CHAPTER 3

The Theory of Culture Care Diversity and Universality

Marilyn R. McFarland

> *"The goal of the theory…is to provide culturally congruent care that would contribute to the health or wellbeing of people or to help them face disabilities, dying, or death" (Leininger, 2002d, p. 76).*
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> *"The theory with its focus on care and culture [was] held by Leininger as the heart and soul of nursing and essential for developing new transcultural nursing knowledge and practices and to move nursing into a predicted multicultural and global world" (Leininger, 2006a, p. 7).*

ETHNOHISTORY OF THE THEORY

Leininger's first book, *Nursing and Anthropology: Two Worlds to Blend* (1970), laid the foundation for her creation of the Theory of Culture Care Diversity and Universality (known as the Culture Care Theory or CCT) and the subsequent integration of culturally- based care into the healthcare system as well as the evolutionary development of the field of transcultural nursing. Her next book, *Transcultural Nursing: Concepts, Theories, and Practice* (1978), identified major concepts, theoretical ideas, and practices in transcultural nursing and was the first definitive publication to describe transcultural nursing. During the next 60 years Leininger established, explicated, and used the Culture Care Theory to study many cultures across the United States and worldwide. She developed the Ethnonursing Research Method to fit and be used with the theory and to qualitatively discover insider or emic views about the care beliefs, views, and practices of diverse cultural groups (Leininger, 1991b, 2002d, 2006d; Wehbe-Alamah & McFarland, 2015b). The Ethnonursing Research Method was the first qualitative research method designed for nurse researchers to study and discover culture care phenomena (Leininger, 1978, 1985, 1991b, 1995b, 2002d, 2006d;

Wehbe-Alamah & McFarland, 2015b).

In 1981, Leininger was recruited by Wayne State University in Detroit and was appointed Professor of Nursing and Adjunct Professor of Anthropology and Director of Transcultural Nursing Offerings, where she remained until her semi-retirement in 1995. In 1989, Leininger launched the *Journal of Transcultural Nursing*, serving as its first editor until her retirement. While at Wayne State, she developed several courses and seminars in transcultural nursing, caring constructs, and qualitative research methods for baccalaureate, master's, doctoral, and postdoctoral nursing and non-nursing students. During her years at Wayne, she taught and mentored many students and nurses in transcultural nursing research guided by the Culture Care Theory using the Ethnonursing Research Method. She continued teaching and consulting about transcultural nursing and the Culture Care Theory at various universities across the United States and worldwide throughout her retirement.

Leininger wrote or edited more than 30 books during her lifetime; among the most significant were those that explicated her theory and the ethnonursing method more fully and focused on the discipline of transcultural nursing. They included *Nursing and Anthropology: Two Worlds to Blend* (1970); *Transcultural Nursing: Concepts, Theories, and Practice* (1978); *Culture Care Diversity and Universality: A Theory of Nursing* (1991a); *Transcultural Nursing: Concepts, Theories, Research, and Practice* (Leininger & McFarland, 2002); and *Culture Care Diversity and Universality: A Worldwide Theory of Nursing* (Leininger & McFarland, 2006). In 2012, Dr. Leininger charged Dr. Marilyn McFarland and Dr. Hiba Wehbe-Alamah to carry on her work with the Culture Care Theory, and the ethnonursing method, and in transcultural nursing. Dr. Leininger remained an active contributor to works bearing her name until her death in August 2012. In 2015, the third edition of *Leininger's Culture Care Diversity and Universality: A Worldwide Nursing Theory* by McFarland and Wehbe-Alamah included two chapters that Dr. Leininger had written before her death.

PURPOSE AND GOAL OF THE THEORY

The purpose of the Theory of Culture Care Diversity and Universality is to discover, document, know, and explain the interdependence of care and culture phenomena with differences and similarities between and among cultures (McFarland & Wehbe-Alamah, 2015b, pp. 5-6). Using the ethnonursing research method with the CCT, the researcher is challenged to discover the similarities and diversities about human care among cultures. The theory was predicted to help guide the nurse researcher to discover new meanings, patterns, expressions, and practices related to culture care that have influenced the health and wellbeing of individuals, families, and cultural groups. In the discovery process, both similarities (commonalities) and diversities (differences) can be identified as culture-specific modalities to provide as culturally congruent care related to the desired goal of health or wellbeing (Wehbe-Alamah & McFarland, 2015b, p. 39).

The goal of the theory is to provide culturally congruent care that contributes to the health and wellbeing of people or to help them face disabilities, dying, or death using the three modes of culture care decisions and actions. Ultimately, the goal is to establish a body of

