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Document:

**Overview of Leininger's Theory of
Culture Care Diversity and Universality**

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Overview of Leininger's Theory of Culture Care Diversity and Universality

The Culture Care Theory

The theory of Culture Care Diversity and Universality is the creative outcome of independent thinking, a keen awareness of a rapidly changing world, and more than five decades of using and refining the theory. The roots of the theory reflect the theorist's early and current nursing practice and draws upon the theorist's experiences and creative thinking relevant to nursing and health fields. It has been independently developed and soundly constructed as a highly relevant theory to discover the care and health needs of diverse cultures in hospitals, clinics, community settings, and her study of many cultures worldwide.

The theory has become a major caring theory with a unique emphasis on *nursing* as a means to know and help cultures. Culturally based care factors are recognized as major influences upon human expressions related to health, illness, wellbeing, or to face death and disabilities. The theory has become meaningful as a guide to nurses' thinking, practices, and research. This process of envisioning and reconceptualizing care is the essence of nursing. The theorist postulates that human care is what makes people human, gives dignity to humans, and inspires people to get well and to help others and further predicts there can be no curing without caring, but caring can exist without curing (Leininger, 1984, 1988a; Leininger & McFarland, 2002).

Research focused on culture care as an interrelated phenomenon is crucial to help nurses discover and identify new ways to understand and advance nursing, healing, and health care. Leininger holds that care needs to become meaningful, explicit, and beneficial; it needs to be conceptualized showing the interrelationships of care to culture and to different cultures – the

transcultural nursing focus. Care is a powerful and dynamic force to understand the totality of human behavior in health and illness. Action modes related to care that are culturally based and maintained beneficial health outcomes are needed. Care needs to be understood and actualized in diverse and specific cultural contexts.

Leininger holds that culture is the broadest, most comprehensive, holistic and universal feature of human beings and care is predicted to be embedded in culture. Both need to be understood to discover clients' care needs. Caring is held as the action mode to help people of diverse cultures while care is the phenomenon to be understood and to guide actions and decisions. Culture *and* care together are predicted to be powerful theoretical constructs essential to human health, wellbeing, and survival. In-depth knowledge of the specific culture care values, beliefs, and lifeways of human beings within life's experiences is held as important to unlock a wealth of new knowledge for nursing and health practices.

Basic Theoretical Differences

Philosophically and professionally many questions about culture, care, and nursing have been raised. In the past, many nurses viewed *care* linguistically as an important word to use in teaching and practice, but very few could provide substantive knowledge or explain care within a culture. It was then clearly evident that within nursing a troubling knowledge deficiency existed for obtaining authentic, scientific, and accurate data about cultures and their care meanings, expressions, and beneficial outcomes (Leininger, 1985). The theorist found care and culture had been limitedly studied in nursing yet she predicted they would guide nursing in powerful ways.

In developing the theory, it became apparent to Leininger that the Theory of Culture Care would be very different from other existing ideas or emerging nursing theories in several respects. First, the central domain of the theory was focused on the close interrelationships

between culture and care. Second, the terms *theories* and *models* are often used in the same way but are different. Theories should predict and lead to discovery of unknown or vaguely known *truths* or interrelated phenomena, whereas models are mainly pictorial diagrams of some idea and are not theories as they usually fail to show predictive relationships. There are different kinds of theories used by different disciplines to generate knowledge; however, all theories (including the Culture Care Theory) have as their primary goal to discover new phenomena or explicate vaguely known knowledge (Leininger 1991a/b). Third, the Culture Care Theory is open to the discovery of new ideas that were vague or largely unknown but with bearing on people's culture care phenomena related to their health and wellbeing. Leininger's theory focuses on culture care as a broad yet central domain of inquiry with multiple factors or influencers on care and culture. Fourth, the theorist values an open discovery and naturalistic process to explore different aspects of care and culture in natural or familiar living contexts and in unknown environments. Fifth, Leininger has developed a new and unknown research method different from ethnography, namely the ethnonursing method, to systematically and rigorously discover the domain of inquiry (DOI) of culture care. The ethnonursing method is designed as an open, natural, and qualitative inquiry mode seeking informants' ideas, perspectives, and knowledge, and did not control, reduce, or manipulate culture and care as with quantitative methods.

