Chapter 3

Leininger's Enablers for Use with the Ethnonursing Research Method

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> *Both the theory and method are creative contributions to nursing and society which took several years to perfect and systematically examine. Discovering what is universal and diverse remains most timely in nursing as nursing becomes a truly global profession and discipline with substantive transcultural research knowledge to guide teachers and practitioners of nursing. By the year 2020 I have predicted that nursing must become a transcultural discipline and profession. When this occurs, the pioneering work I have begun with the theory and ethnonursing method will be more fully recognized and used worldwide.*
>
> (Leininger, 1997, p. 51)*

INTRODUCTION: ETHNONURSING RESEARCH ENABLERS TO DISCOVER HUMAN CARE AND RELATED NURSING PHENOMENA

Over the course of several decades, Leininger developed and refined the Theory of Culture Care Diversity and Universality (also known as *culture care theory*) and the ethnonursing research method with the goal of using

*Leininger, M. M., *Journal of Transcultural Nursing 8*(2), pp.32–52, copyright 1997 by Sage Publications. Reprinted by Permission of SAGE Publications.

qualitative culture care research findings to provide specific and/or general care that would be culturally congruent, safe, and beneficial to people of diverse or similar cultures for their health, wellbeing, and healing, and to help people face disabilities and death (Leininger, 1963, 1991a, 1991b, 1994a, 1995, 2006a). Leininger (2006b) held that in accordance with any given method, the methodologist develops not only the major features of the method, but also techniques, strategies, and ways that can be used with the method to attain envisioned purposes. She maintained that it is the methodological features with specific techniques and guides that differentiate one research method from another (Leininger, 2006b). In the late 1950s and before conducting her first ethnonursing and ethnographic study with the Gadsup Akuna and Arona of the Highlands of New Guinea, Leininger conceived the idea of *enablers* as ways to explicate, probe, or discover in-depth phenomena that seemed as complex, elusive, and ambiguous as human care. She disliked use of the terms *tool* or *instrument* as she felt that they were too impersonal, mechanistic, and more fitting with objectification, experimentation, and other methods and logical features of the quantitative paradigm. Her vision of enablers and friendly researchers communicated a participatory and cooperative way to obtain ideas that were often difficult to know without the researcher gently probing informants who were willing to share their cultural secrets. Leininger viewed the use of enablers as congruent with the qualitative paradigm and as a means to explicate cultural care.

The research enablers, as part of the ethnonursing method, have been extremely valuable for teasing out hidden and complex data. The enablers, as the name implies, facilitate the discovery of informants' ideas and stories in natural and unstructured ways. With the ethnonursing method, the researcher is expected to adapt the enablers to fit the domain of inquiry (or area) about culture and care to be studied. The enablers are facilitators, and not models per se. They are also not tools or scales, but are ways to examine the major tenets of the theory and the domain of inquiry (DOI). The most commonly used of Leininger's enablers are:

- Sunrise Enabler
- Stranger-to-Trusted-Friend Enabler
- Observation-Participation-Reflection Enabler
- Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health
- Leininger's Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways

- Leininger's Phases of Ethnonursing Data Analysis Enabler for Qualitative Data
- Leininger-Templin-Thompson (LTT) Ethnoscript Coding Enabler
- Life History Healthcare Enabler

Enablers do not neglect professional or *etic* medical knowledge about human beings in illness and health such as biophysical, social, and nursing or medical factors, but focus mainly on total lifeways and care or caring factors influencing health and/or wellbeing, disabilities, and death. Traditional *emic* medical and nursing knowledge exist but are often lodged in social structure, ethnohistory, and environmental factors. These emic sources of knowledge (limitedly discovered in the past) are now providing very rich and new insights about people in their familiar and general cultural holistic contexts with specific cultural needs (Leininger, 2006a).

Although Leininger developed several unique enablers over the past 6 decades, the authors present in this chapter only those of major importance that are frequently used by ethnonurse-researchers to study comparative culture care. The ethnonursing research studies that follow this chapter have used some of these common enablers, and some researchers have developed their own specific enablers for a particular focus of their study.

MAJOR ENABLERS TO FACILITATE ETHNONURSING RESEARCH DISCOVERY

The Sunrise Enabler

The Sunrise Enabler (**Figure 3-1**), also known as Leininger's Sunrise Enabler to Discover Culture Care, has been widely used and valued to expand nurses' views and culture care discoveries. Originally developed as a model, and later refined into an enabler, the Sunrise Enabler is not the theory per se, but depicts multiple factors predicted to influence culture care expressions and their meanings (Leininger, 1988, 1991a, 1991b, 1994b, 1995, 1997, 2002, 2006a). It serves as a *cognitive map* to discover embedded and multiple factors related to the theory, tenets, and assumptions with the specific domain of inquiry under study. It is a visual diagram that reminds the researcher to search broadly for diverse factors influencing care within any culture under study and is used as a major guide throughout the study to explore comprehensive and multiple influences on care and culture.

The Sunrise Enabler assists the researcher in identifying factors that could potentially influence human care phenomena including but not limited to technology; religion and philosophy; kinship; cultural values, beliefs,