transcultural nursing knowledge for current best care practices for future generations of nurses in a global world. Such knowledge is essential for current and future professional nursing care practice as well as for use by other healthcare providers. This body of knowledge continues to change and transform nursing and health care with benefits to people from similar and diverse cultures (McFarland & Wehbe-Alamah, 2015b). The theory has guided nurses and other healthcare providers toward explicating care meanings so that culture care values, beliefs, and lifeways can serve as accurate and reliable bases for co-participatively making culture-specific care decisions and actions as well as to identify universal or common features about care (Leininger, 1994; McFarland & Wehbe-Alamah, 2015a). The theory states that nurses cannot separate worldviews, social structure factors, and cultural beliefs or practices (lay/folk/generic and professional) from health, wellness, illness, or care when working with cultures because these factors are closely linked and interrelated (Leininger, 1994; McFarland & Wehbe-Alamah, 2015a). Social structure factors such as religion, politics, culture, economics, and kinship are significant forces affecting care and influencing illness patterns and wellbeing (Leininger, 2006a, pp. 17-18). The theorist and others have long believed that discovering all forms of generic care beliefs, values, and expressions held by cultures and combining them with professional care practices to be of essential importance for the provision of culturally congruent care (Leininger, 1991a, 1995b; Leininger & McFarland, 2002, 2006; McFarland & Wehbe-Alamah, 2015a). Ethnonursing studies that have supported this premise include Gunn and Davis (2011); Lee (2012); Liang (2002); Mixer, McFarland, Andrews, and Strang (2013); Morris (2012); Moss (2014); Outwater, Tarimo, Miller, and Campbell (2012); Schumacher (2010); Strang and Mixer (2015); Wanchi, Armer, and Stewart (2015); and Wolf et al. (2014).

TENETS OF THE THEORY

Tenets are the positions held or the givens set forth by the theorist for use with a theory. In developing the Culture Care Theory, the following four major tenets were conceptualized and formulated by Leininger:

- Culture care expressions, meanings, patterns, and practices are diverse and yet there are shared commonalities and some universal attributes;
- Worldview, multiple social structure factors, ethnohistory, environmental context, language, and generic and professional care are critical influencers of culture care patterns to predict health, wellbeing, illness, healing, and ways people face disabilities and death;
- Generic emic [folk] and etic [professional] health factors in different environmental contexts greatly influence health and illness outcomes; and
- From an analysis of the above influencers, three major decision and action modes [culture care preservation and/or maintenance; culture care accommodation and/or negotiation; and culture care repatterning and/or restructuring] were predicted to provide ways to provide culturally congruent, safe, and meaningful health care to cultures. (McFarland & Wehbe-Alamah, 2015b)

In conceptualizing the theory, a major and central theoretical tenet was "…care diversities (differences) and universalities (commonalities) existed among and between cultures in the world" (Leininger, 2002d, p. 78). However, Leininger asserted that culture care meanings and uses first had to be *discovered* so as to establish a body of transcultural knowledge. Transcultural nurses conducting ethnonursing research guided by the CCT have discovered care diversities and universalities in both care themes and care patterns in their study findings. However, more *universal* than *diverse* care themes and patterns have been discovered and reported. Leininger commented that care diversities may be more covert and embedded in informant data/descriptors than are universalities (M. M. Leininger, personal communication, January-August, 2012). Studies with universal as well as diverse findings include McFarland and Zehnder's (2006) study about German-American elders; Mixer's (2011) study about nursing faculty teaching culture care; Embler, Mixer, and Gunther's work (2015) about end-of-life care with the Yup'ik people of Alaska; and Morris' (2015) book chapter about the subculture of urban African American adolescent gangs.

A second major theoretical tenet was that the "…worldview; social structure factors such as religion, economics, education, technology, politics, kinship (social), ethnohistory, environment, language; and generic care and professional care factors would greatly influence culture care meanings, expressions, and patterns in different cultures" (Leininger, 2002d, p. 78). Leininger (2002d) maintained that knowing the cultural and social structure factors [of a particular culture or group] was necessary in order to provide meaningful and satisfying care to people, and predicted they would be powerful influencers on culturally-based care (p. 78). She stated these factors also needed to be discovered directly from cultural informants to confirm them as being influencing factors related to health, wellbeing, illness, and death.

A third major theoretical tenet was "…both generic (emic or the insider's view) and professional (etic) health factors in diverse environmental contexts greatly influence health and illness outcomes" (McFarland & Wehbe-Alamah, 2015b, p. 7), and that these "…need to be taught, researched, and brought together into care practices for satisfying care for clients, which leads to their health and wellbeing" (Leininger, 2002d, 2006a). This tenet was added by Leininger in 2006a based on supporting data from published studies about resident care in a culturally-focused nursing home (McFarland & Zehnder, 2006) as well as other community settings (Leuning, Small, & van Dyk, 2002) and was later supported by additional studies (Strang & Mixer, 2015).

A fourth major theoretical tenet was the conceptualization of the three major culture care modes of decisions and actions [previously stated] to arrive at culturally congruent care for the general health and wellbeing of clients, or to help them face death or disabilities (Leininger & McFarland, 2002, 2006; McFarland & Wehbe-Alamah, 2015a). These decision and action modes were predicted to be *key* for the provision of culturally congruent, meaningful, and acceptable care and beneficial outcomes. When using the modes, individuals, families, groups, communities, or institutions are assessed and responded to in dynamic and participatory nurse-client relationships (Eipperle, 2015). These social structure factors need to be studied, assessed, and responded to in a dynamic and co-participatory nurse-client relationship. The researcher or clinician then draws upon findings from the

social structure factors; generic care and professional practices; and other influences to develop individualized approaches in the plan of care using the three culture care modes with the care recipients/clients to provide culturally-based and culturally congruent care for the individual, family, or group (Eipperle, 2015; Leininger, 1991a; Leininger & McFarland, 2002, 2006; McFarland & Wehbe-Alamah, 2015a).