The Culture Care Theory focuses on obtaining indepth knowledge of care and culture constructs from key and general informants related to health, wellbeing, dying, or disabilities. Leininger's theory differs markedly from other nursing theories as it does not rely upon the four metaparadigm concepts to explain nursing of persons, environment, health and nursing. These four concepts were too restrictive for open discovery about culture and care. Another major and

unique difference in Leininger's theory in comparison with other nursing ideas are the three action modalities or decision modes necessary for providing culturally congruent nursing care.

These three theoretically predicted action and decision modalities of the culture care theory were defined as follows (Leininger, 1991a/b; Leininger & McFarland, 2002).

1. Culture care preservation and-or maintenance referred to those assistive, supporting, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve or maintain beneficial care beliefs and values or to face handicaps and death.
2. Culture care accommodation and-or negotiation referred to those assistive, accommodating, facilitative, or enabling creative provider care actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe and effective care for their health, wellbeing, or to deal with illness or dying.
3. Culture care repatterning and-or restructuring referred to those assistive, supportive, facilitative, or enabling professional actions and mutual decisions that would help people to reorder, change, modify or restructure their lifeways and institutions for better (or beneficial) health care patterns, practices or outcomes. (Leininger, 1991a/b, 1995; Leininger & McFarland 2002).

These three modes based on research data are held to be essential for caring and are to be used with specific research care data discovered from the theory. The theory challenges nurses to discover specific and holistic care as known and used by the cultures over time in different contexts. Leininger's theory directs nurse researchers toward discovering and using culturally based or derived research care knowledge in nursing obtained from culture informants. To achieve this goal, both emic [insider] and etic [outsider] knowledge are used to differentiate the informants inside knowledge in contrast with the researcher's or professional knowledge. Both

emic and etic data are studied as integral parts of the theory to obtain comparative and contrasting care knowledge and are held as invaluable insights for nurses in caring for cultures. The reader will find that the frequently used phrase *nursing interventions* is seldom used in the Culture Care Theory or in transcultural nursing because it often refers to cultural imposition practices which may be offensive or in conflict with the client's lifeways. Cultural imposition practices are often destructive, ethnocentric, offensive, and lead to cultural pain and conflicts (Leininger, 1991a/b, 1995).

Other Central Constructs in the Culture Care Theory

There are several additional constructs used in the Culture Care theory that need to be briefly identified. These theory definitions are orientational (not operational) to encourage the researcher to discover new qualitative knowledge. These constructs and their definitions have also been presented in several published research studies with the domains of inquiry (Leininger, 1991a/b, 1995; Luna, 1998; McFarland, 1997) and can be studied further in Leininger's first and primary theory book (Leininger, 1991a/b).

1. Care refers to both an abstract and-or a concrete phenomenon. Leininger has defined care as those assistive, supportive, and enabling experiences or ideas towards others with evident or anticipated needs to ameliorate or improve a human condition or lifeway (Leininger, 1988a/b/c, 1991a/b, 1995a; Leininger & McFarland, 2002). Caring refers to actions, attitudes and practices to assist or help others toward healing and wellbeing (Leininger, 1988a/b/c, 1991a/b, 1995a; Leininger & McFarland, 2002). Care as a major construct of the theory includes both folk and professional care which are a major part of the theory and have been predicted to influence and explain the health or wellbeing of diverse cultures.

2. Culture as the other major construct central to the theory of Culture Care has been equally as important as care; therefore it is not an adverb or adjective modifier to care. The theorist conceptualized culture care as a synthesized and closely linked phenomena with interrelated ideas. Both culture and care require rigorous and full study with attention to their embedded and constituted relationship to each other as a human care phenomenon. Leininger has defined culture as “...the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally” (Leininger, 1991a/b; 1997a). Anthropologically, culture is usually viewed as a broad and most comprehensive means to know, explain, and predict people lifeways over time and in different geographic locations. Culture phenomena distinguish human beings from nonhumans but is more than social interaction and symbols, more than ethnicity or social relationships. Culture can be viewed as the blueprint for guiding human actions and decisions and includes material and nonmaterial features of any group or individual.
3. The constructs *emic* and *etic* care are another major part of the theory. The theorist wanted to identify differences and similarities among and between cultures. It is desirable to know what is universal [or common] and what is different [diversities] among cultures with respect to care. The term *emic* refers to the local, indigenous, or insider’s cultural knowledge and view of specific phenomena; whereas, *etic* refers to the outsider’s or stranger’s views and often

health professional views and institutional knowledge of phenomena (Leininger, 1991a/b).

