

# Chapter 9

## Whites (Non-Hispanic)



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### Chapter Objectives

*Upon completion of this chapter, the nurse will be able to:*

1. Identify traditional health beliefs of Whites (non-Hispanics) with a European heritage.
2. Describe cultural phenomena affecting health care among Whites (non-Hispanics).
3. Plan for nursing care delivery that considers the cultural beliefs of Whites (non-Hispanic) patients.

## Introduction

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There are vast differences among all people. Certain cultural characteristics will be described, which may or may not be associated with individual patients. The intent is not to be stereotypical but to provide the nurse with a starting point to establish some common ground to learn about the individual patient under their care so that the patient can have nursing care that meets their unique, individual needs. A stereotype is an ending point, and no effort is then made to ascertain whether it is appropriate to apply it to the person in question. A generalization, on the other hand, serves as a starting point. Having knowledge of cultural customs and beliefs can help avoid misunderstandings and enable nurses and nurse practitioners to provide better care.

## Historical Background

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Over the past 4 centuries, tens of millions of immigrants have come to the “new world” to begin a new life. Immigration is a central component in the development of the United States. The constant wave of immigrants contributed to the growth and development of the United States as it developed from a new emerging nation to a country with emerging economic power and eventually into its development as a dominant world power. It is believed that the tens of millions of immigrants who have settled in the United States have significantly contributed to the country’s development making the United States what it is today—a world power (Diner, 2008). Although most Americans view the United States as a White European nation, the result of continuous European migration since the 17th century, we now understand that European immigration was only one stage in the peopling of the American continent. From the 1820s through the 1990s, two thirds of the nearly 65 million immigrants to the United States came from Europe. By 1965, however, less than half of the immigrants came from Europe; by the 1990s, it was less than 10% (Katzman, 2000).

The United States was a settler society and required large waves of immigrants to settle into large areas that were undeveloped. The establishment of a settler society is not unusual as it is associated with Canada, Australia, and New Zealand, among other countries (Diner, 2008). The United States, like other settler societies, had land and capital to tap into its natural resources but lacked sufficient manpower. The reliance on the use of Native Americans, and later on African slaves who were brought here against their will, was not enough to meet the labor demands, and the call for immigration was launched.

Immigration not only led to the development of the country but also was responsible for shaping our society and national culture.

During the period when European immigration dominated, the source of immigrants changed. In the first two thirds of the 19th century, most immigrants came from Ireland, Germany, and Great Britain. In the 1880s, a permanent shift occurred. In 1882, the peak year of the “old immigration,” 87% of the immigrants came from Ireland, Germany, Great Britain, Scandinavia, Switzerland, and Holland. In 1907, the peak year of the “new immigrants,” 81% of immigrants came from Italy, Russia, Austria-Hungary, Greece, Rumania, and Turkey. From the 1820s to World War II, Germany provided 16% of immigrants, Ireland 12%, Italy 12%, Austria-Hungary 12%, Great Britain 11%, Russia 10%, and Scandinavia 5% (Katzman, 2000).

Historians have divided immigration to the United States into distinct time periods, each of which is associated with varying rates of immigration from differing areas of the world. All immigration, however, has contributed to shaping our national psyche.

## Settlers of the New World

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The first and, by far, longest of the 5 time periods extended from the 17th century through the early 19th century. Although immigrants from this time came from a variety of places, by far, the largest volume came from the British Isles (England, Scotland, Wales, and Ireland). Others came from southwest Germany (Palatinate), France, and the Netherlands as well as Jews from Poland and the Netherlands (Diner, 2008). The common denominator among these immigrants from Western and Northern Europe was the lack of ability to take advantage of the modernization of their home countries' economies and the promise of cheap land in America. Reasons for leaving their homeland included desire for personal or religious freedom, crop failure, land and job shortages, famine, and rising taxes. The goal was to come to America, which was seen as the land of economic opportunity. Because of the high travel costs associated with the journey to the United States, many of the settlers of the new world were able to come here by becoming indentured servants. A contract was signed and, in exchange for a commitment of a specific amount of time spent in hard labor, they would receive transport and, at the end of the contract, ownership of a small piece of land. The vast majority of the early immigrants were farmers who were lured here by the call of cheap land. European immigrants entered the United States through East Coast ports. The vast majority entered through New York City (more than 70%). Although many immigrants stayed close to the port of entry, some did find their way inland. Many underpopulated states would actively recruit for immigrant settlers offering jobs or land for farming.

## Mass Migration of the 1820s to the 1880s

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During the years of 1820–1880, 15 million immigrants came to the United States (Diner, 2008). Although many of these immigrants also came to farm in the Midwest and the Northeast, a large number settled in cities like New York, Philadelphia, and Boston. The opening of the Erie Canal in 1825 permitted the development of the Midwest for farming and agriculture, and industrial development led to the need for many textile workers in the cities.

European conditions influenced the stream of migrants. Poor harvests and famine sent millions of Irish, Swedes, and some Germans to the United States in the 1830s and after (Katzman, 2000). In the 1840s, political upheaval sent more Germans across the ocean, and a steady flow of religious dissenters came at all times. Limited economic opportunities in Europe sent tens of millions of peasants, small farmers, craftsmen, and unskilled workers, men and women alike, both as individuals and families, to America (Katzman, 2000). Ethnic and religious minorities including Jews from Eastern Europe, Poles and Germans from Russia, Macedonians from the Balkans, and Czechs and Bohemians from Austria-Hungary found freedom in the United States and formed settlements in Kansas (Katzman, 2000).

Young men from France, newly freed from the military after the fall of Napoleon, came to the United States as did others from England, Scandinavia, and central Europe in response to the changes in their home economies that resulted in great difficulty in making a living in their country of origin's new order (Diner, 2008).

Upon arrival to the United States, the newly arrived immigrants tended to cluster together in homogenous groupings. The Midwest was populated with immigrants from Sweden, Norway, Denmark, and from many regions of what would later become the country of Germany. The vast majority of these immigrants were Protestants, but during this time the first large scale wave of Irish Catholics came to the United States. The arrival of Catholics was met with hostility and a wave of nativism—a fear of Catholicism and of the Irish. The nativism movement was so sweeping that it even gave birth to a political party (the Know Nothings) which made anti-immigration and anti-Catholicism its purpose.

Also during this period, a small number of Chinese came to settle in the American West. Unfortunately, the reaction of Native Americans was extremely negative, and the government response was to pass legislation entitled the Chinese Exclusion Act of 1882, the only immigration law to specifically exclude an immigrant group.

An explosion of immigration was facilitated by improvements in technology and transportation. Ocean travel advanced from

sailing to motor power. The ships also became much larger, permitting 25 million European immigrants to make the transatlantic crossing during this period. Immigrants came from Italy, Greece, Hungary, and Poland. Approximately 3 million of these immigrants were Jewish. This wave of immigrants gravitated toward the cities and sought jobs in the industrial labor pool (steel, coal, garment production, textiles, and automobiles). This influx of labor resulted in America becoming an economic strength, but there was a second wave of nativism. By the 1890s, immigration was viewed as posing a serious threat to our nation's health and security. In 1893, the Immigration Restriction League was formed and lobbying of Congress began in earnest to further restrict future immigration into the United States. Several pieces of legislation were passed over the ensuing years. In 1924, Congress passed the final version of the National Origins Act. The Act essentially gave preference to immigrants from northern and western Europe, severely limited the numbers from eastern and southern Europe, and declared all potential immigrants from Asia to be unworthy of entry into the United States. Because the Act did not apply to countries in the western hemisphere, immigration from western hemisphere countries exploded in the 1920s. Historians consider the 1920s as the penultimate era in the US immigration history. Immigrants came to America from Mexico; various countries in the Caribbean such as Haiti, Jamaica, and Barbados; and from Central and South America. The 1924 legislation was enforced until 1965. During that 40-year period, exceptions were made on a case-by-case basis for refugees (Jewish refugees from World War II, Cubans fleeing communism and Fidel Castro, and defectors from behind the Iron Curtain), but the law remained intact and enforced.

A consequence of the civil rights revolution in the United States during the 1960s was the passage of the Hart-Cellar Act in 1965, which eliminated the racially-based quota system. Preference was given to potential immigrants with family already in the United States and to the applicants who had skills or occupations that were deemed critical by the US Department of Labor. Immigrants came from Europe but also from Korea, China, India, the Philippines, Pakistan, and from some African countries. By the year 2000, immigration had returned to the levels of 1900. No matter where they come from or the timing of when they come, immigrants bring to the United States languages, cultures, and religions that over time contribute to the nation as a whole. European immigrants have a positive and negative legacy. On the negative side, there has been little respect for the indigenous population of the United States (Native Americans) with a history of ethnic and religious

intolerance (Katzman, 2000). The positive contributions include language from the English, the Irish gave personalized politics, and the Germans contributed to the culture of US cities (Katzman). The United States has evolved into an industrial, modern, and multicultural nation.

## Projections

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In the history of the United States, the majority population has been White (non-Hispanic). Although this majority status is still true with 6% of the US population projected to be White in the year 2010, it is changing. Those numbers will start to decline around the 2030s as White deaths begin to outpace White births (US Census Bureau, 2008a). By the year 2042, a White majority will no longer be the reality (US Census Bureau, 2008a). By the year 2023, more than half of the country's children will be present-day minorities. By the mid-century mark, when the United States is projected to have a population of 439 million people, 54% of the population will consist of present-day racial minorities. Whites will be outnumbered by Americans who call themselves Hispanic, African American/Black, Asian, American Indian, Native Hawaiian, and Pacific Islander. In some geographic areas (such as New York, Los Angeles, Chicago, Houston, Philadelphia, and Detroit, as well as the states of California and Texas), the change in status for Whites to a minority group has already occurred (US Census Bureau, 2008b). Earlier projections said this change in majority status to minority status for Whites would not happen until the year 2050. There will also be an explosion of population growth in the United States during this same time period. It is estimated that we will reach the 400 million people milestone in the United States by the year 2039 and that more than 130 million additional people will be added to the population by the year 2050 (raising the US population to over 439 million people) (US Census Bureau, 2008a). All US Census Bureau projections are based on actual Census 2000 results and assumptions about future childbearing, mortality, and net international migration.

In addition to declining birth rates, another contributing factor are the declining immigration rates from European countries to the United States. In the year 2005, 15.7% of immigrants entering the United States self-identified as being from Europe. See Table 9-1 for a listing provided by the Office of Homeland Security identifying the top 20 countries of birth for immigrants admitted into the United States in the year 2005. The first European country on the listing is the Ukraine and that is in tenth place (Office of Homeland Security, 2005).