ASSUMPTIVE PREMISES OF THE THEORY

The major theoretical tenets of the theory led to the formulation of specific theoretical hunches or assumptions that a researcher could use with diverse cultural groups in different geographical locations. Major assumptions of The Theory of Culture Care Diversity and Universality presented here were derived from Leininger's definitive works on the theory and subsequent evolving changes that were discovered and/or confirmed by her and other researchers. For example, in her 2011 study, Mixer used five assumptive premises from the CCT to guide her research with faculty teaching transcultural nursing in the southeastern United States. Strang and Mixer (2015) stated five assumptions from the Culture Care Theory to guide a study of Malaria care among the Maasai of southern Kenya. These researchers reported that the assumptive premises derived from the CCT were supported by discoveries from both studies, which contributed the building of nursing theory (Mixer, 2011; Strang & Mixer, 2015). These findings also supported Leininger's statement (based on the 5th assumptive premise) that the universality of care reflects the common nature of human beings and humanity, whereas the diversity of care reflects the discovered variability and unique features of human beings. The assumptive premises of the CCT are:

- Care is the essence and central dominant, distinct, and unifying focus of nursing
- Humanistic and scientific care is essential for human growth, wellbeing, health, survival, and to face dying, death, and disabilities;
- Care (caring) is essential to curing or healing for there can be no curing without caring (this assumption was held to have profound relevance worldwide);
- Culture care is the synthesis of two major constructs [culture and care] that guide the researcher to discover, explain, and account for health, wellbeing, care expressions, and other human conditions;
- Culture care expressions, meanings, patterns, processes, and structural forms are diverse but some commonalities (universalities) exist among and between cultures;
- Culture care values, beliefs, and practices are influenced by and embedded in the worldview, social structure factors (e.g., [spirituality] religion, philosophy of life, kinship, politics, economics, education, technology, biological factors [new revision/addition], and cultural values) and the ethnohistorical and environmental contexts;
- Every culture has generic [lay, folk, naturalistic; mainly emic] and usually some professional [etic] care to be discovered and used for culturally congruent care practices;
- Culturally congruent and therapeutic care occurs when culture care values, beliefs, expressions, and patterns are explicitly known and used appropriately, sensitively, and

meaningfully with people of diverse or similar cultures;

- Leininger's three theoretical modes of care offer new, creative, and different therapeutic ways to help people of diverse cultures;
- The Ethnonursing Research Method and other qualitative research paradigmatic methods offer important means to discover largely embedded, covert, epistemic, and ontological culture care knowledge and practices; and,
- Transcultural nursing is a discipline with a body of knowledge and practices to attain and maintain the goal of culturally congruent care for health and wellbeing. (McFarland & Wehbe-Alamah, 2015b, pp. 8-9)

CENTRAL CONSTRUCTS OF THE CULTURE CARE THEORY

For several decades, transcultural nursing has been defined as *a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic healthcare practices that are culturally-based* (Leininger, 1991b, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b). Transcultural nursing researchers continue to identify and use comparative care discoveries, practices, and guidelines to help human beings in beneficial ways by delivering culturally congruent care to similar and increasingly diverse and vulnerable populations (Douglas et al., 2014).

Several central constructs used in the Culture Care Theory have been described and defined in numerous ethnonursing studies (Leininger, 1991a, 1995b; Leininger & McFarland, 2002, 2006; McFarland & Wehbe-Alamah, 2015b). These constructs were adapted in several ethnonursing research studies, which were subsequently published, including Farrell (2006); McFarland and Zehnder (2006); Mixer (2011); Schumacher (2010); Strang and Mixer (2015); and Wolf et al. (2014). The theory definitions are orientational and not operational as in quantitative studies. The orientational definitions were adapted from the theory definitions in order for the researchers to be open to discovering new dimensions of the theory constructs and to encourage discovery of new qualitative knowledge from cultural groups. This is a major difference between the Culture Care Theory and other nursing theories that have pre-determined definitions that usually reflect the researchers' interests or viewpoints.

Care

Care refers to both an abstract and/or a concrete phenomenon. Leininger defined *care* as those *assistive, supportive, and enabling experiences or ideas toward others* (Leininger, 1995a, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b). *Caring* refers to *actions, attitudes, and practices to assist or help others toward healing and wellbeing* (Leininger, 1995a, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b).

Care as a major construct of the theory includes both *folk care* and *professional care* and has been predicted and supported to influence and explain the health or wellbeing for similar

and diverse cultures (Leininger, 1978). Based on the current research findings, care is a largely embedded and invisible phenomenon often taken for granted that is sometimes challenging for nurses to quickly identify or understand with in-depth meaning (Leininger, 1991b, 2002c, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b). However, over the past six decades many books, articles, and research studies have become accessible to nurses, enabling them to discover and know different care meanings from both similar and diverse cultures. Some relevant study exemplars include Farrell (2006); Gunn and Davis (2011); Leininger (2002c, 2006b); McFarland (2002a); Mixer (2011); Moss (2014); Strang and Mixer (2015); Wehbe-Alamah (2011, 2015); and Wolf et al. (2014).