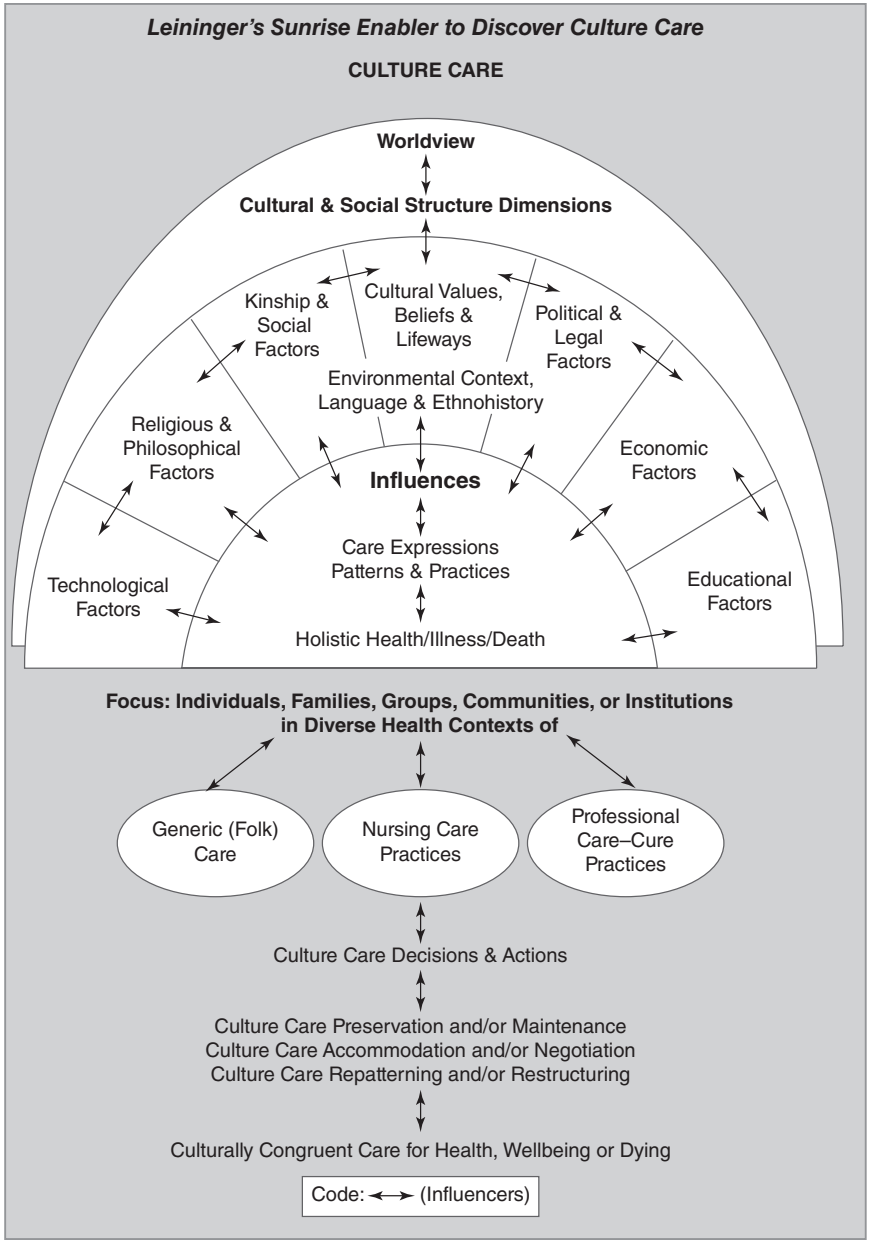

Figure 3-1 Leininger's Sunrise Enabler to Discover Culture Care
Modified with permission from © M. Leininger 2004, by M.R. McFarland and Wehbe-Alamah

and lifeways; politics; economy; and education. Leininger (2002) held that with the Sunrise Enabler to be:

> . . . a true holistic and comprehensive picture can be discovered to reflect the totality of knowing people in their lifeworld or culture. . . Researchers . . . discover hidden, obvious, and unexpected factors influencing care meanings, patterns, symbols, and practices in different cultures. *Let the sun shine and rise* figuratively means to have nurses open their minds to informants to discover many different factors influencing care in their culture with their meanings, and the ways they influence the health and wellbeing of people. (p. 81)

Dr. Leininger's vision encompassed the accessibility and sharing not only of her theory and method but also the enablers. Her only requirement was that researchers, authors, and students cite the full title of each enabler, giving full credit to Dr. Leininger and crediting the source from which each enabler was obtained (Leininger, 2006a, p. 65).

The Stranger-to-Trusted-Friend Enabler

This enabler may be seen in the literature in the following abbreviated form: Stranger–Friend Enabler. This was one of the first enablers developed by Leininger before conducting her ethnonursing and ethnography field study in the Eastern Highlands of New Guinea in the early 1960s (Leininger, 1985a). She further refined this enabler as she studied both Western and non-Western cultures around the globe. Leininger maintained that although some aspects of the enabler were stimulated from reading Berreman's (1962) paper *Behind Many Masks*, it was reconceptualized with new practical indicators to help researchers move from a stranger to friend role when studying people to discover nursing phenomena.

The purpose of the Stranger–Friend Enabler (**Figure 3-2**) is to serve as an assessment or reflection guide for the researcher to become consciously aware of one's own behaviors, feelings, and responses as one moves with informants and works to collect data for confirmation of cultural "truths" (Leininger, 1985a). Each of the indicators or characteristics for the stranger or friend is used and studied over time to identify patterned behaviors and expectations of people-centered studies. These discovered truths have been established as credible and reliable indicators with multiple cultures over many years (Leininger, 1985a, 1985c, 2006b). In using the enabler, the goal is to move from stranger to friend in order to help ensure a credible, meaningful, and accurate study. The enabler can be used by the researcher in hospital settings, community contexts, and many other places where

The purpose of this enabler is to facilitate the researcher (or it can be used by a clinician) to move from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable data (or establish favorable relationships as a clinician); The user assesses him or herself by reflecting on the indicators as he/she moves from stranger to friend.

Indicators of Stranger (Largely *etic* or outsider's views) Informant(s) or people are:	Date Noted	Indicators as a Trusted Friend (Largely *emic* or insider's views) Informant(s) or people are:	Date Noted
1. Active to protect self and others. They are "gatekeepers" and guard against outside intrusions. Suspicious and questioning.		1. Less active to protect self. More trusting of researchers (their 'gatekeeping is down or less'). Less suspicious and less questioning of researcher.	
2. Actively watch and are attentive to what researcher does and says. Limited signs of trusting the researcher or stranger.		2. Less watching the researcher's words and actions. More signs of trusting and accepting a new friend.	
3. Skeptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger.		3. Less questioning of the researcher's motives, work, and behavior. Signs of working with and helping the researcher as a friend.	
4. Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values and beliefs. Dislikes probing by the researcher or stranger.		4. Willing to share cultural secrets and private world information and experiences. Offers most local views, values, and interpretations spontaneously or without probes.	
5. Uncomfortable to become a friend or to confide in stranger. May come late, be absent, and withdraw at times from researcher.		5. Signs of being comfortable and enjoying friends and a sharing relationship. Gives presence, on time, and gives evidence of being a 'genuine friend.'	
6. Tends to offer inaccurate data. Modifies 'truths' to protect self, family, community, and cultural lifeways. *Emic* values, beliefs, and practices are not shared spontaneously.		6. Wants research 'truths' to be accurate regarding beliefs, people, values, and lifeways. Explains and interprets *emic* ideas so researcher has accurate data.	

*Developed and used since 1959: Leininger.

Figure 3-2 Leininger's Stranger-to-Trusted-Friend Enabler

nurses study nursing phenomena but requires consistent use from the beginning of the research until its completion (Leininger, 1991a, 1991b; Leininger & McFarland, 2002). Leininger (2006b) viewed this enabler as a powerful means for self-disclosure, self-reflection, and assessment and a means for providing high reliability and confirmability with informants as the researcher carefully moves from a stranger role to becoming a trusted research friend.