4. Cultural and Social Structure Factors are another major feature of the theory. Social structure phenomena provide broad, comprehensive, and special factors influencing care expressions and meanings. Social structure factors of clients include religion (spirituality); kinship (social ties); politics; legal issues; education; economics; technology; political factors; philosophy of life; and cultural beliefs, and values with gender and class differences. The theorist has predicted that these diverse factors must be understood as they directly or indirectly influence health and wellbeing.
5. Ethnohistory is another construct of the theory that comes from anthropology; the theorist has reconceptualized its meaning within a nursing perspective. The theorist defines ethnohistory as the *past facts, events, instances, and experiences of human beings, groups, cultures, and institutions that occur over time in particular contexts that help explain past and current lifeways about culture care influencers of health and wellbeing or the death of people* (Leininger 1991a/b; Leininger & McFarland, 2002).
6. Environmental context refers to the *totality of an event, situation, or particular experiences that gives meaning to people's expressions, interpretations, and social interactions within particular physical, ecological, spiritual, sociopolitical, technologic factors in cultural settings* (Leininger 1989, 1991a/b; Leininger & McFarland, 2002).

7. Worldview refers to the *way people tend to look out upon their world or their universe to form a picture or value stance about life or the world around them* (Leininger 1991a/b; Leininger & McFarland, 2002). Worldview provides a broad perspective of one's orientation to life, people, or group that influence care or caring responses and decisions. Worldview guides one's decisions and actions especially related to health and wellbeing as well as care actions.
8. Culture Care Preservation and-or Maintenance, Culture Care Accommodation and-or Negotiation, and Culture Care Repatterning and-or Restructuring have been defined earlier.
9. Culturally Congruent Care refers to *culturally based care knowledge, acts and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death* (Leininger, 1963, 1973b, 1991a/b, 1995; Leininger & McFarland, 2002). To provide culturally congruent and safe care has been the major goal of the Culture Care Theory.
10. Care Diversity refers to the *differences or variabilities among human beings with respect to culture care meanings, patterns, values, lifeways, symbols or other features related to providing beneficial care to clients of a designated culture* (Leininger, 1995, 1997a; Leininger & McFarland, 2002).
11. Culture Care Universality refers to the *commonly shared or similar culture care phenomena features of human beings or a group with recurrent meanings, patterns, values, lifeways, or symbols that serve as a guide for care givers to*

provide assistive, supportive, facilitative, or enabling people care for healthy outcomes (Leininger, 1995).

Transcultural nursing has been defined as a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic health care practices that are culturally based (Leininger, 1963, 1991a/b, 1994b, 1995; Leininger & McFarland, 2002).

Transcultural nursing continues to identify and use comparative care discoveries and skills to help human beings of diverse or similar cultures in beneficial ways based on direct field experiences and discoveries using the Culture Care Theory and Ethnonursing Research Method.

Philosophical and Theoretical Roots

The theory of Culture Care Diversity and Universality was developed independently without any particular persons or schools of thought. The theorist used her philosophy of life, her extensive professional nursing experiences, anthropological and other relevant knowledge and diverse intellectual scholarly interests, and spiritual insights and beliefs were reflected upon and used as key components in the development of the theory. The theorist believes that God created all human beings with His caring interest and love, and that He wanted human beings to be healthy and contribute love and help to other human beings. Nursing was viewed as a unique caring profession to serve others worldwide and is influenced by ethnohistory, culture, social structure and environmental factors in different geographic areas and by the different needs of people. Nursing is a dynamic field of study and practice that takes into account culture, social change, and multiple factors that influence health and wellbeing. It is a profession with discipline knowledge to help people, whether ill or well, with their diverse care needs.

The focus of the theory is toward developing new practices for nursing to meet diverse cultural needs and to provide therapeutic care with comprehensive and holistic care practices in a caring discipline. Holistic and broad worldviews respecting the sacredness and uniqueness of humans and their culturally based values are imperative.

Theoretical Tenets and Predictions.