**Table 9-1**

## Immigrants Admitted by Region and Top 20 Countries of Birth for the Year 2005

Region and Country of Birth	Number	Percent
Africa	85,102	7.6
Asia	400,135	35.7
Europe	176,569	15.7
North America	345,575	30.8
Caribbean	108,598	9.7
Central America	53,470	4.8
Other North America	183,507	16.3
Oceania	6546	0.6
South America	103,143	9.2
Unknown Country	5303	0.5
1. Mexico	161,445	14.4
2. India	84,681	7.5
3. China, People's Republic	69,967	6.2
4. Philippines	60,748	5.4
5. Cuba	36,261	3.2
6. Vietnam	32,784	2.9
7. Dominican Republic	27,504	2.5
8. Korea	26,562	2.4
9. Colombia	25,571	2.3
10. Ukraine	22,761	2.0
11. Canada	21,878	1.9
12. El Salvador	21,359	1.9
13. United Kingdom	19,800	1.8
14. Jamaica	18,346	1.6
15. Russia	18,083	1.6
16. Guatemala	16,825	1.5
17. Brazil	16,664	1.5
18. Peru	15,676	1.4
19. Poland	15,352	1.4
20. Pakistan	14,926	1.3
<b>Other</b>	<b>395,180</b>	<b>35.2</b>
<b>All countries</b>	<b>1,122,373</b>	<b>100.0</b>

Source: Office of Homeland Security (2005).

### Statistics

According to the most recently available census data from July 1, 2007, the White non-Hispanic population of the United States is 199,091,567. The median age for both genders is 40.8 years of age. The majority of this population are female (101,346,238 compared to 97,745,329 males). The White population has seen only a

minor increase of slightly over 3 million people from 195,575,485 (based on 2000 census data from the US Census Bureau). This pace is significantly less than the growth rate seen in other racial/ethnic groups.

Beginning in 1980, the US Census began to include a question regarding a person's ancestry self-identification. Ancestry is a broad concept that can mean different things to different people. The Census Bureau defines ancestry as a person's ethnic origin, heritage, descent, or "roots," which may reflect their place of birth, place of birth of parents or ancestors, and ethnic identities that have evolved within the United States. The top 10 most common self-identified ancestries listed in descending order from the 2000 census were: German, Irish, African American, English, American, Mexican, Italian, Polish, French, and American Indian. See Table 9-2 for the top 10 self-identified European-only ancestries from the 2000 census. See Table 9-3 for the top 10 countries of birth of the foreign-born population for the years of 1850–2000 from the US Census Bureau.

Several White ethnic groups will be described in this chapter with a focus on common cultural beliefs related to traditional health beliefs, disease management, and interactions with the healthcare delivery system to help the nurse plan for and deliver culturally appropriate care.

**Table 9-2**

Top 10 Most Common Self-Identified European Ancestries from the 2000 US Census

2000 Ranking Among All Ancestries	European Ancestry Group	Number	Percentage
1	German	42,841,569	15.2
2	Irish	30,524,799	10.8
3	English	24,509,692	8.7
4	Italian	15,638,348	5.6
5	Polish	8,977,235	3.2
6	French	8,309,666	3.0
7	Scottish	4,890,581	1.7
8	Dutch	4,541,770	1.6
9	Norwegian	4,477,725	1.6
10	Scotch-Irish	4,319,232	1.5

The ancestry groups listed on this table were self-identified. Many respondents listed more than one area of ancestry. Overall, about 500 different ancestries were reported during the 2000 census.

Source: US Census Bureau. (2004). Ancestry 2000. Retrieved August 28, 2009, from <http://www.census.gov/prod/2004pubs/c2kbr-35.pdf>.



**Table 9-3**

Top 10 Countries of Birth of the Foreign-Born Population of the United States, 1850–2000

<b>Ten Leading Countries by Rank</b>					
<b>Rank</b>	<b>1850</b>	<b>1880</b>	<b>1900</b>	<b>1930</b>	<b>1960</b>
1.	<b>Ireland</b> 962,000	<b>Germany</b> 1,967,000	<b>Germany</b> 2,663,000	<b>Italy</b> 1,790,000	<b>Italy</b> 1,257,000
2.	<b>Germany</b> 584,000	<b>Ireland</b> 1,855,000	<b>Ireland</b> 1,615,000	<b>Germany</b> 1,609,000	<b>Germany</b> 990,000
3.	<b>Great Britain</b> 379,000	<b>Great Britain</b> 918,000	<b>Canada</b> 1,180,000	<b>United Kingdom</b> 1,403,000	<b>Canada</b> 953,000
4.	<b>Canada</b> 148,000	<b>Canada</b> 717,000	<b>Great Britain</b> 1,168,000	<b>Canada</b> 1,310,000	<b>United Kingdom</b> 833,000
5.	<b>France</b> 54,000	<b>Sweden</b> 194,000	<b>Sweden</b> 582,000	<b>Poland</b> 1,269,000	<b>Poland</b> 748,000
6.	<b>Switzerland</b> 13,000	<b>Norway</b> 182,000	<b>Italy</b> 484,000	<b>Soviet Union</b> 1,154,000	<b>Soviet Union</b> 691,000
7.	<b>Mexico</b> 13,000	<b>France</b> 107,000	<b>Russia</b> 424,000	<b>Ireland</b> 745,000	<b>Mexico</b> 576,000
8.	<b>Norway</b> 13,000	<b>China</b> 104,000	<b>Poland</b> 383,000	<b>Mexico</b> 641,000	<b>Ireland</b> 339,000
9.	<b>Holland</b> 10,000	<b>Switzerland</b> 89,000	<b>Norway</b> 336,000	<b>Sweden</b> 595,000	<b>Austria</b> 305,000
10.	<b>Italy</b> 4,000	<b>Bohemia</b> 85,000	<b>Austria</b> 276,000	<b>Czechoslovakia</b> 492,000	<b>Hungary</b> 245,000
<b>Ten Leading Countries by Rank*</b>					
<b>Rank</b>	<b>1970</b>	<b>1980</b>	<b>1990</b>	<b>2000</b>	
1.	<b>Italy</b> 1,009,000	<b>Mexico</b> 2,199,000	<b>Mexico</b> 4,298,000	<b>Mexico</b> 7,841,000	
2.	<b>Germany</b> 833,000	<b>Germany</b> 849,000	<b>China</b> 921,000	<b>China</b> 1,391,000	
3.	<b>Canada</b> 812,000	<b>Canada</b> 843,000	<b>Philippines</b> 913,000	<b>Philippines</b> 1,222,000	
4.	<b>Mexico</b> 760,000	<b>Italy</b> 832,000	<b>Canada</b> 745,000	<b>India</b> 1,007,000	
5.	<b>United Kingdom</b> 686,000	<b>United Kingdom</b> 669,000	<b>Cuba</b> 737,000	<b>Cuba</b> 952,000	
6.	<b>Poland</b> 548,000	<b>Cuba</b> 608,000	<b>Germany</b> 712,000	<b>Vietnam</b> 863,000	
7.	<b>Soviet Union</b> 463,000	<b>Philippines</b> 501,000	<b>United Kingdom</b> 640,000	<b>El Salvador</b> 765,000	
8.	<b>Cuba</b> 439,000	<b>Poland</b> 418,000	<b>Italy</b> 581,000	<b>Korea</b> 701,000	
9.	<b>Ireland</b> 251,000	<b>Soviet Union</b> 406,000	<b>Korea</b> 568,000	<b>Dominican Republic</b> 692,000	
10.	<b>Austria</b> 214,000	<b>Korea</b> 290,000	<b>Vietnam</b> 543,000	<b>Canada</b> 678,000	

\*Data are not totally comparable over time because of changes in boundaries for some countries. Great Britain excludes Ireland. United Kingdom includes Northern Ireland. China in 1990 includes Hong Kong and Taiwan.

Source: US Census Bureau. (2001). Profile of the Foreign-Born Population in the United States: 2000. Retrieved August 28, 2009, from <http://www.census.gov/prod/2002pubs/p23-206.pdf>.

## Irish Americans

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### Historical Background

Ireland comprises 26 counties and became a free state in 1921. The Republic of Ireland was proclaimed in 1948, when Ireland withdrew from the British Commonwealth. The British government reasserted its claim to Northern Ireland, a claim that was not recognized by the Republic of Ireland. Since that time, warfare has been present with repeated on and off cease-fires negotiated. Today, the unrest continues and many Irish Americans send money to support the Irish Republican Army. Today, the population of Ireland is 4,062,235 (World Almanac, 2006). Ireland is bordered on the northeast by Northern Ireland (province of Ulster), which remains a part of the United Kingdom. It is bordered by the Atlantic Ocean to the South and West. The ocean separates Ireland from Great Britain by an average of 50 miles. Ireland was colonized by European settlers from Great Britain with the Celtic influence remaining dominant today.

Throughout the history of the United States, immigrants have made their way from Ireland. During colonial times, the early Irish immigrants were Presbyterian Protestants from Ulster, now known as Northern Ireland. The motivation to come to America was to seek financial gain and a better life. The majority of the Ulster-born Irish immigrants were tenant farmers or skilled artisans. The Irish who came later were motivated not to seek a better life but to simply survive. The famine in Ireland, as a result of a blight that struck the potato crop between the years 1845–1854, left death and destruction in its wake. Tenant farmers were left with no crop and therefore no money. Although some landlords were initially compassionate, the passage of the Poor Law Extension Act of 1847 by Parliament changed that. Because of that law, a landlord became financially responsible for the cost of care for their tenants—an expense that many landlords were just not able to financially handle so evictions became extremely common. Once evicted, the tenant farmer was left with few options: move into a disease-infested workhouse or starve while searching for food and shelter. Many chose to flee their native land—to America—with the goal and hope of survival. These Irish immigrants were different than the Ulster Irish in many ways. The Ulster Irish were Protestant and the newer Irish immigrants were Catholics. The penal laws in Ireland had long placed Irish Catholics at a distinct disadvantage. They were poor farmers who were uneducated and totally dependent on their rocky plot of land (that was owned by the landlord) for survival. The potato crop was the

sole food source. They came from large families with a lifestyle that favored close social interaction. Although they possessed little, they shared readily and enjoyed celebrating their beliefs with tradition, song, dance, and religious rituals. When their land was lost, they felt there was no place left for them in Ireland. Between 1840 and 1860, more than 1.5 million Irish came to the United States. Where they settled was determined by their financial situation. Although a large contingent settled in New Orleans and other cities, the Irish who immigrated to escape the famine stayed in the Eastern port cities of New York or Boston simply because they had no money or marketable skills to move on. Some were forced to move westward to Chicago in search of employment. The vast majority were poor and Catholic and were the first wave of non-Anglo-Saxon immigrants to the United States, and because of this difference, they were often met with hostility. Another unique difference was that many of the immigrants were unaccompanied women. Many women took jobs as domestic servants in the homes of the wealthy. The uneducated men took jobs of hard labor digging ditches or building canals or bridges. Both worked and saved with the goal to bring additional family members to America. Although they were on the lowest rung of American society, over time they began to dare to dream their own version of the “American Dream.”