The enabler was designed with the philosophical belief that the researcher should always assess and gauge the relationships with the people being studied in order to enter or get close to the people or situation under study. It was anticipated that the researcher needed to move from a stranger or distrusted person to a trusted and friendly person during the ethnonursing research process to obtain truthful, sensitive, meaningful, and credible data. Leininger held that researchers usually viewed by informants as etic strangers (outsiders) needed to be trusted before they would be able to obtain any accurate, reliable, or credible data. Initially, most cultures or informants find the researcher to be an outsider or a distrusted stranger until proven otherwise and someone to watch in regard to actions, motives, and behaviors. During the time that researcher remains a distrusted stranger, the people are generally quite reluctant to share their ideas with the researcher; therefore, research data are often superficial, inaccurate, and incomplete (Leininger, 1970, 1978, 1985c). Informants often want to protect themselves, their people, and their ideas until they get to know and trust the researcher(s). The pattern of moving from stranger to trusted friend can be identified in all research studies that have been published over the past six decades (Leininger, 1970, 1978, 1985a, 1985c, 2006b).

The Stranger–Friend Enabler also serves to gauge the researcher's progress, with some researchers remaining in the distrusted role longer than others. The enabler assists the researcher in becoming reflective of and honest about one's own behavior as he/she moves from a stranger to a trusted friend. Becoming aware of self-behavior as a researcher as well as observing those being studied is a major task for the researcher while actively participating with the people. If one remains a stranger to informants, mistrust prevails, and limited personal, intimate, reliable, and accurate details and data are shared by informants (Leininger, 2002a, 2006b).

The Stranger–Friend Enabler is a valuable means for mentoring transcultural nursing students as they perfect their transcultural nursing clinical skills. It is also especially useful as nurses study nurse–client, nurse–group, and nurse–family relationships in the hospital or home. Researchers using this enabler learn to appraise the progress in the study by remaining sensitive to verbal feedback or responses from the people. This enabler is

essential to all people-centered investigations, and can be used by many non-nurse researchers involved in humanistic qualitative studies to facilitate the research process, get close to people, and obtain accurate data in a sensitive and skilled manner within different life contexts.

The Observation-Participation-Reflection Enabler

The Observation-Participation-Reflection (OPR) Enabler (**Figure 3-3**) guides the researcher to obtain focused observations of the informants in their familiar and natural living or working environments. Leininger developed this enabler in the early 1960s, and refined and used it for six decades along with many graduate students (Leininger, 1978, 1985a, 1990, 2006a, 2006b). The OPR Enabler was partially derived from the traditional participant-observation approach used in anthropology, but was modified in several ways with the added focus on reflections to fit the philosophy, purposes, and goals of the ethnonursing method. The enabler is different from the conventional anthropological participant-observation approach in that the process was reversed. With the OPR Enabler, the researcher is expected to devote a period of time making observations before becoming an active participant. This *resequenced role* serves the important function of allowing the nurse-researcher to become fully cognizant of the situation or context before becoming a full participant or *doer*. In addition, the reflection phase was added to obtain important and essential confirmatory data from the people being studied. Reflection occurs throughout the research process, but especially during the last phase of research. The four phases in the OPR Enabler were especially conceptualized and developed to fit with the people-centered nursing ways in which professional nurses are expected to work throughout their daily client encounters or experiences.

Users find that the enabler provides a most helpful and systematic way to enter into, remain with, and conclude an ethnonursing study with individuals, groups, communities, and cultures related to human caring and nursing. This enabler helps the researcher get close to the people, study

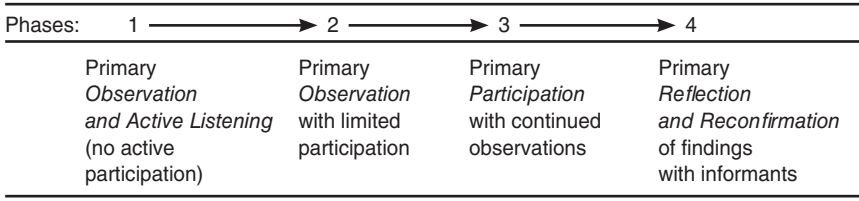

Figure 3-3 Leininger's Observation-Participation-Reflection Enabler

their total context, and obtain accurate data from them. The most difficult phase for most nurse-researchers is the first phase of observation, because most nurses find it difficult to remain in a focused observer role before becoming a participant. Nurses who are active doers and who have not learned to do sustained observing before acting find that this enabler helps them learn about the importance of observing for a period of time before becoming an active participant.

The researcher gradually moves from the observation to participation phase and still later to full reflection and confirmation of data obtained from informants. The researcher continually confirms findings during and after each observation period with informants. These sequenced phases help ensure sound data collection to obtain a full and accurate database from informants. Each phase is essential and builds upon the preceding phase. It is important not to move into the participation phase until the researcher is trusted by and sensitive to the informants. The extensive observations in the first phase help the researcher to later become a trusted participant with informants and provide confidence for data collection in subsequent phases. This enabler can facilitate highly reliable client care cultural assessments. Throughout the research study this enabler becomes a valuable guide for obtaining detailed and systematic observations with informants. The observations are essential as the basis for sound and accurate reflections in the last phase. Reflections are done with the informants to verify the accuracy of their views or the information obtained, and especially to confirm what was observed, as well as to help to identify any gaps and research biases related to the domain of inquiry.

Reflection is an integral part of the ethnonursing method. Reflection on the phenomena observed or ideas heard helps the nurse to focus on all contextual aspects of the research before proclaiming or interpreting an idea or experience. At the conclusion of the study, the researcher reflects back on all findings to recheck and confirm them, primarily with key informants. Reflection on small and large segments of the data is essential at every phase of the research process as it helps one to study meanings-in-context and other aspects of the data. The OPR phases are a critical and important feature of the ethnonursing research method to ensure accurate and systematic observations and interpretations of findings.

Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health

Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health (**Figure 3-4**) was previously known as Leininger's Suggested

Instructions: The purpose of this ethnonursing guide is to enter the world of the client and discover information to provide holistic, culture-specific care. Use broad and open inquiry modes rather than direct confrontational questions. Move with the client (or informant) to make the inquiry natural and familiar. These inquiry areas are examples for the inquiry and not exhaustive. Identify at the outset if assessing an individual, family, group, institution or community. (This inquiry guide focuses on the individual). Identify yourself and the purpose of the inquiry to the client, i.e., to learn from the client about his/her lifeway to provide nursing care that will be helpful or meaningful.