Care has cultural and symbolic meanings such as *care as protection* (Leininger, 2002c, 2006b, 2015a); *care as respect* (Morris, 2012); and *care as presence* (Leininger as cited by McFarland, 2002b, p. 111 [Table 3.7]; Leininger, 2006c, p. 289). These care linkages are essential for the provision of culture-specific care and are often also gender linked.

Many research studies have discovered transcultural care meanings within and between cultures (Refer to Table 3.1). Most of these studies were conducted by doctorally-prepared transcultural nurse researchers who teased out covert and in-depth care meanings in scientific and authentic ways for clinical care practices. The updated Table 3.1 lists care constructs discovered and supported in numerous studies guided by the Culture Care Theory from 1960 to 2016. Among these newer constructs are *collaborative care* (McFarland & Leininger, 2011; M. M. Leininger, personal communication, October 20-22, 2011); *collective care* (McFarland & Zehnder, 2006); *father protective care* (Leininger, 2015a); *mentoring and co-mentoring* (Mixer, 2011); and *herbs as care*, *community as care*, and *praying to/for* (Strang & Mixer, 2015).

TABLE 3.1. Care/Caring Constructs.

1 Acceptance
2 Accommodating
3 Accountability
4 Action (ing) for/about/with
5 Adapting to
6 Affection for
7 Alleviation (pain/suffering)
8 Anticipation (ing)
9 Assist (ing) others
10 Attention to/toward
11 Attitude toward
12 Being nonassertive
13 Being authentic (real)
14 Being aware of others
15 Being clean
16 Being genuine
17 Being involved
18 Being kind/pleasant
19 ***Being listened to**
20 Being orderly
21 Being present
22 Being watchful
23 Bribing
24 Care (caring)
25 *Caritas* (charity)
26 Cleanliness
27 Closeness to
28 Cognitively knowing
29 Collaborative care**
30 **Collective care****
31 Comfort (ing)
32 Commitment to/for
33 Communication (ing)
34 Community awareness
35 ***Community as care**
36 Compassion (ate)
37 Compliance with
38 ***Concern for**/about/with
39 Congruence with
40 Connectedness
41 Consideration of
42 Consultation (ing)
43 Controlling
44 Communion with another
45 Cooperation
46 Coordination (ing)
47 Coping with/for
48 Creative thinking/acts
49 Culture care (ing)
50 Cure (ing)
51 Dependence
52 Direct help to others
53 Discernment
54 Doing for/with
55 Eating right foods
56 Enduring
57 Embodiment
58 Emotional support
59 Empathy
60 Enabling
61 Engrossment in/about
62 Establishing harmony
63 Experiencing with
64 Expressing feelings
65 ***Faith (in God)****
66 Faith (in others)
67 Family involvement
68 Family support
69 **Father protective care****
70 Feeling for/about
71 Filial love
72 Generosity toward others
73 Gentle (ness) & firmness
74 Giving to others in need
75 Giving comfort to
76 Group assistance
77 Group awareness
78 Growth promoting
79 Hands on
80 Harmony with
81 Healing
82 Health instruction
83 Health (wellbeing)
84 Honor (ing)
85 Hope (fullness)
86 Hospitality
87 Improving conditions
88 Inclined toward
89 Indulgence from
90 Instruction (ing)
91 Integrity
92 Interest in/about
93 Intimacy/intimate
94 Involvement with/for
95 Kindness (being kind)
96 Knowing of culture
97 Knowing (another's reality)
98 Know cultural values/taboos
99 **Language as protective care****
100 Limiting (set limits)
101 Listening to/about

102	***Love (kinship)**
103	Loving (love others)—Christian love
104	Maintaining harmony
105	Maintaining privacy
106	Maintaining reciprocity
107	***Malaria**
108	**Mentoring/co-mentoring****
109	Ministering to others—filial love
110	Need fulfillment
111	Noncaring
112	Nurturance (nurture)
113	Obedience to
114	Obligation to
115	Orderliness
116	Other-care (ing)/non self-care
117	Patience
118	Performing rituals
119	Permitting expressions
120	Personalized acts
121	Physical acts
122	Praying with
123	Presence (being with)
124	Preserving (preservation)
125	Prevention (ing)
126	Promoting
127	Promoting independence
128	***Praying to/for**
129	**Protective care**/protecting (other/self)**
130	Purging
131	Quietness
132	Reassurance
133	Receiving
134	Reciprocity
135	Reflecting goodness
136	Reflecting with/about
137	Rehabilitate
138	Regard for
139	Relatedness to
140	Respect
141	Respect for/about lifeways
142	Respecting
143	Respecting privacy/wishes
144	Respecting sex differences
145	Responding appropriately
146	Responding to context
147	Responsible for others
148	Restoration (ing)
149	Sacrificing
150	Saving face
151	Self-reliance (reliance)
152	Self-responsibility
153	Sensitivity to others needs
154	Serving others (*caritas*)
155	Sharing with others
156	Silence (use of)
157	Speaking the language
158	Spiritual healing
159	Spiritual relatedness
160	Stimulation (ing)
161	Stress alleviation
162	Succorance
163	Suffering with/for
164	Support (ing)
165	Surveillance (watch for)
166	Symbols (ing)
167	Sympathy
168	Taking care of environment
169	Technical skills
170	Techniques
171	Tenderness
172	Timing actions/decisions
173	Touch (ing)
174	***Trust (Confidentiality)**
175	***Unconditional giving for the purpose of recovery from illness and wellbeing**
176	Understanding
177	Use of folk foods/practices
178	Use of limit setting
179	Using nursing knowledge
180	Valuing another's ways
181	Watchfulness
182	Wellbeing (health)
183	Wellbeing (family)
184	Wholeness approach
185	**Worthiness****

* Indicates new constructs with current publication of table.