**Table 9-4**

## Cultural Values of Euro-Americans (White Non-Hispanics)

Competition	Strong Expression of Opinion	Saving for the Future (Retirement)	Mastery over Nature
Individual achievement	Action valued over inaction; direct confrontation	Puritan work ethic; work for work's sake Rigid schedule	Judeo-Christian beliefs; emphasis on a second coming and the need for salvation
Overt identification of accomplishments; pride	Rapid responses and decision making valued	Euro centric obsession with money (i.e., time is money)	Nuclear family orientation; measure of successful child rearing is the child being able to leave home and thrive
Advice giving, directness	Individual ownership; upward social mobility	Future orientation—ability to delay gratification to the future	Follow the rules of dominant society, which is to work to get ahead; one who has developed social and economic mobility.

Source: Hendrix, L. R. Health and health care of American Indian and Alaska Native elders. Retrieved May 4, 2009, from <http://www.stanford.edu/group/ethnoger/americanindian.html>.

Today, approximately 40 million people of Irish descent live in the United States (US Census Bureau, 2002). Irish ranks as the second largest ancestry group in the United States, second only to German.

### **Traditional Health Beliefs**

Some Irish Americans follow folk medicine beliefs. These practices are considered safe as they have been determined to be “neutral” (do not cause benefit or harm) (Giger & Davidhizar, 2003). These activities include blessing of the throat, tying a bag of camphor around the neck to prevent flu, keeping closet doors closed to block evil spirits, not looking in a mirror at night, keeping a strong and loving family, and the wearing of holy medals.

Irish Americans often have a reactive rather than a proactive approach to illness as they often delay seeking medical attention until the situation is quite serious. The first line of treatment will often be home remedies. Some folk medicine practices are deemed beneficial: getting plenty of rest, maintaining a positive attitude, eating a balanced diet and taking vitamins (Spector, 2004).

### **Impact of Communication**

The official language of Ireland is Irish (Irish Gaelic). English is the second recognized language and is universally spoken in Ireland. An understanding of the Celtic language is necessary. The Celtic language was initially an oral one, so the culture was passed on orally most notably through poetry. Although a modern day Irish language persists today, it was almost wiped out because of the onslaught of the English language in the 19th century. Because many Irish immigrants arriving in the United States spoke English, they had an easier time with assimilation into the dominant American society than other immigrants.

### **Impact of Social Organization**

The parish church was the center of social activity. Because many of these Irish immigrants were viewed as different because they were Catholic, they began to face hostility in society. The result was the formation of tightly knit social circle. As time passed, the children of these immigrants began to see possibilities for a better future because of their large numbers and ambition. They began to explore politics, which was a natural progression from

the organizational structure of the parish system (Bankston & Hidalgo, 2006). In many cities, precinct by precinct, the Irish began to embrace the political system of the United States as not only a tool to improve their personal situation, but as an outlet for social change (Bankston & Hidalgo, 2006). The Irish political machine was particularly powerful and effective in New York (where Alfred E. “Al” Smith became Governor of New York in 1918), Kansas City, and Chicago. Political expansion was difficult outside these strong enclaves caused by fear and distrust of the Irish and the fear of involvement or interference of the Pope in government that existed within the larger American society. These factors contributed to the defeat of Governor Smith when he ran for President of the United States in 1928. These factors were not overcome until the election of President John F. Kennedy (a descendant of peasant Irish Catholic stock) in 1960—a feat that has not been repeated to date.

Labor unions were also a social organizing force for Irish Americans. Political activity and the church were seen as the best means for upward mobility. The Catholic Church also established Catholic Universities such as Notre Dame, Fordham, and Boston College to provide higher education opportunities for Irish Americans.

The family unit is extremely significant to Irish Americans. The nurse should include the family when planning care for it is felt that nursing interventions will only be successful if the family is included. Family roles tend to be gender based with the Irish American women viewing her role as primary caretaker. If the primary caretaker is ill, the nurse must help the family cope with the role strain and to help the family develop strategies to meet the family’s needs in the absence of the caretaker.

### **Impact of Faith and Spirituality**

The Ulster Irish were Protestant, and the majority of famine Irish were Catholic. The Irish Catholics were isolated by their religious beliefs and set up parishes within their neighborhoods. The Catholic parishes evolved into social and educational centers for the community. The parish priest served as a role model and counselor for the community. The church cared for the immigrants’ spiritual, social, educational, medical, and emotional needs. As the number of immigrants increased, parishes and religious orders built schools, hospitals, and orphanages to meet the needs of the communities (Bankston & Hidalgo, 2006).

**Biologic Variations**

Some genetic variations have been identified in Irish Americans. Some are only associated with some identified Irish subgroups such as the Travellers of Ireland. These genetic variations include neural tube defects, sarcoidosis, cystic fibrosis, Tay-Sachs disease, bimaxillary dental protrusion, abdominal aortic aneurysm, and alcoholism.

Among all American ethnic groups, Irish Americans have either been ranked the highest or near highest for alcoholism rates (Butler, 1996). The nurse should remember that for Irish Americans, alcoholism is influenced by a variety of factors, including patterns and characteristics of the family, social and economic conditions, and psychologic orientation, rather than a biologic variation. Because some Irish drink for reassurance and to escape what is perceived as an intolerable burden, the nurse must develop strategies to teach such individuals more positive ways to alleviate stress and tension. Such individuals should be taught to verbally communicate feelings and anxiety rather than repressing or denying such feelings. The client must be taught the value of verbal expression to communicate needs. In addition, it is important to assist these clients in developing positive outlooks on life that may be perceived as positive coping strategies. The nurse also must remember the value of working not only with the client but also with the family because of the perception of family relationships as being paramount to a healthful existence.

**Table 9-5**

Nursing Considerations for the White Non-Hispanic Patient (Euro-American)

<b>Appropriate Ways to Show Respect and Establish Rapport</b>	<b>Culturally Appropriate Verbal and Nonverbal Communication</b>	<b>Language Assessment/Literacy Level</b>
Utilize a firm handshake as it denotes power and authority. Self-disclosure is valued. Strive for an open and honest communication style. Expect directness in all patient interactions: Direct criticism will be utilized to alter behavior; disapproval will be directly expressed; and request will be made directly.	Use direct eye contact as it is viewed as a sign of honesty and sincerity. Rely on the verbal expression of ideas/feelings (the speech is more important than the behavior). Speaking is emphasized over listening. The expression of one's opinion is highly valued. Verbal and written communicated valued over nonverbal communication.	Consider the use of alternative methods for patient education such as media and Internet as this type of information passing is culturally appropriate.

Source: Hendrix, L. R. Health and health care of American Indian and Alaska Native elders. Retrieved May 4, 2009, from <http://www.stanford.edu/group/ethnoger/americanindian.html>.

## Case Study 9-1

### Irish American Case Study

This case demonstrates what can occur during a cross-cultural encounter (the culture of the patient and the provider are different).

A middle-aged Irish woman was hospitalized and scheduled to have bowel resection surgery once her condition had been stabilized. After a few days, the patient suddenly started complaining of severe abdominal pain to her family but said nothing to her physician. Her physician was unaware of the cultural manifestations of pain in Irish Americans, that is, the Irish, as a group, tend to minimize expressions of pain. When the patient's family spoke to the physician about the patient's pain, the physician expressed little concern because in the physician's country, women having serious pain are much more vocal than this patient was being. The physician did not listen to the patient's family and also did not follow up with the patient to see if the pain complaint was legitimate. The physician ignored the family's request that the surgery be done sooner, deeming it unnecessary. The surgeon had placed his cultural beliefs onto the patient which impacted his medical judgment.

By the time the patient went to surgery, her condition had worsened, and she died from the surgery. The family felt that had the surgeon operated when they first complained about the patient's pain, she might have lived, and they filed a malpractice case against the surgeon.

Rationale: In this case, the surgeon made the mistake of stereotyping the patient—she was a woman, and in the physician's experience, women complained loudly when in pain. Therefore, the physician exercised poor and negligent medical judgment when he failed to re-examine the patient. If the physician had been aware of the generalization about Irish people in pain, the patient's complaints may have been taken more seriously, which may have led to an earlier surgical intervention.

From: Galanti, G. A. (2000). An introduction to cultural differences. *Western Journal of Medicine*, 172, 5, 335–336.

## Italian Americans

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### Historical Background

Italian Americans are actual immigrants or descendants from mainland Italy, Sicily, Sardinia, and other Mediterranean islands that make up Italy. Most of these immigrants came to the United States during the “Great Migration” between 1880 and 1922. Today, the descendants of those early immigrants number nearly 16 million; making them the fifth largest ethnic group in the United States (US Census Bureau, 2000). The frequency of intermarriage has resulted in the number of Americans who have at least one Italian grandparent to be estimated at 26 million.

### Traditional Health Beliefs

Italian Americans have several traditional health beliefs including the belief that the cause of illness is a result of a contagion or contamination caused by heredity related to a supernatural or human cause, related to wind currents that bear diseases, or psychosomatic causes. First-generation immigrants are more likely to ascribe to these traditional health beliefs.

It is important to make the distinction between “fresh air” and drafts. Fresh air is considered healthy and vital for health maintenance while drafts, on the other hand, are a cause of illness. Ventilation of the home and workplace is valued, but avoidance of drafts is essential.

Supernatural causes of illness include the “evil eye” (*malocchio*) and curses (*castiga*). The severity of the illness is related to the supernatural causes with curses resulting in the most serious or even fatal medical problems. Curses are the result of either God or sent by an evil person, and they may be seen as a punishment for sinning or other bad behavior.

Emotions need to be released, which is one explanation for the animation associated with the Italian culture. Keeping emotions bottled up is unhealthy, and if an outlet for release of these emotions is not found, serious consequences will result.

### Impact of Communication

According to data from the 2000 US Census, there are 1 million speakers of Italian in the United States, which ranked sixth on the top 10 list of languages spoken in the home excluding English and Spanish (Box 9-1). Many scholars have attributed the loss of the Italian language to Italian Americans during World War II. The American government had a strong propaganda campaign telling Americans not to speak the enemy’s language. Also during the war, some Italian Americans (as well as Japanese Americans) were placed in internment camps—this was more likely to occur if Italian was spoken.



**Box 9-1****Ten Languages Most Frequently Spoken at Home Other Than English and Spanish: 2000**

Population Aged 5 Years and Older	Number in Millions
Chinese	2.0
French	1.6
German	1.4
Tagalog	1.2
Italian*	1.0
Vietnamese*	1.0
Korean	0.9
Russian	0.7
Polish	0.7
Arabic	0.6

\*The number of Vietnamese speakers and the number of Italian speakers were not statistically different from one another.

Source: US Census Bureau. (2000). United States Census 2000. Retrieved September 21, 2009, from <http://www.census.gov/main/www/cen2000.html>.

The Italian language of today (what is taught in schools/colleges) is different than traditional Italian. Over 80% of Italian Americans are of Southern Italian descent where the Neapolitan or Sicilian dialects were spoken. Today, this Italian is anachronistic and demonstrates Southern Italy dialects of the past and not the language of the present (Italian Standard). The language situation is even more pronounced for Italian Americans of Northern descent, as their language is even more linguistically different than Southern Italian dialects. Because of this, Italian Americans who wish to learn Italian are learning a language that does not include many of the phrases they may have learned from their families.