Domains of Inquiry: Suggested Inquiry Modes

1. Worldview	I would like to know how you see the world around you. Could you share with me your views of how you see things are for you?
2. Ethnohistory	In nursing we can benefit from learning about the client's cultural heritage, (e.g., Korean, Philippine, etc). Could you tell me something about your cultural background? Where were you born and where have you been living in the recent past? Tell me about your parents and their origins. Have you and your parents lived in different geographic or environmental places? If so, tell me about your relocations and any special life events or experiences you recall that could be helpful to understand you and your needs. What languages do you speak? How would you like to be referred to by friends or strangers?
3. Kinship and Social Factors	I would like to hear about your family and/or close social friends and what they mean to you. How have your kin (relatives) or social friends influenced your life and especially your caring or healthy lifeways? Who are the caring or non-caring persons in your life? How has your family (or group) helped you to stay well or become ill? Do you view your family as a caring family? If not, what would make them more caring? Are there key family responsibilities to care for you or others when ill or well? (Explain) In what ways would you like family members (or social friends) to care for you? How would you like nurses to care for you?
4. Cultural Values, Beliefs, and Lifeways	In providing nursing care, your cultural values, beliefs, and lifeways are important for nurses to understand. Could you share with me what values and beliefs you would like nurses to know to help you regain or maintain your health? What specific beliefs or practices do you find most important for others to know to care for you? Give me some examples of "good caring" ways based on your care values and beliefs.

Figure 3-4 Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health

Source: Leininger, M. M. (2002). Culture Care Assessments for Congruent Competency Practices. In M. M. Leininger, & M. R. McFarland (Eds.), *Transcultural nursing: Concepts, theories, research, & practices* (3rd ed., pp. 117–143). New York: McGraw-Hill Companies, Inc.

5. Religious/ Spiritual/ Philosophical Factors	When people become ill or anticipate problems, they often pray or use their religion or spiritual beliefs. In nursing we like to learn about how your religion has helped you in the past and can help you today. How do you think your beliefs and practices have helped you to care for yourself or others in keeping well or to regain health? How does religion help you heal or to face crisis, disabilities or even death? In what ways can religious healers and nurses care for you, your family or friends? What spiritual factors do we need to incorporate into your care?
6. Technological Factors	In your daily life are you greatly dependent upon "high-tech" modern appliances or equipment? What about in the hospital to examine or care for you? (Explain) In what ways do you think technological factors help or hinder keeping you well? Do you consider yourself dependent upon modern technologies to remain healthy or get access to care? (Give some example)
7. Economic Factors	Today, one often hears "money means health or survival." What do you think of that statement? In what ways do you believe money influences your health and access to care or to obtain professional services? Do you find money is necessary to keep you well? If not, explain. How do you see the cost of hospital care versus home care cost practices? Optional: Who are the wage earners in your family? Do they earn enough to keep you well or help you if sick?
8. Political and Legal Factors	Our world seems full of ideas about politics and political actions that can influence your health. What are some of your views about politics and how you and others maintain your well-being? In your community or home what political or legal problems tend to influence your wellbeing or handicap your lifeways in being cared for by yourself or others? (Explain)
9. Educational Factors	I would like to hear in what ways you believe education contributes to your staying well or becoming ill. What educational information, values or practices do you believe are important for nurses or others to care for you? Give examples. How has your education influenced you to stay well or become ill? How far did you go with formal education? Do you value education and health instruction? (Explain)
10. Language and Communication Factors	Communicating with and understanding clients is important to meet care needs. How would you like to communicate your needs to nurses? What language(s) do you speak or understand? What barriers in language or communication influence receiving care or help from others. What verbal or nonverbal problems have you seen or experienced that influences caring patterns between you and the nursing staff? In what ways would you like people to communicate with you and why? Have you experienced any prejudice or racial problems through communication that nurses need to understand? What else would you like to tell me that would lead to good or effective communication practices with you?

(*continues*)

11. Professional and Generic (folk or lay) Care Beliefs and Practices	What professional nursing care practices or attitudes do you believe have been or would be most helpful to your wellbeing within the hospital or at home? What home remedies, care practices or treatments do you value or expect from a cultural viewpoint? I would like to learn about your home healers or special healers in your community and how they help you. What does health, illness or wellness mean to you and your family or culture? What professional and/or folk practices make sense to you or are most helpful? Could you give some examples of healing or caring practices that come from your cultural group? What folk or professional practices and food preferences have contributed to your wellness? What foods are taboo or prohibited in your life or in your culture? In what ways have your past or current experiences in the hospital influenced your recovery or health? What other ideas should I know about what makes you well through good caring practices?
12. General and Specific Nursing Care Factors	In what ways would you like to be cared for in the hospital or home by nurses? What is the meaning of care to you or your culture? What do you see as the link between good nursing care and regaining or maintaining your health? Tell me about some of the barriers or facilitators to good nursing care. What values, beliefs or practices influence the ways you want nursing care? What stresses in the hospital or home need to be considered in your recovery or in staying well? What else would you like to tell me about ways to care for you? What community resources have helped you get well and stay well? Give some examples of non helpful care nursing practices. What environmental or home community factors should nurses be especially aware of to give care to you and your family? What cultural illnesses tend to occur in your culture? How do you manage pain and stress? (Clarify) What else would you like to tell me so that you can receive what you believe is good nursing care? Give specific and general examples.

Figure 3-4 Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health (*continued*)

Inquiry Guide for Use with the Sunrise Model to Assess Culture Care and Health. This enabler was developed by Leininger to assist researchers to enter the world of informants, hear their stories, and make holistic and culture-specific discoveries. This enabler correlates closely with the culture care theory (CCT) and includes the following 12 domains of inquiry derived from the Sunrise Enabler: Worldview; ethnohistory; kinship and social factors; cultural values, beliefs, and lifeways; religious/spiritual/philosophical factors; technological factors; economic factors; political and legal factors; educational factors; language and communication factors; professional

and generic (folk or lay) care beliefs and practices; and general and specific nursing care factors (Leininger, 2002a, pp. 137–139).

When using this enabler, researchers develop several open-ended questions for each DOI using an adaptation of the questions suggested in this enabler. Using semi-structured open-ended questions generally elicits more information than closed-ended inquiries during interviews and cultural assessments. Such questions are flexible rather than rigid in content, order, and method of questioning. This type of question allows researchers to remain respectful active listeners, learners, and reflectors throughout the entire research process. Researchers can collaborate with informants, use indirect probing techniques that focus on areas of inquiry, and encourage informants to share their personal stories and life experiences. Nurse-researchers who have moved from the stranger to the trusted friend status find this enabler very helpful in tapping informants' cultural secrets and in collecting truthful and credible data (Leininger, 2002a).

