.

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Cultural Diversity: Eating in America

Asian

Patti Hill

Confucius said, "A man cannot be too serious about his eating, for food is the force that binds society together." This statement summarizes the importance of food in the Asian culture. Preparation is meticulous, and consumption is ceremonious and deliberate. Two key elements draw the diverse cultures of the Asian region together: 1) the composition of meals (emphasis on vegetables and rice, relatively little meat); and 2) cooking techniques.

Description of Region

Asian-Americans have emigrated from the Philippines, China, Hong Kong, Cambodia, Vietnam, Laos, Thailand, Korea, and Japan. The religions they practice include Confucianism, Buddhism, Taoism, and Shinto (Japanese only). A large number of native Filipinos are Roman Catholic. The Vietnamese, Laotian, and Hmong cultures are discussed in separate fact sheets.

Food Habits and Their Relationships to Dietary Guidelines

Most Asians living in America adhere to a traditional Asian diet interspersed with American foods, particularly breads and cereals. Dairy products are not consumed in sufficient quantity, except for ice cream. Calcium is consumed through tofu and small fish (bones eaten). Fish, pork, and poultry comprise the main proteins. Significant amounts of nuts and dried beans are also eaten. Vegetables and fruits make up a large part of their food intake. Rice is the mainstay of the diet and is commonly eaten at every meal.

Eating Practices, Food Preferences and Food Preparation Techniques

A typical day's menu might include:

**Breakfast**-hot cereal, bread, fruit juice, soy milk, fruit, nuts, rice

**Lunch**-rice or bread with vegetables or fruits

**Dinner**-rice, vegetable soup mixed with tofu, vegetables, fish or meat
Thai food is generally spicy, hot, and high in sodium. Hot peppers are used daily.

The Japanese are very concerned about the visual appeal of the food and the "separateness" of the foods and tastes. Garlic and hot pepper are not common ingredients.

Koreans make kimchee in October or November for use throughout the winter. Kimchee is cabbage marinated in salt water, layered with peppers and spices in crockery, and left to ferment through November and December. Kimchee is eaten with every meal.

Asian food preparation techniques include stir-frying, barbecuing, deep-frying, boiling, and steaming. All ingredients are carefully prepared (chopped, sliced, etc.) prior to starting the cooking process.

**Teaching Implications**

Bowing is important, but most Asian-Americans will shake hands. Bowing is a gesture similar to waving.

The elderly, children, and pregnant women are held in high esteem.

Most Japanese women in the United States breastfeed their babies. Thai women usually breastfeed their children up to age two. Many Korean parents bottle-feed their babies. New Korean mothers eat seaweed soup for the first month after delivery; the soup is believed to cleanse the blood.

Positive health factors related to diet include: low incidence of heart disease, bowel cancer and breast cancer.

Major diet-related diseases or concerns include stomach cancer and lactose intolerance.

**Customs and Family Traditions**

New Year's Day is the major holiday of the year. It is generally the only holiday that work days are taken as vacation. Asian clients tend to use American holiday breaks to travel.

**Summary**

Because of the diverse cultures within the Asian region, specific cultural customs should be addressed when programs are arranged.

**Cultural Diversity: Eating in America**

Cultural diversity is a major issue in American eating. To fully understand the impact cultures play in American nutrition, one must study both food and culture.
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Cultural Diversity: Eating in America

Vietnamese

Deidre Betancourt

The Vietnamese come from both remote agricultural and fast-paced urban areas of southeast Asia. Most Vietnamese practice Buddhism, but some practice Confucianism or Taoism.

Food Habits and Their Relationship to Dietary Guidelines

The basic food in Vietnam is dry, flaky rice supplemented with vegetables, eggs, and small amounts of meat and fish. Although similar to Chinese cooking, Vietnamese cooking uses little fat or oil for frying. "NuocMam" fish sauce is a principle ingredient in almost every Vietnamese dish. Vietnamese are fond of fruits - bananas, mangos, papayas, oranges, coconuts, and pineapple. They are accustomed to little milk and cheese, and many cannot produce the enzymes needed to properly digest dairy foods (lactose intolerance). They drink a large amount of hot green tea and coffee without adding sugar, milk, or lemon.

The Vietnamese have three meals a day with some snacking on fruits and soups.

Breakfast - (light) soup "pho," rice or rice noodles; thin slices of beef, chicken, or pork; bean sprouts; greens; green tea or green coffee; boiled eggs; and crusty bread

Lunch and Dinner - (both similar in food content, with smaller portions for dinner)-rice, fish, or meat; vegetable dish with NuocMam or fish sauce; tea or coffee

Snacks- fruits, clear soup

Eating Practices, Food Preferences and Food Preparation Techniques

In their home country, Vietnamese either grow food or purchase it daily. There are few refrigerators. Teaching Vietnamese living in the United States proper food storage of perishable foods is important. Encourage home and community gardening as a source of native vegetables. Soybeans, mung beans, and peanuts are used extensively. New, inexpensive legumes should be introduced.