** Indicates new care constructs described in 2015 (Jones & Bartlett) publication of table.

Adapted and revised, with permission, from: McFarland, M. R., & Wehbe-Alamah, H. B. (2015). The theory of culture care diversity and universality. In M. R. McFarland and H. B. Wehbe-Alamah (Eds.), *Leininger's Culture Care Diversity and Universality: A Worldwide Nursing Theory* (3rd ed., pp. 11-13). Burlington, MA: Jones & Bartlett Learning. www.jblearning.com.

In addition, some researchers identified and confirmed culture care constructs in their studies that had been discovered in earlier ethnonursing research guided by the CCT. In her doctoral study about faculty teaching culture care, Mixer (2011) supported six care constructs previously discovered by Leininger and others; these were *respect*; *praying with*; *listening*; *collective care*; *reciprocal care*; and *surveillance care*. Strang and Mixer (2015) also reported confirmation for the formerly discovered care constructs of *respect for/about lifeways*; *acceptance*; *purging*; and *interest in and about*.

Culture

Culture is another major construct central to the Theory of *Culture* Care Diversity and Universality. Leininger (1991b, 2002d, 2006a) defined culture as the *learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guide thinking, decisions, and actions in patterned ways*. From an anthropological perspective, culture is usually viewed as *the broadest and most comprehensive means to know, explain, and predict people's lifeways over time and in different geographic locations*. Moreover, culture is more than social interaction and symbols. Culture can be viewed as the blueprint for guiding human actions and decisions and includes material and nonmaterial features of any group or individual. It has been a major construct in anthropology for nearly a century. Culture is more than ethnicity or social relationships. Cultural phenomena distinguish human beings from nonhumans (Leininger as cited by McFarland & Wehbe-Alamah, 2015b, p. 10).

Culture Care

Transculturally-prepared nurses are advancing culture care knowledge in many ways by uniting culture and care together conceptually and for research purposes. This approach in nursing is encouraging. The powerfulness of the *culture care* dual construct to discover and understand illness, wellness, and other human health expressions remains an important focus in transcultural nursing. The theorist held that culture care phenomena conceived and linked together have great power to explain health and/or illness. Leininger (1978) conceptualized culture care as synthesized and closely linked phenomena with interrelated ideas. Both culture and care require rigorous and full study with attention to their embedded and constituted relationship to each other as human care phenomena (McFarland & Wehbe-Alamah, 2015b).

Emic and Etic

The constructs *emic* and *etic* care are also major parts of the Culture Care Theory. Leininger (1978, 1991b, 2002d, 2006a) wanted to identify differences and similarities among and between cultures and to differentiate the client's insider knowledge, in contrast with the researcher's outsider or professional knowledge. She also believed it was desirable to know what was universal [or common] and what was different [or diverse] among cultures with respect to care. The term *emic* refers to the local, indigenous, or insider's cultural knowledge and view of specific phenomena; *etic* refers to the outsiders' or stranger's—and often health professional's—views and the institutional knowledge about culture care phenomena (Leininger, 1991b, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b).

The terms *emic* and *etic* were derived from linguistics but were reconceptualized by Leininger (1978) within her theoretical perspectives to discover contrasting culture care phenomena. These two dual constructs, emic and etic, have been invaluable in explicating the differences and similarities among cultural informants' and professional nurses' knowledge and practices over the past several decades (Leininger, 1991b, 2002d, 2006a; Morris, 2012).

In transcultural nursing, emic and etic—when coupled with generic and professional care—are formally defined as:

- **Generic (emic) care** refers to the learned and transmitted lay, indigenous, traditional, or local folk (emic) knowledge and practices that are assistive, supportive, enabling, and facilitative acts for or toward others with evident or anticipated health needs in order to improve wellbeing or to help with dying or other human conditions (Leininger, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b).
- **Professional (etic) care** refers to formal and explicit cognitively learned professional care knowledge and practices obtained generally through educational institutions. These constructs are taught to nurses and other healthcare professionals so as to enable them to provide assistive, supportive, enabling, or facilitative acts for or to another individual or group in order to improve their health, prevent illnesses, or to help with dying or other human conditions (Leininger, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b).

The construct of *Integrative Care* is a recently added central construct of the CCT that emerged through further development and evolution of Leininger's earlier work (Leininger, 2002e; M. M. Leininger and H. B. Wehbe-Alamah, personal communications, October 20-22, 2011). This new central construct blends professional care and generic care and replaces *Nursing Care Practices* as the linking construct between *Generic* (folk) and *Professional Care-Cure Practices* in recognition of the integrative nature of culturally congruent care that transculturally-prepared nurses currently provide. This evolutionary change is now reflected in the revised 2016 Sunrise Enabler (Refer to Figure 3.1 and Color Insert 1).