Leininger's Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways

The purpose of this enabler (**Figure 3-5**) is to help assess the extent of acculturation of an individual or group with respect to a particular culture or subculture and to identify the extent to which informants are more traditionally or nontraditionally oriented toward their culture (Leininger, 1991a; 1991b, pp. 98–103; 2002, p. 92). Leininger's Acculturation Healthcare Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways was developed as part of the ethnonursing research method to identify cultural variability or universality features of individuals or groups of a particular culture along major lines of differentiating cultural experiences (Leininger, 1978, 1991b). Since the early 1960s, this enabler has been used, modified, confirmed, and perfected with many informants and in diverse contexts in that acculturation factors such as social structure, worldview, and human care factors were added.

With this enabler, the researcher can obtain a profile of the extent and areas of acculturation with respect to traditional and nontraditional cultural orientations. Data from this enabler are analyzed and reported in the study findings in different creative ways such as pictorial graphs, bar graphs, narratives, or informant or group profiles. There is provision for written narrative statements to support the cultural assessments in each area. The researcher may want to use percentages or simple numerical data to show the direction or degree of acculturation, which is in keeping with qualitative analysis. The acculturation enabler has shown high credibility, reliability,

Name of Assessor: _____ Date: _____

Informants or Code No.: _____ Sex: _____ Age: _____

Place or Context of Assessment: _____

Directions: This enabler provides a general qualitative profile or assessment of traditional or nontraditional orientation of informants of their patterned lifeways. Health care influencers are assessed with respect to worldview, language, cultural values, kinship, religion, politics, technology, education, environment, and related areas. This profile is primarily focused on *emic* (local) information to assess and guide health personnel in working with individuals and groups. The *etic* (or more universal view) also may be evident. In Part I, the user observes, records, and rates behavior on the scale below from 1 to 5 with respect to traditional or nontraditionally oriented lifeways. Numbers are plotted on the summary Part II to obtain a qualitative profile to guide decisions and actions. The user's brief notations on each criterion should be used to support ratings and reliable profile. This enabler was not designed for quantitative measurements, but rather as a qualitative enabler to explicate data from informants.

Part I: Rating of Criteria to Assess Traditional and Nontraditional Patterned Cultural Lifeways or Orientations

Rating indicators:	Mainly Traditional 1	Moderate 2	Average 3	Moderate 4	Mainly Nontraditional 5	Rater Value No.

Cultural Dimensions to Assess Traditional or Nontraditional Orientations

1. Language, Communication and Gestures (Native or Nonnative). Notations: _____
2. General Environmental Living Context (Symbols, material and nonmaterial signs). Specify: _____
3. Wearing Apparel and Physical Appearance. Notations: _____
4. Technology Being Used in Living Environment. Notations: _____
5. Worldview (How person looks out upon the world). Notations: _____
6. Family Lifeways (Values, beliefs and norms). Notations: _____

Figure 3-5 Leininger's Acculturation Health Care Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways

Rating indicators:	Mainly Traditional 1	Moderate 2	Average 3	Moderate 4	Mainly Nontraditional 5	Rater Value No.

7. General Social Interactions and Kinship Ties. Notations: _____

8. Patterned Daily Activities. Notations: _____

9. Religious (or Spiritual) Beliefs and Values. Notations: _____

10. Economic Factors (Rough cost of living estimates and income). Notations: _____

11. Educational Values or Belief Factors. Notations: _____

12. Political or Legal Influencers. Notations: _____

13. Food Uses and Nutritional Values, Beliefs, and Taboos. Specify: _____

14. *Folk* (Generic or Indigenous) *Health Care* (*-Cure*) Values, Beliefs & Practices. Specify: _____

15. *Professional Health Care* (*-Cure*) Values, Beliefs and Practices. Specify: _____

16. Care Concepts or Patterns that.guide actions, (i.e., concern for, support, presence, etc.): _____

17. Caring Patterns or Expressions: _____

18. Views of Ways to: a) Prevent illnesses: _____
    b) Preserve or maintain wellness or health: _____
    c) Care for self or others: _____

19. Other Indicators to support more traditional or nontraditional lifeways: _____

(*continues*)

Part II: Acculturation Profile from Assessment Factors

Directions: Plot an X with the value numbers rated on this profile to discover the orientation or acculturation gradient of the informant. The clustering of numbers will give information of traditional or nontraditional patterns with respect to the criteria assessed.

Criteria	1 Mainly Traditional	2 Moderate	3 Average	4 Moderate	5 Mainly Nontraditional
1. Language and Communication Modes					
2. Physical Environment					
3. Physical Apparel and Appearance					
4. Technology					
5. World View					
6. Family Lifeways					
7. Social Interaction and Kinship					
8. Daily Lifeways					
9. Religious Orientation					
10. Economic Factors					
11. Educational Factors					
12. Political and Legal Factors					
13. Food Uses					
14. Folk (Generic) Care-Cure					
15. Professional Care-Cure Expressions					
16. Caring Patterns					
17. Curing Patterns					
18. Prevention/ Maintenance Factors					
19. Other Indicators					

Note: The assessor may total numbers to get a summary orientation profile. Use of these ratings with written notations provide a wholistic qualitative profile. More detailed notations are important to substantiate the ratings.

Figure 3-5 Leininger's Acculturation Health Care Assessment Enabler for Cultural Patterns in Traditional and Nontraditional Lifeways (*continued*)

and confirmability as it has been used with many cultures over the past six decades to identify specific characteristics or patterns of a culture bearing on cultural lifeways, worldview, beliefs, values, care practices, and related nursing phenomena. It is one of the few major acculturation enablers available in nursing, anthropology, and the social sciences (Leininger, 2006b).

Leininger's Phases of Ethnonursing Data Analysis Enabler for Qualitative Data

A major concern for qualitative researchers is to find ways to systematically analyze large amounts of field data. To meet this challenge, Leininger developed and refined the Phases of Ethnonursing Data Analysis (**Figure 3-6**) as

Fourth Phase (Last Phase)

Major Themes, Research Findings, Theoretical Formulations, and Recommendations

This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher's task is to abstract and confirm major themes, research findings, recommendations, and sometimes make new theoretical formulations.

Third Phase

Pattern and Contextual Analysis

Data are scrutinized to discover saturation of ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meanings-in-context and along with further credibility and confirmation of findings.

Second Phase

Identification and Categorization of Descriptors and Components

Data are coded and classified as related to the domain or inquiry and sometimes the questions under study. *Emic* or *etic* descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.