Chopsticks and small bowls are used for eating. Bowls are brought to the mouth to eat.

Vietnamese eat a wide variety of vegetables. Fruit is served as a dessert and snack. Encourage variety in their diet through introducing unfamiliar vegetables and fruits. Discourage low-nutrient foods such as soft drinks, candy, and chips.
Teaching Implications

Education is extremely important to the Vietnamese. Their learning system emphasizes memorization and repetition, not critical study. Vietnamese show great respect to elders, superiors, and strangers. They clasp both hands against their chests to welcome. Shaking hands is seldom done; a smile and nod would suffice. Beckoning with a finger is a sign of contempt used toward an animal or inferior.

Vietnamese people tend to be excessively polite and delicate. Because frankness and outspokenness are usually considered rude, true feelings are often veiled. Vietnamese people may just smile and nod when they do not understand you. Keep in mind that this means, "Yes, I hear you," or, "Yes, I see what you mean even though I don't truly understand it!"

Vietnamese are typically friendly and giving people. Hospitality and food are related. A Vietnamese person might not ask, "How are you?" but "Have you eaten yet?"

They love to give gifts, but it is considered rude to open them in front of people.

Customs and Family Traditions

The Vietnamese family structure is paternal spanning three generations and is the chief source of social identity. The three generations live together in a single family house, the father upholding traditions and setting moral standards.

Vietnamese names are written in reverse order of American names: family - middle - personal. Nguyen Van Hai would be called Mr. Hai. Some have reversed name order to comply with American customs.

The calendar followed is a lunar one with Tet - or the Lunar New Year, which usually occurs in February - being the most important holiday and feast. Tet is considered everyone's birthday, and individual birthdays are not celebrated.

Pregnant women do not increase their caloric intake. Milk consumption is low or nonexistent during pregnancy and lactation. Infants are breastfed to about one year. Rice gruel (rice flour and water) is the only food introduced in the first year, sometimes as early as one month.

Conclusion

Even though Vietnamese immigrants range from farmers to urban dwellers, their move to the United States is one of enormous cultural change. They are a people of tradition yet are open to try new "American" ways. Unfamiliar with most of our grocery items, they not only need to be retaught words and techniques for their own cooking, but need a total introduction to American food culture.

Cultural diversity is a major issue in American eating. To fully understand the impact cultures play in American nutrition, one must study both food and culture.

This fact sheet on the Vietnamese culture is one of a series of nine developed to address cultural diversity in American eating.
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References

*The People and Cultures of Cambodia, Laos, and Vietnam.* Language and Orientation Resource Center, Center for Applied Linguistics, Washington, DC.

Individual and Group Interviews conducted with Vietnamese population at International Institute, Summit County.

Additional resources addressing cultural diversity in nutrition education:


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Keith L. Smith, Associate Vice President for Ag. Adm. and Director, OSU Extension.

TDD No. 800-589-8292 (Ohio only) or 614-292-1868
Cultural Diversity: Eating in America

Appalachian

Wanema C. Flasher

The formal definition of an Appalachian is any one born in the federally designated Appalachian region or anyone whose ancestors were born there.

Appalacia extends as far south as Georgia to as far north as New York. In Ohio, counties in the south and southeastern part of the state are included.

Because of the migration of workers into larger industrial areas, some counties not officially in Appalachia may have a sizable number of residents whose roots are in Appalachia.

Food Habits and Their Relationships to Dietary Guidelines

The mountain tradition is that food should be unpretentious, solid, and filling. The typical Appalachian diet could be rated fairly good in variety. Because many people from the region still garden, variety improves during the summer with readily available produce.

The Appalachian diet tends to be high in fat. Fried foods, gravies, sauces, and fattier meats are often included in daily meals. The overuse of salt may also be a problem.

Eating Practices, Food Preferences and Food Preparation Techniques

Beef, pork, chicken, fish, and wild game are all enjoyed and prepared in many ways. Bread in some form is served at nearly every meal.

Vegetables were once a big part of Appalachian meals. But, as with most Americans, this pattern has changed over time. One survey of southeastern Ohio residents showed that fruits and vegetables were consumed an average of 17 times per week. This is better than the average of 15.2 times per week in Ohio's urban areas, but lower than the national average of 23.8 times per week.