Language problems can face the nurse when the elderly or a new Italian immigrant seeks medical care. Modesty may impact the ability to get adequate or complete answers to medical questions, even when an interpreter is used. Italian Americans tend to overreport symptoms or report their symptoms in a very dramatic manner. Because of this, physicians tend to diagnose more emotional problems more often for Italian American patients than for any other ethnic group (Giordano & McGoldrick, 1996).

The nurse should recognize that Italian Americans are motivated to seek full and complete explanations regarding their health status and the proposed treatment plan. If the instructions are clear, cooperation is enhanced. It is recommended to provide thorough oral patient education followed up with the provision of written instructions to ensure safety and adherence.

### **Impact of Social Organization**

The family is the main organizing framework in Italian American culture. The family provides strength, helps with coping with stresses, and provides a sense of continuity. Italian Americans take pride in their family and their home. The man is the head of the household, and the female is considered to provide the heart of the family. The church is also an important focus of Italian American life. Italian feasts are commonplace and provide the opportunity for proliferation of the culture's love of food and its devotion to God and to patron saints.

Often, the care of illness is managed in the home with all family members contributing to patient care and management of household responsibilities. Intermarriage is common with more than 80% of Italian Americans marrying people from a different ethnic group (Giordano & McGoldrick, 1996).

### **Impact of Faith and Spirituality**

Most Italian Americans are Catholic, and it has been reported that many immigrants become even more devoutly Catholic once they arrive in America. There are some who, despite possessing a Catholic background, have chosen to leave the church to practice Protestant Christianity for various reasons. Some worship in non-Catholic churches but continue to enroll their children in parochial schools. Some have become disenchanted with the leadership in the Catholic Church, abhor lack of agreement with certain church rituals, and believe that the Catholics have misinterpreted certain important Christian doctrines.

### **Biologic Variations**

There are two genetic diseases commonly seen in Italian Americans, both of which are anemia disorders. The first is favism, which is a severe hemolytic anemia that results from a deficiency of the X-linked enzyme glucose-6-phosphate dehydrogenase that is triggered when the patient eats fava beans. The second type of anemia disorder is the thalassemia syndromes of which there are two subgroupings. Beta-thalassemia, which is also referred to as Cooley's anemia or thalassemia major, is a serious form of the disease, and alpha-thalassemia. The thalassemias are a diverse group of hereditary blood diseases that result in reduced or flawed production of hemoglobin. Some cases of thalassemia can be quite debilitating, requiring extensive medical intervention, whereas others require little or no medical intervention.

# Appalachians

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## Historical Background

Appalachians are people who were either born in or live in the Appalachian Mountain region of the United States. This large area crosses 13 states and is considered a rural, nonfarming area. Although there is diversity among Appalachians, there are some commonalities. The majority of the population is White (approximately 96%), primarily of Scottish-Irish or British descent, and predominately follow the fundamentalist Protestant religion. Others trace their ancestry to Germany and France. Most Appalachians also share a genetic link to Native Americans who lived in the area prior to European settlement. The ruggedness of the terrain has resulted in a deep-rooted work ethic, loyalty, family-oriented, religious, and resourceful people (Marger & Obermiller, 1987).

## Traditional Health Beliefs

There is a general distrust of all outsiders, which includes nurses and other healthcare professionals. There is an acceptance of a wide variety of healers. Because of the isolation, these folk healers are often the primary providers of health care available. One of these is the “granny midwife.” Granny midwives are usually older women who may be responsible for all of the births in their region of the Appalachians.

The traditional healer’s goal is the restoration of harmony. Products from nature are utilized, including poultices and teas. A strong belief in folk medicine is a strong part of the culture, and these practices are followed by all persons from all socioeconomic and educational levels. It is essential that the nurse become familiar and knowledgeable about these herbs because their use is so prevalent. Some of the ingredients can have serious side effects and may interact with prescribed pharmacologic therapies. The nurse must ascertain if the patient intends to use folk medicines at the same time as any prescription medications so that the treatment plan can be modified and essential education imparted to the patient to prevent untoward or adverse events. See Table 9-6 for information about herbal remedies.

## Impact of Communication

Although the dominant language is English, there are some words from the 16th century Gaelic and Saxon languages that persist. Also, some areas have perpetuated Elizabethan English that can cause communication difficulties during health encounters if the nurse is not

Table 9-6

## Appalachian Traditional Herbal Therapies

Medical Condition	Herbal Therapy
Arthritis	<ol style="list-style-type: none"> <li>1. Ginseng tea—ingested orally or rubbed onto affected joints. Nursing implication: Ginseng can prolong bleeding; use caution with heparin, warfarin, aspirin, and nonsteroidal anti-inflammatory drugs. Interacts with monoamine oxidase inhibitors. Use in combination with stimulants (caffeine) can elevate blood pressure. Concomitant use with furosemide, nifedipine, and estrogen may increase risk of side effects.</li> <li>2. Tea made from alfalfa seeds or stems, or tea from the stems of the barbell plant.</li> <li>3. Drinking a combination of liquor with the roots of ginseng and goldenseal, or tea from rhubarb and whiskey.</li> <li>4. Drink a mixture of honey, vinegar, and liquor.</li> </ol>
Asthma	<ol style="list-style-type: none"> <li>1. Drink tea from the bark of wild yellow plum trees, mullein leaves, and alum twice a day.</li> <li>2. Combine gin and the heartwood of a pine tree twice a day.</li> <li>3. Drink a mixture of honey, lemon juice, and whiskey.</li> </ol>
Boils/Sores	<ol style="list-style-type: none"> <li>1. Apply a poultice of walnut leaves or the green hulls with salt.</li> <li>2. Apply a poultice of the house leek plant.</li> <li>3. Apply a poultice of flaxseed meal.</li> </ol>
Fever	<ol style="list-style-type: none"> <li>1. Drink water from wild ginger. Nursing implication: Ginger may inhibit platelet aggregation/decrease thromboxane production theoretically, increasing bleeding risk. There is evidence that ginger may increase stomach acid production, which may be of significance in patients with peptic ulcer disease or who are prescribed antacids, H2 receptor antagonists, or proton pump inhibitors. Other studies indicate that ginger may act to protect the stomach. Ginger may interfere with medications affecting heart contraction (including beta-blockers and digoxin among others). Ginger may also interact with drugs taken for nausea/vomiting, arthritis, blood disorders, high cholesterol, high/low blood pressure, allergies (antihistamines), cancer, inflammation, vasodilators, or weight loss. Caution is advised when taking ginger with drugs that weaken the immune system, because of a possible interaction.</li> <li>2. Drink tea made from butterfly weed, wild horsemint, or feverwood.</li> </ol>
Headache	<ol style="list-style-type: none"> <li>1. Drink tea made of lady's slipper plants. Nursing implications: Lady's slipper contains quinines, which may have an additive effect when taken concomitantly with other quinine-containing agents, often used to treat malaria. Lady's slipper is thought to contain tannins, glycosides, resins, and quinines. Patients taking cardiac glycosides or digoxin should use with caution. Based on traditional use, lady's slipper may have additive effects when used with other sedatives.</li> <li>2. Rub camphor and whiskey on the head.</li> </ol>
Hypertension	<ol style="list-style-type: none"> <li>1. Drink sarsaparilla tea.</li> <li>2. Drink a half cup of vinegar</li> </ol>
Heart Disease	<ol style="list-style-type: none"> <li>1. Drink tea made from heartleaf leaves or bleeding heart.</li> <li>2. Eat garlic.</li> </ol>
Kidney Disease	<ol style="list-style-type: none"> <li>1. Drink tea made from peach leaves or mullein roots.</li> <li>2. Drink tea made from corn silk or arbutus leaves.</li> </ol>
Sore Throat	<ol style="list-style-type: none"> <li>1. Gargle with the sap from a red oak tree.</li> <li>2. Eat honey and molasses.</li> <li>3. Drink honey and whiskey.</li> <li>4. Apply a poultice of cottonseed to the throat.</li> </ol>
Warts	<ol style="list-style-type: none"> <li>1. Apply milkweed juice to the affected area.</li> </ol>

Source: Purnell, L. D., & Paulanka, B. J. (1998). *Transcultural health care: A culturally competent approach*. Philadelphia: F. A. Davis.

familiar with the characteristics of that speech. The best policy when confronted with an unfamiliar word is to request clarification from the patient.

### **Impact of Social Organization**

The traditional household is male led with the women responsible for childrearing. Women usually marry young (by age 20), whereas men marry by the age of 28 (McNeil, 1989). Because of a loss of welfare benefits/services upon marriage, some Appalachians are deciding not to marry. Women are also relied upon for their emotional strength. Older women are responsible to perpetuate the culture and to care for the ill through the preparation of remedies. Grandparents are often called upon to be caregivers to the children of the family. The elders are rewarded for this commitment to the family as the physical structures of many Appalachian homes are designed to permit function in aging persons. Nursing home placement is not culturally acceptable as it is considered the equivalent of a death sentence (Halperin, 1994). The rough mountainous terrain makes travel difficult in the Appalachians. The result of this has been the formation of informal social networks that also serves to meet the need for worship. Difficulty with travel makes attendance at organized churches difficult, although Fundamentalist Protestant religion is important to the community. Difficulty with access and the lack of public transportation and insufficient and inadequate roads are responsible for the continued geographic and social isolation. Isolation has also resulted in a dichotomous population divided by educational level: poorly educated or well educated.

Acceptance is an important characteristic of Appalachian culture. Alternative lifestyles (divorce, homosexuality) are accepted, but not usually discussed. This acceptance is linked to the Appalachians need for privacy and the desire not to interfere with other's lives through the avoidance of arguments and seeking common ground.

### **Biologic Variations**

The Appalachians are predominately a White population that has incurred little variation over time. Some can trace their genetic background to include a mixture of White European ancestry with either Cherokee or Apache Native American blood. This mixture has resulted in a darker pigmentation than would exist without the genetic Native American influence. There is a very small minority of Blacks who self-identify as Appalachians. There are no reported studies that have found variations in drug metabolism specific to this population.

**Mortality/Morbidity**

The environmental factors associated with geographic location and occupations of Appalachians have resulted in serious health problems. Appalachians are at a higher risk for respiratory diseases such as black lung disease, emphysema, and tuberculosis. Parasitic infections are common because many Appalachians live without electricity or access to plumbing. The incidence of type II diabetes is 400–600% greater than the national average (Brown & Obermiller, 1994). Cancer, myocardial infarction, cerebral vascular accident, mental illness, accidental injury, and suicide rates are significantly higher in the Appalachian versus the general population ranging from 150 to 400% greater (Brown & Obermiller, 1994; Edwards, Lenz, & East-Odom, 1993).