First Phase

Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer)

The researcher collects, describes, records, and begins to analyze data related to the purposes, domain of inquiry, or questions under study. This phase includes: Recording interview data from *key* and *general* informants; making observations, and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the DOI or phenomenon under study mainly from an *emic* focus. Attention to *etic* ideas is also recorded. Field data from the condensed and full field journal can be processed directly into the computer and coded, ready for analysis.

Figure 3-6 Leininger's Phases of Ethnonursing Data Analysis Enabler for Qualitative Data

another enabler to facilitate the research process. This enabler was refined during the past 6 decades as a part of the ethnonursing method to provide rigorous, in-depth, and systematic analysis of qualitative ethnonursing research data, especially research findings bearing on the cultural care theory and the ethnonursing research method (Leininger, 1987).

The Phases of Ethnonursing Data Analysis Enabler offers four sequenced phases of analysis. The researcher begins data analysis on the first day of research and continues with regular data coding, processing, and analysis until all data are collected (saturation). The data are continuously processed and reflected on by the researcher during each phase. In Phase I, the researcher collects, records, describes, and begins to analyze detailed raw data related to the purposes, domain of inquiry, or questions under study. Raw data include interviews from key and general informants, researcher's observations, accounts of participatory experiences, descriptions of contextual meanings, preliminary interpretations, identification of symbols, and data recordings related to the DOI or phenomenon under study mainly from an emic focus. In Phase II, the researcher identifies, codes, and categorizes the descriptors, indicators, and raw data collected in Phase I. In Phase III, the researcher identifies the recurrent patterns from the data derived from Phases I and II. In Phase IV, themes of behavior and other summative research findings are abstracted from the data derived from the three previous phases. At all times, research findings from the data analysis can be traced back to each phase and to the raw data in Phase I (Leininger, 1987). This interphase check is essential to preserve emic data and to confirm findings by checking back on the findings at each phase. This detailed and rigorous process of data analysis is essential to understand the data and to be able to trail back on the findings or conclusions as well as to show how the researcher met the criteria of qualitative analysis including but not limited to credibility, recurrent patterning, confirmability, and meaning-in-context.

Data from ethnonursing interviews and the enablers such as the Observation–Participant–Reflection Enabler, Stranger–Friend Enabler, Healthcare Life History Enabler, and others are integrated into the total ethnonursing mode of data collection and analysis. The culminating abstraction and identification of themes in Phase IV constitute the highest level of data analysis. This phase also presents the most difficult level of analysis as it requires critical examination of all data and keen intellectual abilities to synthesize and abstract meanings from all four phases so that conclusions are credible and understandable. Additionally in Phase IV, findings related to contextual factors, cultural interpretations, language analysis,

social structure, and other influencers of human care and wellbeing are also included in the data analysis.

To conduct an accurate synthesis, the researcher must be fully immersed into and familiar with the data. The researcher must carefully preserve relevant verbal statements, meanings, and interpretations from informants in a meaningful way and not reduce data to spurious or questionable themes. Attention is given to special linguistic terms, verbatim statements (quotes), and subjective and experiential data of emic and etic content. In addition, the key informants' interpretations of diverse themes and universalities (commonalities) are identified. Ethnohistorical facts, artistic expressions, worldviews, material cultural items, values and beliefs, and many other aspects influencing culture care and health are integral elements for analysis. Each phase of analysis builds on and supports previous phases so that accurate and meaningful findings are evident.

It is important to note that research assistants and nurses who have had no preparation with the ethnonursing method may have difficulty processing and analyzing vast amounts of data using these phases unless assisted by a teacher or a mentor experienced with the method. For those prepared in the method, this enabler offers a highly rewarding process to make sense out of large or small volumes of ethnonursing qualitative data. Studies presented in this book provide examples of detailed and rigorous analyses of data using the four phases of Leininger's data analysis. These studies have provided new knowledge and insights about culture care transculturally.

The Leininger–Templin–Thompson Ethnoscript Coding Enabler

To facilitate the previously described systematic mode of data collection, processing, and analysis, the Leininger–Templin–Thompson Ethnoscript Qualitative Software was developed around 1985 (Leininger, 1990). The LTT Software was designed as a tailor-made means to process large amounts of ethnonursing data for the culture care theory (Leininger, 1987). This software was initially used for ethnonursing data analysis in that the researcher could directly process large amounts of detailed qualitative data using computer technology. It assisted with coding and processing data focusing on the worldview; social structure; cultural values; language; environmental context; historical facts; folk and professional healthcare systems; specific caring modes; key and general informants; field observations; and other data (Leininger, 1990). The LTT Ethnoscript Qualitative Software Program was developed, refined, and tested by several doctoral nursing students under Dr. Leininger's mentorship—namely, Marie Gates, Teresa

Thompson, Linda Luna, Cynthia Cameron, Zenaida Spangler, and Rauda Gelazis (Leininger, Templin, and Thompson, 1991, p. 3).

As part of the software program, a coding system was developed for Leininger's Theory of Culture Care Diversity and Universality. This coding system followed the general and specific domains of the Sunrise Enabler and included six categories that correlate with the CCT. Although the LTT Ethnoscript Qualitative Software is no longer used, the coding system originally developed for it has become an *enabler* designed to assist researchers using diverse qualitative research software in their quest to code their data. The Leininger–Templin–Thompson Ethnoscript Coding Enabler (**Figure 3-7**) has been used by many researchers conducting ethnonursing

Code Numbers, Categories, and Domains of Information: (Includes processing of observations, interviews, interpretations, material, and nonmaterial data)

Code Numbers	Categories and Domains of Information
Category I: General Cultural and Holistic Domains of Inquiry	
1	Worldview
2	Cultural–social lifeways and activities (typical day/night)
3	Ethnohistorical (includes chrono-data, acculturation, cultural contacts, etc.)
4	Environmental contexts (i.e., physical, ecological, cultural, social)
5	Linguistic terms and meanings
6	Cultural foods related to care, health, illness, and environment
7	Material and nonmaterial culture (includes symbols and meanings)
8	Ethnodemographics (numerical facts, dates, population size, and other numerical data)
9	*
Category II: Domain of Cultural and Social Structural Data (Includes normative values, patterns, functions, and conflicts)	
10	Cultural values, benefits, norms
11	Economic factors
12	Educational factors
13	Kinship (family ties, social network, social relationships, etc.)
14	Political and legal factors
15	Religious, philosophical, and ethical values and beliefs
16	Technological factors
17	Interpersonal relationships (individual groups or institutions)
18	*
19	*

Figure 3-7 Leininger–Templin–Thompson Ethnoscript Coding Enabler
Source: Adapted as an enabler by Wehbe-Alamah, H.B., & McFarland, M.R. from the original document by Leininger, M.; Templin, T.; Thompson, F. (1991). *The Leininger–Templin–Thompson Ethnoscript Qualitative Software Program User's Handbook* (pp. 16–19), Wayne State University (MI), the Madeleine M. Leininger Collection on Human Caring and Transcultural Nursing (ARC-008, Folder 6–29). Retrieved from the Archives of Caring in Nursing, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL.