When vegetables are included in meals in Appalachia, favorites tend to be green beans, cabbage, turnips, beets, garden greens, tomatoes, onions and carrots. In some areas, potatoes are eaten at nearly every meal.

The favored preparation techniques are fried, stewed, roasted, or baked. Casseroles are not really a favorite, but are becoming more accepted. Stir-frying would not be as familiar.
Teaching Implications

An effective teaching strategy may be to relate healthy eating to the overall benefit of the children in the family. Children are highly valued in Appalachian families. If adults select healthier foods or preparation techniques for the sake of the children, the adults themselves might also begin to eat healthier.

As with many of us, change is sometimes difficult to accept. This is also true of Appalachian audiences. Try teaching the concept of cutting down, not out, or cutting down gradually. For instance, suggest changing from whole milk to two percent to one percent. This would meet with more acceptance than telling the audience to switch from whole milk to skim milk.

Substituting foods or preparation techniques would be more accepted as well. For instance, suggest that instead of frying chicken, family members try a recipe for oven-fried chicken with the skin removed.

Because dried beans and peas are popular, encourage families to continue to eat these high-fiber foods instead of high-fat meats. Because quite a few people in the Appalachian community still garden, classes to update food preservation techniques would be useful.

Customs and Family Traditions

Breastfeeding is an acceptable practice in the Appalachian community, but not nearly as many young mothers adopt this method of feeding their babies as nutrition specialists would like. Also, the recommendation to hold off feeding infants solid foods until five to six months of age is hard for this group to accept.

Sunday dinner was, and to some degree, still is a special meal. A typical "big" dinner might include several different meats, five or six vegetables, gravy, biscuits, pickles, preserves, pies or custards, coffee, and milk.

The typical American holidays are celebrated with food, friends, family and fun.

Cultural Diversity: Eating in America

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Cultural Diversity: Eating in America

Amish

Patricia Shenberger

The Amish are often referred to as the plain people, known for their unadorned style of dress, horse-drawn vehicles and family-centered lifestyle. A strong faith in God and church traditions determine their ways.

Ohio has the largest settlement of Amish in the United States; Pennsylvania ranks second and Indiana ranks third. The largest communities in Ohio are in Holmes, Wayne, Ashland and Geauga counties. Each of the groups within the Amish culture—Old Order Amish, New Order Amish, Mennonite, Beachy Amish, "Swiss" Mennonites, or Swartzentruber Amish, for example—have their own set of rules about what is acceptable from the world around them.

Food Habits and Their Relationship to Dietary Guidelines

Eating habits vary among the Amish depending on where they live, the type of work they do, and the mode of transportation they use. Traditionally the Amish community has been farm based with families growing or raising most of their own food and traveling by horse and buggy. This pattern is changing in urban areas, however, because of the scarcity of land and hazards of horse-and-buggy travel. Many Amish are leaving their farms, and gardens are becoming smaller.

Most Amish, especially those who still tend large gardens and orchards, eat a variety of foods. Because much of their work is physically demanding, many are not concerned about reducing the amount of fat in their diets. Those with access to motorized transportation buy more high-fat snack foods and eat out in restaurants more often than those who travel by horse and buggy.

Breads and cereals are usually made from whole grains and served often. In some families, cakes and cookies are available at most meals; in others sweets are limited.

High cholesterol and blood pressure may be a concern. However, because the Amish do not visit the doctor often, many ailments are not detected until a serious problem arises. The Amish do not carry health insurance or accept any type of public assistance.

Eating Practices, Food Preferences and Food Preparation Techniques

Most Amish do not have electricity in their homes. For cooking, many use either wood or kerosene oil stoves; they cool their food in ice boxes, spring houses, or their basements. A minority have freezers.
The Amish prepare most of their food from scratch, but some also use mixes and instant foods. They preserve all of their own fruits and vegetables and much of their meat by canning. Homemade bologna is popular and is usually made without the casing. Some Amish will occasionally purchase frozen foods as a change of taste or as a treat. Many rural families have their own milk cow and make cheese, cottage cheese, yogurt, and ice cream. Those near urban areas usually buy these items at the supermarket or cheese houses.

Many farm families eat cornmeal mush - made from oven-roasted field corn - for breakfast. Eggs and cooked cereal are other typical breakfast foods. Fruits or juice may be included.

The main meal of the day typically consists of noodles, macaroni, or potatoes; meat, which is often fried; and canned vegetables. Homemade or supermarket-bought bread is served at every meal. The lighter meal commonly consists of soup, cheese or bologna, and fruit. Snacks are usually apples, cookies, or leftovers.

**Teaching Implications**

Because of their desire to remain separate from the world, sharing information and new ways of doing things with the Amish can be difficult. Very few have telephones and most do not attend public meetings. Going to their homes, places of business, or schools may be the best method of contact. Because the man is the head of the household, he should be approached first. In some groups, going through the bishop may be necessary.