**Impact of Nurses and Nurse Practitioners in Appalachia**

Lay midwives (often referred to as granny midwives) have been practicing in Appalachia for many decades but it was not until 1927, when Mary Breckenridge founded the Frontier Nursing Service, that the people of Appalachia had access to formally trained nurse–midwives and nurses for healthcare delivery. Since then, access has expanded to include the provision of primary care in nurse-managed centers throughout the large geographic area making up Appalachia. Often, it is a struggle to earn the trust of the community as it is a slow process to earn the trust when viewed as an outsider. The nurse providing care in the home is usually a more successful approach. Asking the patient what they consider the problem to be prior to designing the treatment plan is also an effective strategy (Helton, Barnes, & Borman, 1994).

## The Amish

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**Background**

The Amish are linked to the Anabaptists of 16th century Europe. This group broke off from the Catholic Church because they felt the scriptures did not support infant baptism and that only believers should be baptized. The Anabaptists term came from the practice of adults being rebaptized. There were other differences such as a desire for separation of church and states, pacifism, and a commitment to live peaceably. The Anabaptists became a persecuted group throughout the next century in Western Europe. The Anabaptists, despite this persecution, gave birth to three religious movements that still exist today. These three groups are the Mennonites, the Hutterites, and the Swiss Brethren (Hostetler, 1993). The Amish are a branch of the Swiss Brethren and derived its name from their leader Jakob Ammann, who was a Swiss

Brethren bishop from Alsace (Christian Light Publications, Inc.; Gross, 1997). The most well-known descendants of the Anabaptists are the Mennonites and the Amish. According to Christian Light Publications, Inc., the Amish, a smaller body of Swiss Brethren, settled in Pennsylvania in Berks County in 1736. The motivation for German migration to the American colonies was the impact of many wars on Germany and the desire for religious freedom. Taxes were high to pay for the wars, famine spread over the land, and the armies had trampled farmland and burned down farmsteads (Christian Light Publications, Inc). In Europe, the rulers determined the religion of the land and many pious Germans found this difficult to accept. The Colonies and especially Pennsylvania offered the opportunity for religious freedom.

A break occurred between the Swiss Brethren and the Amish under Ammann's leadership in 1693. The Amish then refused to have anything to do with their former brethren or any excommunicated members, a tradition that is referred to as "shunning."

Today, the Amish live in rural areas in over 28 states. The vast majority of the Amish (about 75%) live in Pennsylvania, Ohio, and Indiana (Kraybill, 1993). Recently, the Amish have been expanding their presence in search of affordable farm land in response to a doubling of population over the past 16 years. Reasons given for the increase in population include large families, increase in marriages within the community, a lower than average child mortality rate, and longer life spans. Amish couples typically have five or more children. With more than four out of every five deciding in young adulthood to remain within the church, their population has grown steadily. More than half the population is under 21. A small portion of the increase is also caused by conversions to the faith. In Ontario, Canada, the only Amish community outside the United States is also growing. It consists of about 4500 people, up from 2300 in 1992 (Kraybill, Nolt, & Johnson-Weiner, 2008).

The Amish are attracted to areas with relatively cheap farms, a rural lifestyle, and nonfarming jobs such as construction or cabinet making that fit their values and allow them to remain independent. In some cases, they have migrated to resolve leadership problems or escape church-related disputes.

The most important concept that the nurse needs to know in an attempt to understand Amish culture is that the reason for the departure from contemporary American culture is caused by the Amish people's perceived biblical mandate to live a life separated from a world they see as sinful (Kraybill, 2003; Hostetler, 1993). The old-fashioned appearance can be misunderstood. Although the eschewing of modern technological conveniences is present (i.e., reliance on the use of horse and buggy for transportation and the lack of electricity in the home), this does not mean the Amish will not be open to the use of state-of-the-art medical technology if it is deemed necessary to health promotion (Huntington, 1993).

### **Traditional Health Beliefs**

The Amish wish to be born at home and to die at home. God's will is absolute as it determines all and their belief is to accept God's will as it is. This belief is associated with a deep fear of disability—it is feared much more than death. If disability can result from the refusal of treatment, it is essential that the patient and family be educated about this risk. However, a child with birth defects or other disabilities is readily accepted as a child of God and the parents will not be deterred from having additional children. As was stated earlier, the use of modern medicine and medical technology is not forbidden. Prior to accepting medical care, the patient and/or family will ask for the blessing of the church. The reason for this is that the community will need to come together to help pay the medical bills as the Amish do not have medical insurance because it is viewed as a “worldly product” and therefore reflects a lack of faith in God. If deemed necessary, the Amish will permit surgery, anesthesia, dental work, and even blood transfusions and transplantation. The only exception is for heart transplantation, as the heart is viewed as the soul of the body. The Amish do not want to be seen by or have student practitioners participate in their care. Because they are paying cash for their medical care, they only want to be seen by experienced and licensed medical professionals. All medical decisions will be jointly made by both the husband and the wife because of the belief that they are true partners in family life (Lee, 2005).

The Amish are unlikely to seek medical attention for minor complaints. Instead, they are more likely to rely on folk or herbal remedies. They like to use healing aids such as vitamins, homeopathic remedies, health foods, reflexology, and chiropractors.

Traditional health beliefs are shaped by their conservative rural values, a preference for natural remedies, a lack of information, unfamiliarity with technology, difficulties with access, and a strong reliance on God with an associated willingness to suffer if it is God's will (Kraybill, 1993).

### **Impact of Communication**

The Amish speak English and a hybrid language of German and Dutch referred to as “Pennsylvania German” or “Pennsylvania Dutch.” It is a Germanic language with a large amount of English mixed in. The Pennsylvania Dutch language is an oral one. Writing done by the Amish is in English. Many Amish are trilingual as they also speak “high German,” which is the language of their bibles and the language used during church services.



## Impact of Social Organization

The social organization of the Amish is guided by the desire to avoid assimilation and acculturation into dominant American culture. The Amish have been able to maintain a distinctive ethnic subculture by successfully resisting acculturation and assimilation. The Amish try to maintain cultural customs that preserve their identity. They have resisted assimilation into American culture by emphasizing separation from the world, rejecting higher education, selectively using technology, and restricting interaction with outsiders.

The Amish church prescribes dress regulations for its members, but the unwritten standards vary considerably by settlement. Men are expected to wear a wide brim hat and a vest when they appear in public. In winter months and at church services, they wear a black suit coat that is typically fastened with hooks and eyes rather than with buttons. Men use suspenders instead of belts.

Amish women are expected to wear a prayer covering and a bonnet when they appear in public settings. Most women wear a cape over their dresses as well as an apron. The three parts of the dress are often fastened together with straight pins. Various colors, including green, brown, blue, and lavender, are permitted for men's shirts and women's dresses, but designs and figures in the material are taboo. Although young girls do not wear a prayer covering, Amish children are typically dressed similar to their parents.

Although some holidays are celebrated, such as Thanksgiving, Christmas, Easter, and New Years Day, they are free from commercial trappings. The Amish, as conscientious objectors, do not celebrate holidays that are military based such as Memorial Day, Veterans Day, and the Fourth of July.

Cultural ties to the outside world are curbed by speaking the dialect, marrying within the group, spurning television, prohibiting higher education, and limiting social interaction with outsiders. Parochial schools insulate Amish youth from outside influences and threatening ideas. From birth to death, members are embedded in a web of ethnicity. These cultural defenses fortify Amish identity.

## Biologic Variations

As a result of the inbreeding associated with a closed community like the Amish, genetic abnormalities are common because of the "founder effect." Almost all Amish are descended from about 200 founders. These genetic disorders, such as dwarfism, unusual blood typing, and metabolic disorders, are accepted as God's will.

## Roma (Gypsies)

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### Historical Background

The Roma most likely originated in India around the year 1000 AD. The Roma are travelers and have settled in many different European countries since then. The population has experienced many divisions over the years, which makes the placement of the Roma into one ethnic group impossible. Today, there are approximately 12 million Roma living in the world. The term Roma is preferred as the more well-known terminology of Gypsy, which has negative connotations. There is no census data on the Roma but estimates range from 100,000–300,000 members of several diverse groups in the United States.

### Traditional Health Beliefs

There is a general lack of knowledge about access to health services and how to provide them appropriately to the Roma population. The Roma people possess a strongly held set of health-related beliefs in which some diseases are seen as belonging to the Roma (to that group), therefore requiring treatment by their own traditional healers, whereas other diseases are seen as a result of contact with the outside world and as such require medical care from the American healthcare delivery system. The majority of Roma are governed by a series of rules about what is considered pure or impure. There are also a range of specific rituals dealing with birth, death, and caring for the ill. These beliefs and reliance on rituals can result in the Roma people accepting some aspects of medical care and rejecting other aspects. This behavior can be labeled as nonadherent and can be viewed as irresponsible for not fitting in with the norms of dominant American society.

### Impact of Communication

The Roma speak many different dialects of the Roma language. Those from Western Europe and the majority in the United States speak Romany (also known as Romanes or Romani). Romany is a Sanskrit-based language that belongs to the Indo-Aryan branch of Indo-European languages. All of the dialects have traces of other languages in them because of the influence of the many different countries in which Roma have lived. All Roma speak a second or even a third language from the countries in which they have lived or travelled. The Romany language is a principal factor of Roma ethnic identity. It is primarily a spoken rather than written language. Until recent years, most Roma were illiterate, and illiteracy rates remain very high in most Roma communities. In light of this, the nurse should not rely on

written materials when providing patient education to Roma patients and families.

### **Impact of Social Organization**

Roma families have settled throughout the United States. Family consists of extended members who may or may not be related by blood. The family is a strong, tightly knit unit, known as a clan or “kumpania.” The clan often live, work, and celebrate together. The elder members are the authority figures and decision makers in all situations. Clan leaders sometimes adopt the title of “King” or “Queen.” These titles denote respect and not the possession of an actual political position. The nurse should always speak to the elders if any healthcare decisions are required.

Marriages are often arranged and at a very young age. Until marriage at the age of 12 or 13 for most Roma girls, strict morality is upheld through the use of chaperones. Marriage creates an alliance between a family or clan. The payment of a “bride price” (dowry) is common. This payment from the groom’s family is meant to compensate the bride’s family for the loss of their daughter and to ensure that she will be well treated as a member of her new family.

Disputes are settled within the community itself. An informal Romani court called the kris decides matters of common law and custom and determines penalty. A kris-determined penalty can be as severe as exclusion from the community.

Most Roma currently living in this country were born here and have since adopted to many of the dominant American society cultural norms. This goes against traditional Roma beliefs which include that society is “dirty” and potentially polluting, and in traditional clans, children are often removed from school at puberty (Sutherland, 2004).

Today, some have a less nomadic lifestyle that is contradictory to traditional Roma lifestyle, which holds that isolation away from the dominant society is crucial to maintaining Roma culture (Rundle, Carvalho, & Robinson, 1999). There are a number of diverse Roma groups and not all of them have the same cultural practices.