Code Numbers	Categories and Domains of Information
Category III: Care, Cure, Health (Wellbeing), and Illness of Folk and Professional Lifeways and Systems	
20	Folk (includes popular health and illness benefits, values, and practices)
21	Professional health
22	Human care/caring and nursing (general beliefs, values, and practices)
23	Folk care/caring (emic or indigenous beliefs, values, and lifeways)
24	Professional care/caring (etic beliefs, values, lifeways)
25	Professional nursing care/caring (etic and emic) lifeways (congruence and conflictareas)
26	Noncare/caring beliefs, values, and practices
27	Human cure/curing beliefs, values, and practices
28	Folk and generic cure/curing (etic beliefs, values, and practices)
29	Professional cure/curing (etic and emic perspectives)
30	Alternative or emerging care/cure systems
31	*
32	*
33	*
34	*
Category IV: Health Care, Social Structure Institutions/Systems (Includes administrative norms, beliefs, and practices with meanings-in-context)	
35	Cultural–social norms, beliefs, values, and context
36	Political–legal factors
37	Economic factors
38	Technological factors
39	Environmental factors
40	Educational factors (formal and informal)
41	Social organization or structural factors
42	Decisions and action patterns
43	Inter and multidisciplinary norms, values, and collaborative practices
44	Nursing specialties and features
45	Non-nursing specialties and features
46	Ethical/moral care-cure factors
47	*
48	*
49	*
Category V: Life Cycle with Inter- and Intragenerational Patterns (Includes ceremonies, beliefs, and rituals)	
50	Life cycle male and female enculturation and socialization processes
51	Infancy and early childhood years
52	Adolescence (or transitions) to adulthood
53	Middlescence years
54	Advanced years
55	Cultural life-cycle values, beliefs and practices
56	Cultural life-cycle intra and intergenerational conflict areas
57	Special life-cycle subcultures and groups
58	Life passages (includes birth, marriage, death)
59	*
60	*

(*continues*)

Code Numbers	Categories and Domains of Information
Category VI: Methodological, Reflections, Issues, and Research Features	
61	Specific methods or techniques used
62	Key informants
63	General informants
64	Enabling tools or instruments used
65	Problem areas, concerns or conflicts
66	Strengths, favorable and unanticipated outcomes of researcher or informants, subjective data and questions
67	Unusual incidents, interpretations, questions, etc.
68	Factors facilitating or hindering the study (time, staff, money, etc.)
69	Ernie data methodological issues
70	Etic data methodological issues
71	Dialogue by interviewer
72	Dialogue by someone other than informant or interviewer
73	Additional contextual data (includes nonverbal symbols, total view, environmental features, etc.)
74	Informed consent factors
75–100	*

*Denotes areas where researcher adds own additional codes and descriptions

Figure 3-7 Leininger–Templin–Thompson Ethnoscript Coding Enabler (*continued*)

and metasynthesis studies (McFarland, 1995; McFarland, Mixer, Wehbe-Alamah, & Burke, 2012; McFarland, Wehbe-Alamah, Wilson, & Vossos, 2011).

The Life History Healthcare Enabler

The Life History Healthcare Enabler (**Figure 3-8**) is a guide to obtaining longitudinal data from selected informants of *their lived experiences across their lifespan* with focus on care and caring (or related nursing aspects). Life histories have long been of value in anthropology. Ideas for this enabler were derived from several authors' experiences and from anthropological life histories (MacNeil, 1994). Nurses are now learning how to use full life histories to study nursing and healthcare practices.

It is of interest that clients and families often enjoy talking about their life history accounts, especially middlescent and elderly adults. Hence, this enabler was designed to obtain a full and systematic account from informants about their caring healthy—or less healthy—lifeways and how care beliefs and practices influenced their wellbeing. Enormously rich and detailed data have been obtained from the use of this enabler especially with respect to human caring and health values, expressions, and meanings (Leininger,

1. Introduce yourself and explain that you would like to obtain the person's life and health history. Indicate how such a history could be helpful to health personnel and of interest to him or her. Answer questions or clarify concerns of the individual. Obtain written permission from the individual for the autobiographical or biographical health history study (clarify the differences in these methods).
2. If the individual wishes to write his or her own life history (an autobiography), encourage him to write in his own style, but ask him to include his views and experiences about health, care, and illness patterns in order to help him and others benefit from such knowledge. Clarify how you plan to use the research findings.
3. If you are writing the individual's health and care history biographical account, proceed as follows:
   - A. Plan to record the information *before* initiating the interview. Use unobtrusive materials so that you do not distract the informant in celling his history. If you are using a tape recorder, choose one hour tapes to prevent distruption in the flow of the life history with the informant. Written permission must be obtained from the informant prior to any recording (follow the requirements of the committee for human subjects research). If you use ethnographic field notes, you may wish to use the guidelines already described by the author in this book, or use Spradley's suggestions for record keeping (Spradley, 1979, 1980). It is important to note that some informants are not comfortable with having their life history taped and their request must be respected. If an informant consents to taping, offer him or her a copy of the tape without cost. (Usually the informant does want a copy.) If taping is not agreed to, use a stenographer's pad and record words and an outline of what you are observing and talking about. *Immediately* after the history taking, write in detail what you observed, heard, and talked about. Do not wait hours or days, as recall is difficult and accuracy decreases.
   - B. Use primarily the ethnographic open-ended type of interview method described in this book or in Spradley's book (1979) to encourage and promote an open flow of information. The researcher's introductory comment might be, "I would like to learn about you and how you have known and experienced health, caring, illness, or disabilities." "As a nurse, I am interested in your past and present lifeways so I can learn what has made you healthy or less healthy, and who you believe have been caring persons in your life." "Feel free to offer special stories or events as you recall ideas important to you." (Clarify as needed how this information may be helpful to nurses to improve nursing care.)
   - C. Suggest some life history domains or topic areas on which to focus, using with lead-in statements with a sequence, such as the following:
     - (1) "Let us talk about where you were born and what you remember about your early days of growing up, keeping well, or experiencing illness."
     - (2) "Can you recall special events, experiences, and health practices during childhood and adolescent years that were especially important to you in keeping well, or that limited your wellness or healthiness?"