**Customs and Family Traditions**

Family life is extremely important to the Amish; many have large families (10 or more children). Children are viewed as gifts from God. Many women breastfeed their babies; others bottle-feed. Many Amish make their own baby food by grinding a portion of the family's meal. Some will purchase instant baby cereals. Milk is not always served to the children as a beverage, but is used on cereals and in cakes and cookies.

Because of their lack of exposure to the outside world (including radio, television, and magazines), Amish children are influenced solely by their parents' and extended family's eating habits. However, as more young people are forced to seek jobs in the outside community, their food experiences and traditions are changing.

Traditions are important to the Amish, but kept simple compared with "English" (the term Amish people use to describe the non-Amish) standards. Many Amish hold church services and weddings in their homes. The meals that accompany these events are special times for socializing. The Amish celebrate Thanksgiving, Christmas, Easter, and birthdays with traditional foods, but with few decorations or gifts.
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Cultural Diversity: Eating in America

African-American

June Ewing

The present day African-American population, like many other ethnic groups, is several generations removed from their original land. Thus many practices and habits have been lost, dropped, simulated, or modified. The greatest influence on many African-American families is the lifestyle of their parents or grandparents who lived in the southern United States.

Acceptable Nomenclature

Acceptable nomenclature for this cultural group includes: African-American, Black Americans, or People-of-Color. People-of-Color is preferred by many when addressing groups or discussing issues that affect several ethnic groups.

Food Habits and Their Relationship to Dietary Guidelines

Historically, African-American rites revolved around food. The society is based on religious ceremonies, feasting, cooking, and raising food. The popular term for African-American cooking is "soul food." Many of these foods are rich in nutrients, as found in collard greens and other leafy green and yellow vegetables, legumes, beans, rice, and potatoes. Other parts of the diet, however, are low in fiber, calcium, potassium, and high in fat. With high incidence of diabetes, hypertension, heart disease, and obesity, some African-Americans have paid a high price for this lifestyle. Economically disadvantaged families may have no other choice but to eat what is available at low cost. Fresh fruits and vegetables, lean meat, and seafood are not as readily available at low cost. The presenter or educator may want to discuss ways of obtaining quality foods despite economic limitations, such as growing small gardens in community sites; shopping at roadside garden markets; shopping at large supermarkets rather than small corner stores; developing budgeting clubs and food co-ops; and participating in food bank programs.

Eating Practices, Food Preferences and Food Preparation Techniques

Common ways for African-Americans to prepare food include frying, barbecuing, and serving foods with gravy and sauces. Home-baked cakes and pies are also common.

Teaching Implications

Educators or presenters should focus on the way food is prepared, encouraging families to provide low-cost, nutritious alternatives by modifying the sodium, fat, and sugar content of
traditional foods. Simple changes in diet might include substituting herbs for high sodium seasonings, increasing the amount of vegetables and decreasing the amount of meat, removing the fat and skin from meat, and eating more fresh vegetables and fruits. Cutting calories and eating smaller portions should also be encouraged. Some families may resist change because of family traditions. If this is the case, ask them to submit a list of their favorite foods and recipes and then discuss how to modify them. Any opportunity to include information on exercise and teaching their children and teenagers good nutrition should also be taken. Any stereotyping or assumptions that "all" Black people like the same foods and have the same lifestyle should be avoided. Neither do "all" adhere to poor diets, have no concern about their health, have bad cooking habits, or lack nutritional understanding and health education. Taboos about child rearing and nursing are usually common or adhered to if older grandparents are heads of households. Few teenage African-American mothers breastfeed, but it is common with older mothers. Infant feeding methods vary with pressure from parents when babies are crying. Young mothers might give cereal along with formula because they think the infant is hungry.

Custom and Family Traditions

Many African-Americans are Protestant and have no specific food restrictions. However, a large number of families are members of religious groups that may have some restrictions or dietary preferences. These may include Seventh-Day Adventists, Muslims, Jehovah’s Witnesses, and others. This should be discussed openly.

Special Holidays

A large selection and variety of food is prepared and much attention is given to individual's favorite dishes. Besides all the formal and traditional American occasions and holidays, a large number of African-Americans observe and celebrate Kwanza, an African-American cultural holiday created by Dr. Maulana Karenga of Southern California in 1965. Kwanza is celebrated December 26 through January 1. Karamu, held on January 31, is celebrated with ceremonies, a buffet, and festive attire.

Some African-American churches frown on wearing slacks and shorts in the worship area or sanctuary, though wearing them is acceptable in the recreation area.

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