### **Impact of Faith and Spirituality**

Some Roma still practice the religion of their homelands, most commonly Christianity or Islam. Some are Born Again Christians and follow the main Protestant Holy Days (Hancock, 1987). Most practice a religion similar to Wicca which believes in both Satan and God, while placing an emphasis on luck and the supernatural (Rundle et al., 1999). There is resistance to the emergence of Christianity by those who seek to uphold the older traditions such as arranged marriages, dowries, and fortune telling (Hancock, 1987).

### Biologic Variations

There is little research on the Roma population. There is evidence that the life expectancy is 10 years less than that of their non-Roma neighbors and that infant mortality is up to four times higher (Braham, 1993). Two studies conducted in Spain found a high prevalence for the antibody to hepatitis A (a nine times greater prevalence) and for lead poisoning in children (McKee, 1997). Some Roma groups have a high incidence of inherited congenital abnormalities, which may be a result of a closed community and a reluctance to mix with outsiders.

## Jewish Americans

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### Historical Background

The inclusion of Jewish Americans is important because, unlike followers of other religions, being Jewish is not only following a religion but a culture and a way of life, although it is not a race. Terms to describe Jewish people throughout history include Hebrew, Israelite, and Jew. The terms can also be used interchangeably as the people are called Jewish, the faith is Judaism, the land is Israel, and the language spoken is Hebrew. The United States is home to the largest number of Jews in the world second only to Israel. There are several different types of Judaism that range on a continuum from the most extreme or conservative which is strict Orthodox, to the most liberal which is liberal Reform. Although there is no formal social hierarchy within the Jewish American community, in the case of ultra-Orthodox followers, decisions may be made in concert with their rabbi. According to US Census Bureau data (2007), 1.7% of the adult American population is Jewish, which converts to 5,128,000 people. This number is very close to the number of Jews living in Israel, which has been estimated by Israel's Central Bureau of Statistics as 5,435,800 people in the year 2007. See Box 9-2 to see how this compares to other religious organizations in the United States.

The Jewish community of the United States is varied. It consists mainly of Ashkenazi Jews who immigrated to the United States from Eastern and Central Europe and their descendants (who were US-born citizens). There are other Jewish ethnic divisions as well, including Sephardics and Mizrahis. There are also some Jewish Americans who were converts to the religion as well. This variability has resulted in a wide range of Jewish cultural traditions with an associated wide range of religious observance (from extremely religious to those living a secular lifestyle).

Jews have been present in the United States for some time, perhaps even earlier than the 17th century. The early immigrants were almost

**Box 9-2**

## Religious Composition of the United States of America in Descending Order

Religion	Percentage of Adult Population
Protestant—all types	51.3
Catholic	23.9
Unaffiliated (includes atheist, agnostic, and nothing in particular)	16.1
Mormon (also includes Church of Jesus Christ of Latter Day Saints)	3.3
Do not know	0.8
Jehovah's Witness	0.7
Unitarians and other liberal faiths	0.7
Buddhist	0.7
Muslim	0.6
Orthodox	0.6
Hindu	0.4
New Age (includes Wiccan, Pagan, and other New Age groups)	0.4

From the Religious Landscape Survey, a survey conducted in the summer of 2007 among a representative sample of 35,556 adults (over age 18) living in the continental United States. (US The Pew Forum on Religion & Public Life. Religious Landscape Survey. Retrieved August 28, 2009, from <http://www.census.gov/compendia/statab/tables/09s0074.pdf>.)

exclusively Sephardic Jews of Spanish and Portuguese descent. Large scale Jewish immigration began in earnest in the 19th century with the arrival of many secular Ashkenazi Jews from Germany.

Over 2,000,000 Jews arrived between the late 19th century and 1924, when the Immigration Act of 1924 and the National Origins Quota of 1924 restricted immigration. Most settled in the city of New York and its immediate surrounding areas, establishing what is today one of the world's major concentrations of the Jewish population. Today, the top three states with the highest proportion of Jews are New York, New Jersey, and Florida.

During the early 20th century, assimilation was encouraged and Jews became a part of American life. Half of all Jewish adult males aged 18 to 50 served in World War II (500,000 men), and after the war ended were part of the suburban sprawl that occurred in the United States. Further assimilation and high intermarriage rates further contributed to secularization. As a group, American Jews have been very active in civil rights and fighting prejudice and discrimination. Some Jewish scholars attribute this to the history of the Jews beginning in slavery and the yearning for freedom.

Although Jewish Americans are included in this chapter on White non-Hispanic cultures, do not conclude that there are no African American Jews. Estimates range from a low of 20,000 to a high of 200,000 African American Jews in the United States. These Jews, who are not of European descent, are sometimes referred to as “Black Jews” to differentiate them from Jews who are directly descended from the Israelites of the Torah. Despite this distinction being made, the relations between the two groups are apparently amicable.

### **Traditional Health Beliefs**

Jewish Americans are health conscious and believe in keeping both the mind and body healthy. They practice preventative health care and will participate in routine screenings and complete all recommended immunizations. It is believed that illness requires early and prompt treatment. All branches of Judaism believe that religious requirements (if a conflict were to exist) may be disregarded if a life is at stake or if the person is suffering with a potentially life-threatening illness.

Ancient Jews followed good hygiene and sanitation practices, which have provided the basic principles for public health care. It was Lillian Wald, a Jewish nurse, who established the prototype for public health nursing when she established the Henry Street Settlement in Manhattan, New York City, in 1893. Physicians and nurses are held in high regard by Jews. There is the belief that once standard therapy has failed and there is no further treatment available, the physician must be willing to change hats from “curer” to “carer” (Rosner, 1993).

### **Impact of Communication**

American Jews speak English and a large number are bilingual speaking Modern Hebrew as well. Modern Hebrew is the official state language of Israel and is the language used for prayers. Hebrew is read from right to left and books are opened from the opposite side compared to books written in English. Recent immigrants from Israel may only speak Modern Hebrew. A number of other languages may also be spoken depending on the type of Jew the patient is. Many Hasidic Jews (of Ashkenazi descent) speak Yiddish. Yiddish was the primary language spoken by many European Jewish immigrants to the United States and is a Judeo-German dialect. Some Yiddish terms have become a part of American English (some examples are schmuck for fool and nosh for snack).

The Persian Jewish community (mainly centered in Los Angeles and Beverly Hills, California, and eastern parts of New York including Great Neck, Long Island) speak Persian during religious services, in the home, and even publish Persian language newspapers.

Russian Jews may speak Russian, often as the primary language in the home. American Bukhori Jews speak Bukhori (a Persian dialect) as well as Russian.

Although Modern Hebrew is primarily spoken today, Classical Hebrew is the language of Jewish religious literature including the Tanakh (Bible) and Siddur (prayer book).

There is also a contingent of Hispanic Jews who descended from immigrants from Latin America who speak Spanish in the home.

### **Impact of Time, Space, and Touch**

Jewish Americans have a time orientation that encompasses the past, the present, and the future all at once. Although the emphasis is on living for today and plan for and worry about tomorrow, they cannot escape the past for fear that if the past, and that includes the Holocaust, is forgotten, it can be repeated. This unique time orientation focus is a dominant part of the culture.

Modesty and humility are important Jewish values. Modesty is expressed not only by dress but by actions. Jews do not like to call attention to self or appreciate when someone tries to call attention to self or impress others. This is tied to the belief that people are judged by their actions.

Hasidic American males consider women to be seductive and may not look directly upon a female's face or talk with them. Touching of the female is also an issue. They may even keep their hands in their pockets to avoid touching a female as they are not permitted to touch a woman who is not their wife. The female nurse should not offer her hand in greeting to the male Hasidic Jew and if it is done the nurse should not consider the patient rude if the patient refuses to accept the offered hand. Non-Hasidic Jews may be more informal maintaining a shorter spatial distance during communication and may use touch.

### **Impact of Social Organization**

The family is the heart and soul of Jewish society with an emphasis placed on making sure all family members' needs are met and respected. Today, because of assimilation, there is little difference in gender roles between Jewish American and other White American families as both parents share the home and family responsibilities. Parents are honored and that means the adult children will care for them in old age. Providing respect to the elderly is essential even if the elderly is senile or acts inappropriately, respect is still essential. Marriage is considered the ideal state since it is stated in the Bible that man should not be alone. Marriage is viewed as being of benefit for procreation but also for procreation. Sexuality is deemed an important part of marriage and

nonprocreative sexual intercourse is acceptable but only in marriage. Premarital sexual activity goes against Jewish values.

### **Biologic Variations**

The skin complexion associated with a Jewish American is dependent on the type of Jew they have descended from. Ashkenazi Jews have the same skin coloring as other White Americans. Darker complexioned Jews, similar to people from the Mediterranean areas, are Sephardic Jews. There are also Jews from throughout Africa whose pigmentation of skin is considered black.

Just as skin color is dependent on the type of Jew the patient is, so are the biologic variations the nurse should consider or assess for. Most genetic conditions are seen in descendants of immigrants from Eastern Europe (Ashkenazi Jews). The majority of genetic conditions result from autosomal-recessive disorders (the gene is carried by both parents) and as such most of the resulting genetic conditions result in death in infancy or early childhood. These genetic disorders include Tay-Sachs disease, Bloom's syndrome, cystic fibrosis, familial dysautonomia, and Gauchers disease (Fares et al., 2008). Unlike with Tay-Sachs disease, there is no simple biochemical or enzymatic test to detect for carriers of these autosomal recessive disorders (Vallance & Ford, 2003). Tay-Sachs disease, arguably the most widely known of these disorders, results in progressive neurologic degeneration and has a carrier frequency of around 1 in 25 or 30 people of Ashkenazi Jewish origin, which is a likelihood 10 times higher than is found in other groups.

There are a few adult disorders associated with Jews of Ashkenazi descent. Kaposi's sarcoma is most commonly seen in these males who are over 50 years of age. The nurse should expect the manifestation to be malignant tumors of the endothelium that are slow-growing and confined to the skin, and the condition should not be confused with the Kaposi tumors seen in patients with acquired immunodeficiency syndrome (AIDS). The tumors in AIDS patients are much more aggressive, and they also affect internal organs as well as the skin. In one study by Engels, Clark, Aledort, Goedert, and Whitby (2002), it was found that the Kaposi sarcoma herpes virus seroprevalence rate (this virus is the Kaposi sarcoma agent) in elderly US Jews was 8.8% (which is similar to other studies rates which ranged between 5–10%).

An important nursing implication is the higher incidence of a serious adverse drug reaction in persons of Ashkenazi descent with the use of clozapine (an antipsychotic drug especially used to treat schizophrenia). In the general population, the side effect rate for agranulocytosis is about 1%, but in this Jewish population the incidence significantly increases up to 20% (Lieberman, 1990). A genetic reason has been identified to account for this difference. The nurse should remind the



provider that adequate laboratory testing is provided for the Jewish patient on clozapine to monitor for agranulocytosis.