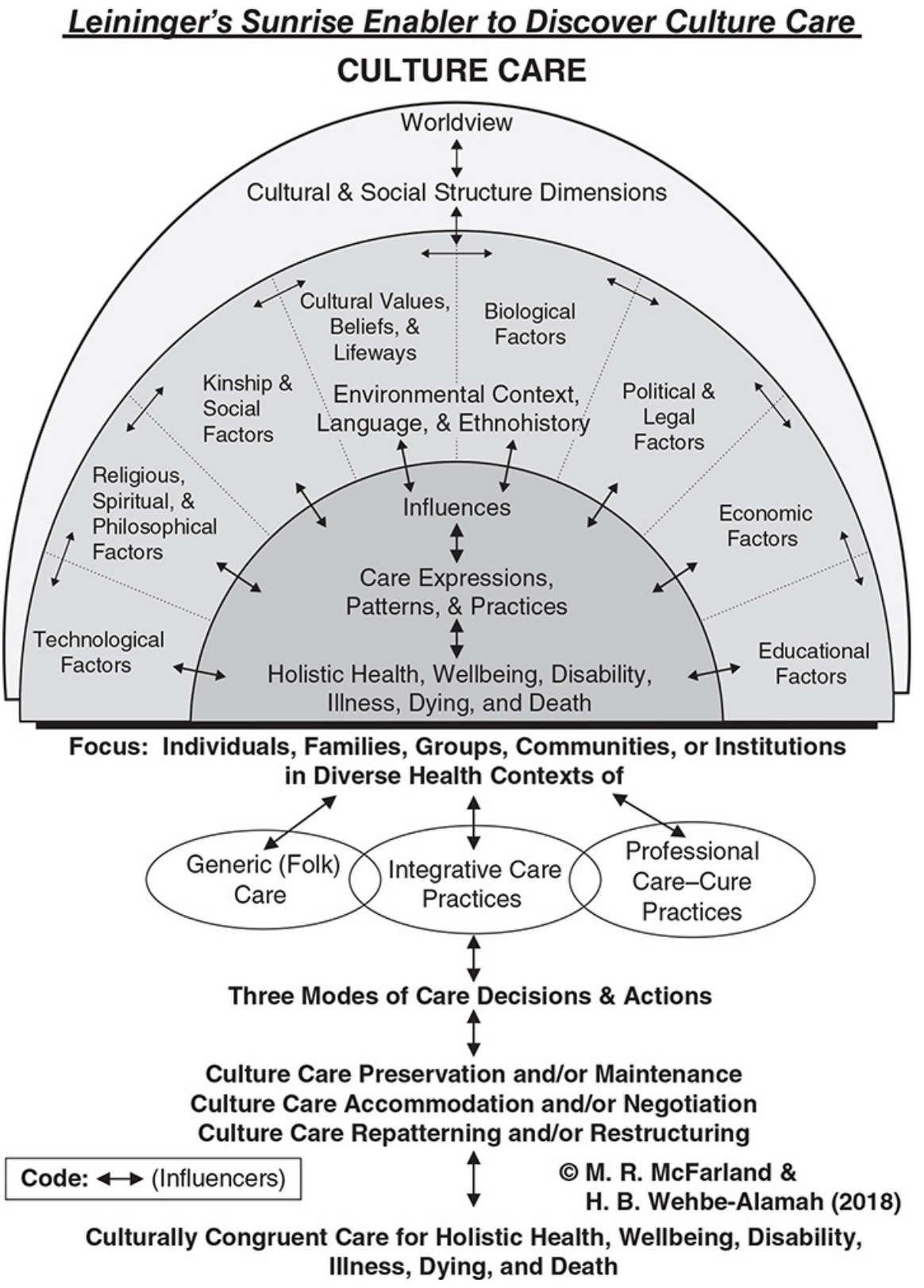

FIGURE 3.1 • Leininger's Sunrise Enabler to Discover Culture Care.
Used with permission. McFarland, M. R., & Wehbe-Alamah, H. B. (2018).

In 2002e, Leininger discussed the construct of *integrative care* as the desired outcome of generic and professional care when appropriately and meaningfully used in therapeutic practices. She defined *integrative care* to refer to *safe, congruent, and creative ways of*

blending together holistic, generic, and professional care knowledge and practices so that the client experiences beneficial outcomes for wellbeingor to ameliorate a human condition or lifeway (pp. 148-149).

Culturally Congruent Care

Culturally congruent care refers to *culturally-based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately andmeaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death* (Leininger, 2006a). To provide culturally congruent care has been the major goal of the Culture Care Theory (Schumacher, 2010).

Strang and Mixer (2015) found that the Maasai voiced preferences for culturally congruent care that included education about professional malaria care to be combined with generic or traditional care that was safe and offered in a respectful manner. Lee (2012) alluded to *safe and respectful care* as culturally congruent care when she described the challenges mothers faced when providing care for their children within the context of family homelessness. She advocated for nurses to influence policies for safe and affordable housing for those persons who are homeless. Morris (2012) also discussed the concept of safety in the context of culturally congruent care among African American adolescent gang members within and for their community.