(*continues*)

Figure 3-8 The Life History Health Care Enabler
Source: Leininger, M. M. (1985). Life History Health Care Enabler. In J. MacNeil, (1994) *Culture care: Meanings, patterns and expressions for Baganda women as AIDS caregivers within Leininger's theory* (pp. 144–146). (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 9519922)

(3) "Let us talk about your speical health care experiences that were particularly clear and pleasant (or unpleasant) to you regarding these periods in your life" (encourage use of folk stories, humorous tales, and descriptions of special events):

   a. Early childhood days
   b. Adolescent years
   c. Mid-life years
   d. Older years

(4) "Give some examples of healthy caring activities or ways of living by your family, cultural group, or significant people who helped you."

(5) "As you think about your life experiences to date, what do you recall about these experiences and what did you value most or least about":

   a. Going to school (primary, secondary, and college days) and your health status.
   b. Employment experiences and how you viewed or experienced them as healthy or less healthy.
   c. Marriage or remaining single throughout life (stresses or nonstresses).
   d. Sudden (or gradual) death of loved persons and how such experiences influenced your thinking and health status.
   e. Accident or illness events to you, your family, or friends and the care expressions.

(6) "I would like to hear about your general philosophy of keeping well and how you believe your religion, political, and cultural values have helped (or hindered) your life goals and health. Can you tell me what beliefs or values have especially guided you to remaining well or become ill?" (Give examples.)

(7) "Can you recall special folk or professional health and caring experiences that were most important to you during your life regarding the following topics?"

   a. Staying well (or becoming ill).
   b. Becoming disabled (and maintaining/ getting well).
   c. Experiencing or dealing with healthy patterns of living.
   d. Recovering from a traumatic experiences as perceived by you.

(8) "Can you recall who you believe were 'good caretakers in the past (and today) and what made them such good caretakers? What noncaring persons influenced your lifestyle or made life difficult or unhealthy for you? What caregivers were important in your life and what made them so? Can you tell me about nurses as caretakers?"

(9) "Throughout your life, what factors seemed to keep you going, living, or establishing healthy patterns of living for yourself and others?"

(10) "What have been some of the greatest rewards or joys in your life? The least rewarding and why? How are these joys related to health or illness?"

(11) "Feel free to tell me other aspects of your life so I can understand it as fully as possible. You can tell me stories, jokes, healing practices, and any special events you believe I should know about to understand you."

Figure 3-8 The Life History Health Care Enabler (*continued*)

D. *Writing and Checking the History*. Covering the above life history points (and others the researchers wishes to include) will take several sessions–usually three to four. Upon completion of the history, you should carefully review and check the history, and then clarify vague points immediately while fresh in the mind of informant. Use the informants own words and account as much as possible. Thank the information and make plans to confirm and share the written (biographical) account. If the account is autobiographical, return and go over the written account to be sure it is understandable and readable, suitable for reproduction as a written document. Express appreciation for the informant's time and information. Present a copy of the tape(s) to the informant. Be sure to provide sufficient time after you have written the account to clarify, confirm, reexamine, or explicate ideas from the informant.

E. *Analysis of Data*. Analyzing the data is a creative art and skill in that the researcher must consciously preserve the informant's statements, but still identify salient themes and synthesize life events in context. It is also an art and skill to both write a health and care life history and keep it accurate and interesting. The verbatim and sequenced account is preserved. Generally thematic, semantic, contexual, and general textual analyses of the data are done with life histories as part of the researcher's separate but special analysis. (See other chapters in this book on these methodological approaches.) Try to identify and analyze patterns of health, care, and illness (if present) so that a synthesis of ideas can be readily identified and used by research consumers. The researcher may wish to present the raw biographical data to the informant and retain theoretical and complex data for the researcher, still sharing dominant findings with the informant at the end of the study.

Figure 3-8 The Life History Health Care Enabler (*continued*)

1985b). Nurse-researchers using the ethnonursing method are encouraged to use this enabler to tease out historical insights about healthcare values and practices, especially related to generic and professional care patterns and practices throughout the lifespan. The life history guide has been useful in obtaining longitudinal narratives about informants' special experiences in folk and professional health care at home and in institutional settings.

Leininger's Ethnodemographic Enabler

This enabler is used as a guide to tap into general ethnographic data about key informants with respect to their environment, history, and related factors. Ethnodemographic factors include social and cultural factors, ethnic orientation, gender, and geographic locations where the informants are living or have lived. Family data, the geographic area, and general environmental factors such as water supply, buildings, and other factors may be included. Specific ethnodemographic facts of different cultures and within a historical context can help to understand the meaning of care and care practices. This enabler is generally used during interviews with key and

general informants and while talking to informants about their family origins, general history, and current or past living and working environments; the present and past history are part of the data obtained during these open-ended interviews (Leininger, 2006b). Many researchers fold this enabler into their adaptation of Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health.

Other Enablers Developed by Leininger

Over time, Leininger developed other enablers for use with specific studies. Some of these enablers were eventually folded into some of the enablers described previously in this chapter. Examples of such enablers include: Cultural Care Values and Meanings; Culturalogical [Cultural] Care Assessment Guide; Audio-Visual Guide; Generic and Professional Care Enabler Guide; Cross-Cultural Interview Guide to Study Ethnonursing, Caring, and Related Aspects; and Ethnonursing Field Research Data Form (Leininger, 1985a, 1988).

CONCLUSION

In addition to using an adaptation of any of the enablers presented in this chapter, Leininger encouraged researchers using the ethnonursing method to study diverse cultures in different domains of inquiry to develop their own additional enablers related to cultural care theory as needed. In developing the culture care theory, ethnonursing research method, and enablers, Leininger's ultimate goal was the discovery of new knowledge that could assist nurses and other healthcare professionals to deliver culturally congruent, sensitive, and meaningful care to people worldwide. Although she is no longer with us, Leininger's passion and vision for transcultural nursing remain ignited as a powerful driving force in transcultural nursing thanks to student and seasoned researchers using her theory, method, and enablers.

DISCUSSION QUESTIONS

1. What are enablers and why/how are they used in ethnonursing research?
2. Discuss use of the Stranger-to-Trusted-Friend Enabler. Provide examples that could indicate reaching *trusted friend* status.
3. Develop interview questions using an adaptation of Leininger's Semi-Structured Inquiry Guide Enabler to Assess Culture Care and Health.
4. Discuss the process of ethnonursing data analysis.

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