### **Impact of Faith and Spirituality**

Judaism is one of the world's oldest religions dating back more than 3000 years. It is a monotheistic faith (the belief in one God as the Creator of the Universe). The history and the laws of Judaism are chronicled and described in the Old Testament of the Bible. The first five books of the Bible are handwritten in the Hebrew language on scrolls made of parchment. This is called the Torah. The Torah is kept in a "Holy Ark: under an eternal light within each synagogue" (Project Genesis, Inc). These are the Jewish laws, and they guide the Jews on every aspect of how they should live their lives. The spiritual leader is the Rabbi (which literally translates to teacher in English), and the Rabbi serves as the interpreter of Jewish law. It is not believed that a Rabbi is any closer to God than any other Jew, and a Jew can pray directly to God. Unlike in other religions, including different types of Christianity, the spiritual leader is not needed to intercede on the person's behalf with God, does not grant atonement, and do not hear confession. The Sabbath is the holiest day, and it begins 18 minutes before sunset on Friday and ends 42 minutes after sunset or when three stars can be seen on Saturday evening. If at all possible, elective or nonemergent procedures should not be performed on the Sabbath but the nurse should be aware that illness is considered a valid reason to keep the Jew from the synagogue on the Sabbath.

Although there is only one Jewish religion, the religion has three main branches: Orthodox (most traditional), Conservative (less strict as the branch make concessions to modern life), and Reform (considered a liberal or progressive denomination). According to a 1990 nationwide survey, 7% of American Jews consider themselves Orthodox Jews and 42% reform Jews (Anonymous). There are also multiple smaller groups of ultra-Orthodox Jews—one of the most widely known of these are the Hasidic Jews as they wear full beards, dark clothing, and fully covered extremities. A newer denomination of Judaism is the Reconstructionists which is an amalgamation of the three main branches, and views the Jewish religion in evolution as its followers seek to adapt to and reside in a more modern world than is described in the Old Testament or the Torah.

The nurse should be careful not to assume that a deep faith or even a belief in God exists in all patients. This is also true of the Jewish American patient. Jewish religious practice is quite varied ranging from the highly devout to the atheist. It appears that American Jews are more likely to be atheist or agnostic than most Americans, especially so compared with Protestants or Catholics. A 2003 Harris poll found that while

79% of Americans believe in God, only 48% of American Jews do, compared with 79% and 90% for Catholics and Protestants, respectively. While 66% of Americans said they were “absolutely certain” of God’s existence, 24% of American Jews said the same. And though 9% of Americans believe there is no God (8% Catholic and 4% Protestant), 19% of American Jews believe God does not exist (Harris Poll, 2003).

Traditional Judaism believes in an afterlife in which the soul continues to thrive. In the afterlife, things that were not understood in life will become known and clear. Although not much thought is given to life after death on a daily or even regular basis, it is believed that the righteous will be rewarded with a place in the afterlife.

The nurse needs to be aware that for an actively religious Jew, the provision of active euthanasia is forbidden. Active euthanasia is considered murder, which is in direct violation with one of the Ten Commandments. Even a dying patient with a terminal prognosis is considered a living being and, as such, active euthanasia (when something is given or done to cause or have the result of death) is not permitted. Suicide is also not permitted. Suicide is so frowned upon that it is considered both a criminal act and a moral violation. It is believed that the act of suicide prevents any repentance. In cases of adult suicide, full burial rights are not provided (unless the patient is deemed mentally incompetent) as the person will be buried in the outer perimeters of the Jewish cemetery and mourning will not be conducted. Children are the exception, as suicide in the case of children is never viewed as a voluntary act.

Passive euthanasia is a grayer area as it may be permitted depending on the situation and interpretation of that situation. Anything that artificially prevents death (i.e., cardiopulmonary resuscitation, mechanical ventilation) may possibly be withheld depending on the patient and family’s wishes, as well as their specific and individual religious views. The nurse should consider this information fully prior to initiating any do not resuscitate discussions with the patient and or his family.

## Russian Americans

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### Historical Background

The former Soviet Union was made up of 15 republics, of which Russia is the largest. Russia is also referred to as The Russian Federation. Russia is the largest country in the world as it extends to both the continents of Europe and Asia and is approximately two times the size of the United States. There are Russian-born nonethnic Russians living inside and outside of Russia, over 100 nationalities in total from Russia, and it is important to distinguish their separate identities. By

far, the largest number are Russian at approximately 81.5% (Central Intelligence Agency, 2009).

There is a huge unemployment problem as well as extensive poverty in Russia. Forty percent of the population of Russia falls below the poverty line. Both of these financial issues have resulted in life today in Russia being very difficult, and crime is on the rise. Health indicators in the country are very poor. Low birthrates and high death rates have contributed to a population decline of more than 500,000 people annually. Life expectancy is significantly less for males—it is believed that men die much sooner than women because of cardiovascular disease, accidents, alcoholism, and suicide (Aslund, 2001). As of 2001, life expectancy at birth for Russians is 57.4 years for men and 72.8 years for women (Central Intelligence Agency, 2001). Infectious disease also has resulted in a public health crisis. The rate of tuberculosis (TB) is astronomical, killing more than 100,000 people in just a few years, while 2 million more Russians have been exposed to TB. Human immunodeficiency virus (HIV) is also believed to be a growing problem, but the extent of the problem is not as well-known as the TB issue. Access to effective treatments, including pharmaceuticals, also makes treatment difficult. Since the financial collapse of Russia in 1998, there are only a few pharmaceutical companies left. The Russian healthcare system is publicly supported but has problems with inefficiency, corruption, and very low salaries for both physicians and nurses.

All of these factors have spurred the desire to emigrate from Russia to come to the United States. A significant increase in immigration rates have been noted recently in response to these factors but immigration to the United States has been ongoing since 1917; this coincides with the end of the Russian Revolution.

The first Russian immigrants were very intelligent and educated and left Russia after the Russian Revolution. Conflict spurred the second wave of immigration, which occurred at the end of World War II. Anti-Semitism after World War II became a significant issue and many Russian Jews who were well-educated entered the United States as refugees. Immigration restrictions limiting US immigration based on family presence has resulted in new Russian immigrants being related to earlier Russian immigrants. This has resulted in a close-knit circle grouping of Russian Americans.

During the waning years of the Soviet Union, the United States encouraged free immigration among Soviet Jews. As a direct result of a 1973 law, a large wave of Soviet Jews arrived in the United States—66,480 people in one 5-year period between 1975 and 1980. Policy in the Soviet Union during these waves of immigration was quite strict. If one family member wanted to leave (and this was usually the younger ones), the entire family also had to leave. This means that there are a significant number of Russian Americans who did not wish

to immigrate and leave their homeland. The amount of time required for immigration has decreased over time. It is not uncommon to find an older immigrant who arrived in the 1980s sharing they experienced a 10-year wait to be able to immigrate while today the wait is often closer to only 1 year in length. This has caused some frustration and bitterness between newer and older immigrants. Toward the end of the Soviet Union, the numbers of immigrants from Russia to the United States dramatically increased. In the final year of the Soviet Union, that country was number one in providing immigrants to the United States.

Another factor impacting immigration is the rise in international adoption rates. There are a growing number of Russian children who have been adopted by citizens of the United States; in fact, the number is so significant that Russia has become the number one source for adopted foreign children in the United States.

The nurse should recognize you may be called upon to care for Russian Americans of all ages—the very young who may be newly adopted, and the elderly who may be here reluctantly. More than half of the arriving Russian immigrants are over age 50 years old, which may impact assimilation. It is important to consider the reasons for immigration or presence in the United States when planning for nursing care delivery. You may encounter Russian immigrants (someone who wishes to live in another country) or Russian American Jews who are refugees. Refugees come to the United States because of declared political problems—in this case, Anti-Semitism and a need for safety. Refugees are entitled to numerous services to assist with the transition that can include financial help, access to training programs, and the granting of permanent resident status.

### **Statistics**

US Census figures show that there are more than 3 million people of Russian ancestry in the country or 1% of the total population in the United States (US Census Bureau, 2007b). Almost a million more (0.3% of the total US population) is of Ukrainian heritage and nearly as many others indicate Slavic origins. All of them could have recognizable ties to history and culture associated with Russian-speaking peoples.

### **Ukraine**

Ukraine is the second largest country in Europe. After the breakup of the Soviet Union, the Ukraine got its independence in 1991. Since this time, the economy has been suffering a crisis in spite of the Ukraine being a highly industrialized country. Agricultural issues, such as inadequate harvests and fuel shortage, have further compounded the economic problems and many are experiencing malnourishment in

the Ukraine. Another complicating factor is the nuclear power plant accident that occurred at Chernobyl in 1986, which caused an explosion and contamination. Approximately 100,000 people were exposed to radiation prior to evacuation. These factors have impacted the desire for many Ukrainians to leave their country of origin and immigrate to other countries, including the United States.

#### *Traditional Health Practices*

Preventive health care is practiced and health screening is seen as the key to good health. The exception to this is that routine mammograms and routine breast examinations are seen as being of little value, as are cholesterol screening tests. In fact, a criticism made by many Russian Americans is the US healthcare system not placing enough emphasis on prevention and instead placing the reliance on pharmaceuticals. Russians instead prefer to utilize alternative therapies such as cupping, massage therapy, and acupressure/acupuncture.

Some Russian immigrants, especially the elderly, like to utilize homeopathic or folk medicines. Amber can be ground into a powder and, when added to hot water, becomes a medicine. Herbs are also utilized in either enema or drink form. Hot steam baths are also utilized as is drinking mineral water.

Health is seen as a goal to strive for and a gift to possess. Illness is seen as a disharmony in the body. Spirituality holds an important place in end of life care. Russians do not believe that a poor prognosis should be given to a terminally ill patient because it will only result in anxiety, lessen hope, and perhaps even hasten death.

In the Ukraine, herbal and folk medicines are used along with Western pharmaceuticals. In rural areas where access is an issue, the use of folk medicines is higher. An example of a commonly used medication is “zelenka” which is a mercurochrome-based green ointment for skin problems. Overall, folk medicines are believed to be less harmful than pharmaceuticals or “chemical medicine” by Ukrainians (Bologova, 1996).

Trust is essential to the doctor–patient or nurse–patient relationship. If the Ukrainian American patient does not trust the provider, the treatment plan will not be followed. Ukrainian Americans prefer a one-on-one relationship and value dialogue in health care. There is a general belief that Western physicians rely too much on fancy diagnostics and not enough on history taking. There is also a preference for the Ukrainian view of medical care, which is to reveal the cause of the disease. Ukrainian Americans feel that in the United States, the physician has little concern with the cause of disease and the main focus is on treatment. The nurse should be aware that it is culturally appropriate for a Ukrainian to offer a gift to ensure cooperation. This may result in an uncomfortable situation because in the Ukraine it is

not uncommon for people to offer their district doctor a “bribe” to maintain a good relationship.