Culture Care Diversity

Culture care diversity refers to the differences or variabilities among human beings regarding culture care meanings, patterns, values, lifeways, symbols, or other features related to providing beneficial care to clients of a designated culture (Leininger, 2002d, 2006a, 2015a). Wolf et al. (2014) identified gender based differences in care when they studied the culture care of Somali immigrant refugees in Minnesota

Culture Care Universality

Culture care universality refers to the commonly shared or similar culture care phenomena features of individuals or groups with recurrent meanings, patterns, values, lifeways, or symbols that serve as a guide for caregivers to provide assistive, supportive, facilitative, or enabling people care for healthy outcomes (Leininger, 2006a, 2015b).

Another major theoretical tenet of the CCT states that *culture care expressions, meanings, and practices are**diverse yet also have shared commonalities**between and among cultures* (McFarland & Wehbe-Alamah, 2015b). Leininger further explained that many researchers have only reported on discovered care findings that are *common or universal* but have reported less often about those that are *diverse* (M. M. Leininger, personal communication, June 2012). However, Mixer (2011) described both universal and diverse care patterns within her overarching theme about faculty teaching culture care.

Health

Health refers to *a state of wellbeing that is culturally defined, valued, and practiced, and which reflects the ability of the individuals or groups to perform their daily role activities in culturally expressed, beneficial, and patterned lifeways* (Leininger, 1991b, 2015a). It is a *restorative state of wellbeing that is culturally constituted, defined, valued, and practiced by individuals or groups that enables them to function in their daily lives* (Leininger, 2002d, 2015a). These definitions of health have been confirmed by numerous ethnonursing researchers in their culture care studies including Gunn & Davis (2011) who studied healing with botanicals among elderly African Americans in the Mississippi Delta region; Lee (2012) who studied family homelessness in urban Appalachia; and Moss (2014) who studied the care and health practices of rural Ecuadorians.

Ethnohistory

Ethnohistory is a construct of the theory that comes from anthropology but one which the Leininger (1978) reconceptualized within a nursing perspective. The theorist defined *ethnohistory* as the *past facts, events, instances, and experiences of human beings, groups, cultures, and institutions that occur over time in particular contexts that help explain past and current lifeways about culture care influencers of health and wellbeing or the death of people* (Leininger, 1991b, 2002d, 2006a, 2015a). Ethnohistory is another essential dimension to consider when providing culturally congruent care. Special past and current events and conditions within the historical context of cultures and their caring modalities are important caring practices to discover and know as transcultural nursing knowledge, especially when studied within the context of care and wellbeing. Wolf et al. (2014) explained how the ethnohistory of the cultural group of Minnesotan Somali refugees who had fled a 20-year civil war profoundly influenced their care access and treatment for mental illness. Moss (2014) also described how healthcare beliefs and practices of *mestizo* Ecuadorians living in rural and remote areas were influenced by their ethnohistory, which included a past intertwined with the indigenous people of Ecuador (the Inca) and Spaniards who ruled present day Ecuador from the 1500s to the 1800s.

Environmental Context

Environmental context refers to *the totality of an event, situation, or particular experience that gives meaning to people's expressions, interpretations, and social interactions within particular geophysical, ecological, spiritual, sociopolitical, and technologic factors in specific cultural settings* (Leininger, 1991b, 1995a, 2002d, 2006a; McFarland & Wehbe-Alamah, 2015b). Strang and Mixer (2015) in their article about the Maasai in Kenya shared the discovery about how the environmental context was both a *facilitator* and *barrier* influence to effective malaria care outcomes. These issues included the geographic environment and location; the expectation to first use traditional care; knowledge of care options; financial resources; and use of insecticide-treated sleeping nets to prevent

transmission of malaria from bites of the Anopheles mosquito (Strang & Mixer, 2015).

Worldview

Worldview refers to *the way people tend to look out upon their world or their universe to form a picture or value stance about life or the world around them* (Leininger, 1978, 1991b, 2002d, 2006a). Worldview provides a broad perspective about one's orientation to life, people, or groups that influence care or caring responses and decisions. Worldview guides one's decisions and actions, especially related to health and wellbeing as well as care decisions and actions. Lee (2012) described how urban and rural Appalachian mothers who were homeless found a sense of faith and hope that allowed them to look toward the future. Wehbe-Alamah (2008, 2011) studied folk care beliefs of traditional Lebanese and Syrian Muslims in the Midwestern United States, discovering worldviews that were diversely and universally embedded in their Islamic religious as well as unique cultural beliefs and practices. The author later compared and further explicated these findings in a follow-up synthesis work (Wehbe-Alamah, 2015).

CULTURE CARE MODES OF DECISIONS AND ACTIONS

In the Culture Care Theory, Leininger (2002b) postulated three culture care decision and action modes for providing culturally congruent nursing care. The three modes were highly innovative and unique in nursing and health care. Leininger (1991b) held that nurses needed creative and different approaches to make care and culture needs meaningful and helpful to clients. These three theoretically predicted decision and action modes of the Culture Care Theory are defined as:

- *Culture care preservation and/or maintenance*, which refers to those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve, or maintain beneficial care beliefs and values or to face illness, disability, dying, and or death;
- *Culture care accommodation and/or negotiation*, which refers to those assistive, accommodating, facilitative, or enabling creative provider care actions or decisions that help cultures adapt [accommodate] to or negotiate with others for culturally congruent, safe, and effective care for their health, wellbeing, or to deal with illness, injury, disability, or dying; and
- *Culture care repatterning and/or restructuring*, which refers to those assistive, supportive, facilitative, or enabling professional actions and mutual decisions that would help people to reorder, change, modify, or restructure their lifeways and institutions for better (or beneficial) healthcare patterns, practices, or outcomes. (Eipperle, 2015; Leininger, 2006a)

The modes have substantively guided nurses to provide culturally congruent nursing care

and thereby fostered the development of culturally competent nurses. Nurses practicing in large urban centers typically care for clients from many different cultures or subcultures. Leininger's Culture Care Theory provides practicing nurses with an evidence-based, versatile, useful, and helpful approach to guide them in their daily decisions and actions regardless of the number of clients under their care or the complexity of their care needs.