Tenets are the position one holds or are given that the theorist uses with a theory. In developing the theory, four major tenets were conceptualized and formulated with the Culture Care Theory:

1. Culture care expressions, meaning, patterns, and practices are diverse and yet there are shared commonalities and some universal attributes.
2. The worldview, multiple social structure factors, ethnohistory, environmental context, language, and generic and professional care are critical influencers of cultural care patterns to predict health, well-being, illness, healing, and ways people face disabilities and death.
3. Generic emic [folk] and professional etic health factors in different environmental contexts greatly influence health and illness outcomes.
4. From an analysis of the above influencers, three major actions and decision guides can lead to providing ways to give culturally congruent, safe, and meaningful health care to cultures. The three culturally based action and decision modes are: a) culture care preservation and /or maintenance; b) culture care accommodation, negotiation; and, c) culture care repatterning and-or restructuring. Decision and action modes based on culture care are key factors to arrive at congruent and meaningful care. Individual, family, group or community factors are assessed and responded to in a

dynamic and participatory nurse client relationship (Leininger 1991a/b, 1993b, 2002; Leininger & McFarland, 2002).

Theoretical Assumptions.

The above major theoretical tenets and predictions of the theory led to the formation of higher level theoretical hunches or assumptions specific to the Domain of Inquiry (DOI) which the researcher could use in Western and nonwestern cultures over time and in different geographic locations. Some of the theoretical assumptions (assumed givens) are the following (Leininger & McFarland, 2002):

1. Care is the essence and the central dominant, distinct, and unifying focus of nursing.
2. Humanistic and scientific care is essential for human growth, wellbeing, health, survival, and to face death and disabilities.
3. Care (caring) is essential to curing or healing for there can be no curing without caring. (This assumption was held to have profound relevance worldwide.)
4. Culture care is the synthesis of two major constructs which guides the researcher to discover, explain, and account for health, wellbeing, care expressions, and other human conditions.
5. Culture care expressions, meanings, patterns, processes and structural forms are diverse but some commonalities (universals) exist among and between cultures.
6. Culture care values, beliefs, and practices are influenced by and embedded in the worldview, social structure factors (e.g. religion, philosophy of life, kinship, politics, economics, education, technology, and cultural values) and the ethnohistorical and environmental contexts.

7. Every culture has generic [lay, folk, naturalistic; mainly emic] and usually some professional [etic] care to be discovered and used for culturally congruent care practice.
8. Culturally congruent and therapeutic care occurs when culture care values, beliefs, expressions, and patterns are explicitly known and used appropriately, sensitively, and meaningfully with people of diverse or similar cultures.
9. Leininger's three theoretical modes of care offer new, creative, and different therapeutic ways to help people of diverse cultures.
10. Qualitative research paradigmatic methods offer important means to discover largely embedded, covert, epistemic, and ontological culture care knowledge and practices.
11. Transcultural nursing is a discipline with a body of knowledge and practices to attain and maintain the goal of culturally congruent care for health and wellbeing.

The above tenets and assumptions of the theory are essential to guide transcultural care research knowledge and practices. The purpose and the goal of the theory must always be kept foremost in researchers' minds. The ethnonursing research method was thoughtfully designed to fit the theory tenets and purpose of the theory. The six enablers of the method were designed to tease out indepth care and culture knowledge from informants from different cultural context.

Overview of the Ethnonursing Research Method

The ethnonursing method is a qualitative nursing research method focused on naturalistic, open discovery, and largely inductive [emic] modes to document, describe, explain, and interpret informants' worldview, meanings, symbols, and life experiences as they bear on actual or potential nursing care phenomena (Leininger 1985, 1995; Leininger & McFarland, 2002).

Ethnonursing is a rigorous, systematic, and indepth method for the studying multiple culture and

care factors within the familiar environment of people and to focus on the interrelationship of care and culture to arrive at the goal of culturally congruent care services. This method is valuable for discovering both emic and etic generic and professional data. Fresh informant ideas, practices, and beliefs from the culture and their care world along with a wealth of related data are discovered using the theory and the ethnonursing method. The indepth, diverse, and rich descriptive data discovered are valuable for discovering care and cultural data findings.