Chiropractors are gaining respect within the Ukrainian American population and the use of a chiropractor in certain situations is preferred (Bologova, 1996). Unfortunately, mental problems are considered taboo and the discussion of this does not occur even within the affected family. In the Ukraine, mental illness was considered shameful, and could even be dangerous to the family if it became known that a family member had mental health issues.

The nurse should recognize the prevalence of alternative therapy use in this population. If the use is nonharmful or neutral, the nurse should remain open to usage. The nurse should ask the patient about the use of any alternative healthcare practices as part of the initial data gathering.

### **Impact of Communication**

Because of increased exposure to English-speaking media by most Russians, English is becoming widely used. Some may have even studied English in school; although, in that case, they most probably studied British English and not American English. Some elderly Russian Americans may also speak Yiddish. In the former Soviet Union, the speaking of Yiddish was discouraged and considered to be an antistate activity (Petersen, 2001). The official language of Russia is Russian. Russian is a Slavic language consisting of a 33-character alphabet; approximately one sixth of the world’s population speaks Russian. There are geographic variances associated with the language. Tone, inflection, speed, and pauses as well as nonverbal cues are important when communicating in the Russian language as it denotes the value being placed on the words that are being said. Russian Americans may use an increased voice volume when attempting to have their needs met. The nurse should not feel that the Russian American patient is being rude if even normal conversation appears to be loud and boisterous. The nurse should also consider the distinction about the importance of nonverbal and subtle meanings underscores the importance of using professional interpreters when working with Russian Americans who are not fluent in American English. The use of family members as interpreters is especially problematic with this population. The close-knit community of Russian Americans breeds a high level of familiarity, which can make confidentiality impossible to maintain or ensure.

### ***Impact of Communication for Ukrainian Americans***

The Ukrainian language was different than other Slavic languages, including Russian since the 12th century. The language continued to develop independently until Russia seized the Ukraine at the end of the

17th century. By the beginning of the 19th century, the Russian Czars began to ban the use of the Ukrainian language and, because of this, the language fell into decay. In the western Ukraine, the language was exposed and absorbed influences from Polish, Hungarian, German, and Romanian. Ukrainian was restored as the official language of the Ukraine in 1917.

Most Ukrainian Pentecostals (many of whom are refugees who came to the United States because of religious oppression) speak only Ukrainian, but can often understand Polish and Russian. Ukrainian Jews, on the other hand, are often bilingual and speak both Ukrainian and Russian. A few may also speak or understand Yiddish as well.

### **Impact of Touch, Space, and Time**

Touch is freely shared among close or intimate friends. Affection is readily demonstrated as women will kiss women and men will kiss men. They may also exchange three kisses on each cheek, which appears to be a cultural trait carried over from the Middle East. A handshake is particularly significant and is often viewed as more binding than a signed document.

A consequence of the many years of communist rule in Russia is that many Russian Americans still try to act in a neutral manner—eye contact is avoided, maintaining a flat affect and slouchy posture. Once exposed to a society that values personal freedom, such as the United States, some will be able to loosen up, but others may maintain the stance of neutrality. Great warmth will be expressed in private when dealing with close friends and family and unannounced or unplanned visits are common. The nurse should expect many visitors when caring for a Russian American patient.

The expectation is that the nurse will remain professional and caring at all times. A robotic approach to healthcare delivery will result in the loss of trust. Formality is also expected and the nurse should greet the patient as Mr. or Mrs. followed by the surname. To address a Russian American patient by their first name only is a major faux pas. It is also considered inappropriate to use terms of endearment in place of the patient's formal name (e.g., "honey" or "sweetie") (Smith, 1996). It is considered appropriate for the nurse to enter the patient's personal space within a professional capacity—this space is usually reserved for the spouse and children. It would be wise for the nurse to fully communicate the need to enter the patient's personal space or if any violation of modesty is required in advance.

Russian American patients place a high premium on a nurse being very friendly, warm, and caring and to be there to help the patient and family cope with physical and psychosocial consequences of illness. The nurse can best communicate friendliness by maintaining an open

body posture, smiling frequently, and speaking in a calm, pleasant tone of voice. It has also been noted, interestingly enough, that Russian American patients prefer to be cared for by a nurse from any other cultural group than Russia. It had been reported anecdotally that for some Russian Americans, it is felt they will experience more compassion and their needs will be better met by a non-Russian provider (Lester, 1998).

### **Impact of Social Organization**

Family is an important concept and in America, like in Russia, extended family members often live together and rely on each other to make life easier. If the Russian American has family still in Russia, those family members who are with the patient in the United States become even more significant to them. Within the family structure, the father exerts the greatest influence. The female role is to care for the child or children. Women's liberation is not a part of the traditional Russian family structure. If she is well-educated, her husband may consult her on some decision making. Arguments within the family, when they occur, can be quite loud and dramatic and objects may be thrown.

Social events are often framed around the arts. The arts, such as ballet, theatre, music, and museums, are highly valued in Russian culture. The family often strives to keep the arts alive by exposing the children to this early in life.

The elderly, who were usually cared for in exchange for child care, may be a reminder of the old ways once immigration by the Russian family has occurred. It is not unusual for the elderly Russian immigrant to lose their authority and status within a short time after immigration to the United States (Aroian, Balsam, & Conway, 2000).

Within a few years of immigration to the United States, children become completely assimilated into American culture. Children are very important in Russian culture as they are seen as symbols of innocence and the family's hopes for the future. Children grow up often overprotected and cared for by elderly family members. One child families are very common and extended family members, such as cousins, are treated as substitute siblings. If a child becomes ill, the family will fight vehemently for the child's rights and may request unnecessary diagnostic testing or prolonged hospital stays. Russians may be accustomed to longer lengths of stay than are typical today in the United States as the average in-patient stay in Russia is 3 weeks (Rundle et al., 1999). The nurse should assure the family that the primary concern is the child's welfare, which may ease the worry. In addition, helping both patients and families understand the differences between the Russian and US healthcare systems and how to navigate the US healthcare system is time well spent by the nurse.



### ***Impact of Social Organization on Ukrainian Americans***

Ukrainians often have very large families, and the older family members help to care for the children. Because of limited housing and cost, it is not uncommon to have three generations of a Ukrainian family all living together in a small living space. Pentecostal Ukrainians, by virtue of their refugee status, are able to receive refugee benefits and services from refugee organizations in their new communities.

### **Impact of Faith and Spirituality**

In Russia, as a consequence of communism, the nonreligious may make up the majority of the population. The nonreligious constitutes anywhere between 24%–48% of the population, according to a study by Zuckerman (2005). Russia ranks third on the listing of top 20 Atheist countries in the world (Zuckerman, 2005). Russian Orthodox has a following of 45% of Russians, although the vast majorities are not churchgoers. In a poll conducted in 2007 by the Russian Public Opinion Research Center, about 75% of Russia's people affirm the Orthodox faith, and only 10% are regular churchgoers. In a post-Soviet Union Russia, Orthodoxy has become the national faith. It is difficult to gauge the actual number of followers because many Russians, although they may never attend church services, identify and consider themselves Russian Orthodox. The Central Intelligence Agency (2006) estimated the number of practicing worshippers of Orthodoxy in Russia as being between 15% and 20%, with Muslims making up 10–15%, and other Christians making up 2%. The Central Intelligence Agency states that post-Soviet rule Russia was left with a large population of nonpracticing believers and nonbelievers. The remaining Russians are made up of Tatars (an Islamic religion) and Jews. Despite these varying statistics, there can be no doubt that the fall of communism has brought a resurgence of the Christian religion in Russia.

### ***Impact of Faith and Spirituality on Ukrainian Americans***

The largest religion in the Ukraine, just as in Russia, is Eastern Orthodox, a branch of Christianity. Prior to 1990, the Ukrainian Orthodox Church was forced to become a part of the Russian Orthodox Church. After Ukrainian independence, the Ukrainian Orthodox Church was restored. The second largest Christian religion in the Ukraine is the Greek Catholic Church. In the past, Pentecostal and Baptist churches were active in western Ukraine. Persecution resulted when Ukraine was under Russian control, prompting many Pentecostal to become refugees from the former Soviet Union. This is another example of people being forced to leave their homeland for the United States in search of religious freedom. Indeed, the primary reason for leaving the Ukraine is religious oppression (Bologova, 1996). Ukrainian Pentecostals value

hard work and the family, and they have strict rules against drugs and alcohol usage. The rejection of birth control usage, which is supported by the religion, often results in very large families.

### **Biologic Variations**

There is a significant genetic mutation problem in the Russian population. It is felt that because of chronic exposure to environmental toxins from pesticides, cigarette smoking, and even the Chernobyl nuclear power plant accident, the genetic mutation rates are higher with an associated higher risk for health consequences caused by accumulated genetic damage. It has been estimated that the rate of accumulated genetic damage is 250% higher in Russians than Americans (Vadlamani et al., 2001). This genetic damage seems to be implicated in higher colorectal neoplasm rates in this population, which should highlight for the nurse the need for vigilant cancer screenings in this population.

The foods that are preferred in Russian culture have contributed to an obesity problem in this population, especially among elderly women. Many foods are high in fat and salt, which also has resulted in a significant problem with hypertension and coronary heart disease. There has been a trend in decreasing life expectancy in Russia since 1990. It is felt that this decrease is a result of a tremendous increase in coronary heart disease mortality among men, which increased by about 30% in Russia between 1990 and 2000 (Landsbergis & Klumbiene, 2003). Poor diet, excessive alcohol intake, and tobacco usage have been implicated in the high coronary heart disease numbers. Hyperlipidemia and hypercholesterolemia are also problematic in this population since most Russians, although compliant with most health screening; do not see the value or accuracy of cholesterol screening tests. Cholesterol levels among Russian Americans are generally well above normal limits (Mehler et al., 2001).

TB also has higher rates in this population. The reasons for this are many and include problems with the Russian healthcare system, significant number of HIV/AIDS patients, increased prison population, as well as indifference. The nurse should consider TB in this population and provide for infection control practices as needed.

Although alcoholism and excessive alcohol usage is a tremendous public health issue in Russia, the incidence of alcohol abuse in Russian immigrants to the United States is very low. The nurse should not assume that the Russian American will have an alcohol issue. Russian alcoholics have lost hope and would not be motivated to emigrate from Russia in search of a new life. Immigrants from Russia to the United States, on the other hand, are extremely motivated in changing their lives for the better and want to survive here in America. Those immigrants who are religious also will be unlikely to drink alcohol because of the religious sanctions against its use/abuse among Jewish and Pentecostal affiliates.

## Summary

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As we have seen the White non-Hispanic population is extremely diverse and is unified by a similarity of skin pigmentation. The White population has diverse and multiple places of origin within Europe. Since presently, the majority of the American population is considered White non-Hispanic, it is important to also understand the differences among various these ethnic groups. An overview of the historical background, statistics, traditional health beliefs, and barriers to care were presented. As with all patients, it is important to question the patient to determine what their health and illness beliefs are so that a culturally competent plan of care can be developed that incorporates the similarities and the differences between all human beings.

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