The Sunrise and five other enablers were developed by the theorist as research guides to obtain broad, yet specific, indepth knowledge bearing on the goal of the theory and researchers' domains of inquiry to cover multiple factors influencing care patterns and expressions. The Sunrise Enabler depicts multiple factors predicted to influence culture care expressions and their meaning (Leininger, 1988c, 1991a/b, 1994b, 1995, 1997a; Leininger & McFarland, 2002) and serves as a cognitive map to discover embedded and multiple factors related to the theory, tenets, assumptions, and the specific domain of inquiry under study. Thereby, this visual diagram reminds the researcher to search broadly for diverse factors influencing care within any culture under study and was designed to assist the researcher in discovering both macro and micro phenomena stated in domain of inquiry using the tenets of the of Culture Care Theory. Such detailed observations and shared information from key and general informants offers scientific and humanistic data as macro or micro findings when using the qualitative ethnonursing method and its paradigm guide. Although the ethnonursing method was designed to focus on culture care phenomena, many new insights and findings have been discovered with the method and theory related to nursing, care and health-illness practices which provide greater depth and breadth to the research knowledge about human care phenomena (Leininger 1985, 1991a/b, 1995, 1997a; Leininger & McFarland, 2002).

Enablers.

The research enablers, as part of the ethn nursing method, have been extremely valuable for teasing out hidden and complex data. The enablers facilitate the informants to share their ideas in natural and casual ways.

1. The Sunrise Enabler. This enabler is used as a major guide throughout the study to explore comprehensive and multiple influences on care and culture. These major dimensions can be seen in Figure 1.1. Further information on the use of the Sunrise Enabler can be studied in McFarland & Leininger (2002, p. 79-83).
- 2 The Observation Participation Reflection Enabler. (Figure 3.2, Leininger & McFarland, 2002, p. 90). This enabler guides the researcher to pursue focused observations of the informants in their familiar and natural living or working environments. The researcher then moves from observation to participation phase gradually and still later to full reflection and confirmation of data collected with informants. The researcher continually confirms findings during and after each observation period with informants. These sequenced phases help ensure a sound data collection process to obtain a full and accurate data base from informants. The extensive observations in the first phase help the researcher to become a trusted participant with informants and provide confidence for data collection in subsequent phases. Throughout the research study this enabler becomes a valuable guide to for obtaining detailed and systematic observations with informants. The observations are essential as the bases for sound and accurate reflections in the last phase. Reflections are done with the informants to verify the accuracy of their views or information obtained, to confirm what was

observed, and to help to identify any gaps and research biases related to the domain of inquiry (Leininger & McFarland, 2002, p. 92-97).

3. The Researcher's Domain of Inquiry Enabler (DOI). Most importantly, researchers develop their own Domain of Inquiry (DOI). Each researcher's enabler is designed to cover every aspect (words or ideas) stated in the DOI, and is focused primarily on the researcher's major hunches and general interests about care and culture. The researcher keeps focused on the DOI and the general tenets of the Culture Care Theory and the theory goal (Leininger, 1991a/b; Leininger & McFarland, 2002).
4. Stranger to Trusted Friend Enabler. This enabler has been a powerful means for self disclosure, self-reflection and assessment to guide the researcher while working with informants and is used from the beginning of the research until the end. (Leininger, 1991a/b; Leininger & McFarland, 2002). Data from this enabler can provide high reliability and confirmability with informants as the researcher carefully moves from a stranger role to becoming a trusted research friend. Entering the world of the key and general informants to learn about care meanings and practices is obtained with this enabler. Meaningful and credible emic data can be authentically and consistently obtained, especially when signs of trust between researcher and informant prevail. It has also been a valuable means for mentoring transcultural nurse students as they perfect their transcultural nursing clinical skills.
5. Ethnodemographic Enabler. This enabler is used as a guide to tap general ethnographic data about key informants with respect to their environment, history

and related factors. Ethnodemographic factors include social and cultural factors, ethnic orientation, gender, and geographic locations where the informants are living or have lived. Family data, the geographic area, and general environmental factors such as water supply, buildings and other factors may be included. Specific ethnodemographic facts of different cultures and within a historical context can help in understanding the meaning of care and care practices. This enabler is generally used during the interviews with key and general informants and while talking to informants about their family origins, general history, and current (or past) living and working environments; the present and past history are part of the data obtained during these open ended interviews.

6. Acculturation Enabler. The purpose of this Enabler has been to identify the extent to which informants are more traditionally or nontraditionally oriented to their culture (Leininger, 1991a/b, p. 98-103; Leininger & McFarland, 2002, p. 92.). The researcher uses all of the above enablers, by using open ended questions or open frames related to all the areas identified and related to the stated domain of inquiry (DOI). A frame such as “Tell me about ____” [let informant finish the statement] must be thoughtfully used to ensure the researcher covers the DOI as stated in order to fully assess the acculturation and life style patterns of the informant(s).

Key and General Informants.

The selection criteria for the informants often includes that the informant: a) is associated or identifies with or is a member of the culture being studied; b) is willing to participate in the study and be interviewed; c) speaks English or the researcher can

understand the language spoken; d) volunteers time to visit with the researchers and be observed; and, e) has lived in the community or country for at least 5 to 10 years. The researcher searches for indepth knowledge about care and confirms ideas with both key and general informants. Leininger & McFarland (2002) provides excellent examples of factors in selection of informants and guidelines for the interviews.

1. The key informants are those who are generally the most knowledgeable about the culture and interested in the DOI. This information comes from the researcher's casual visits in the village, town, hospital, or community, as one talks and listens attentively to suggested informants for the study and inquires about their interest to participate in the study. The study must be clearly discussed with both key and general informants about what they might expect with the researcher and is done before selecting them.
2. The general informants, like the key informants, are thoughtfully and purposefully selected. General informants usually have only general knowledge about the DOI and are not as knowledgeable as the key informants. However, they have some knowledge about the research topic and will likely be able to reflect on the DOI if willing to participate in the study.

A mini [small scale] ethnonursing study has approximately 6 to 8 key informants who are interviewed and observed over approximately 6 to 8 months. A maxi (large scale) ethnonursing study approximately 12 to 15 key informants and 24 to 30 general informants. Key informants are studied indepth, while the general informants are studied for overall reflection on the DOI to ascertain if the data reflect the general culture being studied. General informants are selected to represent the culture at large and have less indepth knowledge and viewpoints about

the DOI. The length of time with key informants may vary until indepth and accurate data has been obtained as stated in the DOI

The six ethnonursing method criteria were developed to systematically examine and discover indepth care and culture meanings and interpretive findings. These six criteria remain in use:

1. Credibility which referred to the *accuracy, believability and truths* of findings largely from the informants.
2. Confirmability referred to repeated direct and documented objective and subjective data confirmed with the informants.
3. Meaning-in-context referred to findings that are understandable to informants studied within their natural and familiar environmental context(s).
4. Recurrent patterning referred to the repeated instances, patterns of expression and patterned occurrences over time.
5. Saturation referred to the exhaustive search from informants of data relevant to the domain of inquiry in which no new findings were forthcoming from informants.
6. Transferability referred to whether the findings from a particular qualitative study can be transferred to or appropriately used in another similar culture or cultures and within their context (Leininger, 1985, 1991a/b, 1995, 1997a; Leininger & McFarland, 2002). The last criterion of transferability is the most difficult to use and often necessitates a good mentor to prevent inappropriate uses.

Each of these criteria meets the purposes and philosophy of qualitative research analysis and the purposes of the ethnonursing method. While some numerical informant data are

included, they are used primarily to confirm data or for directional findings alone. Numbers may be used for weighing interpretive statements or the extent of influences as provided by the informants. The above six criteria address internal and external dimensions of discovering care phenomena but must not be dichotomized or reduced to numbers without qualitative indicators. Leininger holds one does not have to always measure every thing or all phenomena to know or understand them. Lincoln and Guba (1985) use several of these criteria but did not use meanings-in-context and recurrent patterning criteria which Leininger held as critical for culture care discoveries.

Domain of Inquiry.

The theory discovery begins by the researcher making a statement of the domain of inquiry (DOI). This domain must be carefully stated and then rigorously and fully examined with the theory tenets using the six criteria as previously described to perform an *indepth examination of data or confirming the findings*. The tenets, predictions, and the goals of the theory are foremost in the researcher's mind. Indepth, detailed, supportive data are used to report findings with qualitative methods such as ethnonursing. Data from indepth interviews and direct and indirect observations of informants are documented and used to confirm findings. Both material and nonmaterial evidence such as informant biographies, photos, written or verbal stories, and other kinds of qualitative data are used to confirm the findings for the ethnonursing method.

The six standard enablers of the theory, along with recurrent observations of covert and complex phenomena, are used to document and confirm data with informants. The ethnonursing researcher seeks to grasp the world of the informants and the totality of their culture with care meanings and life experiences. The Sunrise Enabler and the other enablers focus on theory

tenets to provide a full and accurate picture of the domain of inquiry. Diverse and similar findings must be documented to remain within the theory tenets.

Studies Presented in Current Book

The first transcultural nursing study was conducted with the Gadsup people of the Eastern Highlands of New Guinea in the early 1960s by Leininger and was an approximately two year indepth ethnonursing and ethnographic study (Leininger, 1991a/b, 1994b; Leininger & McFarland 2002). Culture care findings, beliefs, and values with major care meanings and action modes of the Gadsup were initially discovered and several informants have been assessed over time to determine changes in what they believe and practice.

Wenger's ethnonursing study of the Old Order Amish was another landmark research investigation. It was the first maxi Western transcultural nursing investigation to examine in-depth the care meanings and action modes using the Culture Care Theory and ethnonursing method (1988a/b/c, 1991a/b). This indepth emic study of the Amish revealed that generic care meanings and practices were important, such as care as anticipatory care used within a community context. Amish care was tightly embedded in the worldview and in several social structure factors such as religion, kinship, cultural beliefs, and values.

Luna's (1989) used the Culture Care theory to conduct a 3 year indepth study of Lebanese Muslim immigrants living in a large urban Midwestern city in the United States. Through observation and study of the provision of professional health services to Lebanese Muslims while in hospitals, clinics, and their homes revealed marked differences in informants' generic care values from professional nursing and medical practices (Luna, 1989). This study clearly differentiated that generic care practices were preferred in the home and in the

community, and were different from *modern* professional care practices in the hospitals and clinics.

MacNeil (1998). studied the Baganda people with Acquired Immune Deficiency Disease (AIDS) in Uganda, Africa. This major and important first transcultural nursing study in Africa used both the Culture Care Theory and ethnonursing method to focus on the care meanings, patterns, and expressions of Baganda women as AIDS caregivers. As a transcultural researcher, MacNeil lived in the country and near the people for approximately two years. This is an example of an immersion field study. Such detailed indepth observations and direct, first person experiences with the Bagandan women were essential for discovering many indepth care beliefs and practices of these people that previously had not been revealed to professional nurses and others.

McFarland (1995, 1997) conducted a two year ethnonursing study using both the method and theory to study Anglo and African American clients living in an institutional residence home for the elderly in a large Midwestern city. The purpose of this comparative maxi research study was to explore the indepth emic and etic cultural care of two cultures living in the shared setting of a residential facility. An extension of this unique study was repeated by McFarland (1997) studying *care as the essence of nursing with the two cultures*. Several institutional care policies were developed to guide professional care for the elderly in this institutional setting. This study confirmed the Culture Care Theory tenets and several care patterns that Leininger discovered in an early comparative study of Southern and Northern African Americans and Anglo Americans in two southern United States villages (1985, 1988c, 1991a/b, 1998a).

George (2000) conducted a two year study using the theory of Culture Care Diversity and Universality and the ethnonursing method to focus on the domain of inquiry of the culture care

meanings, expressions, and experiences of a subculture of chronically mentally ill people living in alternative community settings in a Midwestern United States city. The purpose of the study was to discover knowledge to guide nurses in providing culturally congruent care for the chronically mentally ill within a community context so that the clients could maintain and-or regain their mental health and wellbeing. Based on the study findings, George (2000) recommended fresh new approaches for psychiatric and mental health nursing practices by incorporating transcultural factors into nursing care. The findings clearly reaffirmed the importance of obtaining subtle, complex, and covert data with the use of the six enablers of the ethnonursing method.

Stitzlein's (1999) study discovered the nature of moral caring by nurses. The domain of inquiry was to discover if moral caring knowledge existed in nursing education, practice, and administration settings in the United States. The Culture Care Theory was used toward the goal of promoting morally congruent nursing care and professional satisfaction. Stitzlein documented shared narratives of moral caring and nonmoral caring in nurse practice situations. The findings of this study supported the Stitzlein's (1999) hunches that moral caring is a virtue and were congruent with the tenets of virtue ethics and confirmed Leininger's theoretical assumption that care is the essence of nursing with diverse expressions and values.

Summary

In this overview, the nature, importance, and major features of the theory of Culture Care Diversity and Universality were discussed. The ethnonursing research method and the enablers were presented to show the fit between the theory and the method. Knowledge of both the theory and the method are needed before launching an ethnonursing study. Fully understanding the theory and method [with the enablers] leads to credible and meaningful study findings. It is

through complete understanding that the research becomes meaningful, exciting, and rewarding to do, and the researcher develops confidence and competence in the use of the theory and method.

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