The three culture care modes of decisions and actions are essential for care/caring and need to be used with discoveries from ethnonursing research studies guided by the CCT. The Culture Care Theory has challenged nurses to discover specific and holistic care as known and used by cultures over time and in different contexts. Both *care* and *culture* are held to be central and critical for the discipline and practice of nursing. *Nursing interventions* is a term that is seldom used in the Culture Care Theory or in transcultural nursing. This term has often been used inappropriately and is viewed by several cultures as too controlling or all-knowing. When used by nurses, this term may lead to interferences through words or actions with the cultural lifeways, values, and practices of others. This is because the term [nursing interventions] is sometimes viewed as or represents *cultural imposition nursing practices* used when providing care to clients, which may be offensive or in conflict with their lifeways (Eipperle, 2015; Leininger, 2006a).

Leininger proposed that *culture care preservation and/or maintenance* should in most circumstances be considered first, as many times people are doing meaningful and acceptable care for their families and others that leads to beneficial health outcomes. Many nurses from Western cultures are focused on interventions so as to make changes, believing that care should be based solely on professional nursing knowledge. However, it is important to *first* consider what people are doing right in caring for themselves and their families. Many times people are providing exquisite care in their homes or in institutional, community, or primary settings (Eipperle, 2015; Gunn & Davis, 2011; Lee, 2012; McFarland & Zehnder, 2006; Outwater et al., 2014; Wanchai, Armer, & Stewart, 2015; Wehbe-Alamah, 2011).

These generic caring decisions and actions should be maintained and supported and sometimes combined with professional/integrative care by nurses, educators, and students to provide culturally congruent care for people (Leininger, 2002e). In international service-learning courses, preserving and/or maintaining care that is therapeutic is an essential lesson for nurses and nursing students (Knecht & Sabatine, 2015). They need to be guided by the care modes and in most circumstances consider *first* what caring actions should be maintained or preserved; then consider what should be accommodated or negotiated; and only as a final decision consider what should be changed—repatterned and/or restructured (Eipperle, 2015).

SUNRISE ENABLER AND THE CULTURAL AND SOCIAL STRUCTURE DIMENSIONS

The cultural and social structure dimensions refer to the dynamic, holistic, and interrelated patterns of structured features of a culture (or subculture) that include but are not limited to technology factors; religious and philosophical factors; biological factors [new

revision/addition]; kinship and social factors; cultural values, beliefs, and lifeways; political and legal factors; economic factors; and educational factors as well as environmental context, language, and ethnohistory (Wehbe-Alamah & McFarland, 2015a, p. 75).

Cultural and social structure dimensions are other major features of the Culture Care Theory (Leininger, 1978). Social structure phenomena provide broad, comprehensive, and special factors influencing care expressions and meanings. Social structure factors of clients include religion (spirituality); kinship (social ties); politics; legal issues; education; economics; technology; political factors; philosophy of life; and cultural beliefs and values with gender and class differences. The theorist predicted that these diverse factors must be understood as they directly or indirectly influence health and wellbeing (Leininger, 1978). In the past, social structure factors were not explicitly studied in nursing nor in reference to care until the advent of transcultural nursing (Leininger, 1978, 1991a). The use of Leininger's CCT has helped nurses to study these dimensions for a holistic or total view of clients. The study of these influencing factors has provided a wealth of invaluable insights about culturally-based care addressing health, wellness, or illness (McFarland & Wehbe-Alamah, 2015b, pp. 17-18).

The following discussion of the social structure dimensions presents substantive research findings, which can serve as resources for valuable technological, religious and spiritual, kinship and social, cultural political and legal, educational, economic, and technological factors discovered by transcultural nurse researchers who used the CCT to guide their ethnonursing studies.

Technological Factors

Leininger (2006b) studied the Gadsup Akuna of New Guinea in the 1960s and discovered that they had no Western technology for health care or daily lifeways. Their care was based on making cultural artifacts for family members and the rest of the community. Women demonstrated care by making infant and garden string bags and tending gardens to produce healthy foods for their families and the village community. Men made wooden vessels for cooking foods and decorative amulets for ceremonial functions. The Gadsup depended heavily on generic care rather than the professional care and technological interventions available 25 miles away at a small hospital.

In 1997, McFarland discovered that elderly African Americans and Anglo American elders residing in a long-term care facility preferred receiving health care at the small clinic located within the facility rather than being transferred to a large medical center with state-of-the-art technology located just a few blocks way. Most residents *cautiously* considered the discussed potential for better health outcomes from treatment obtained at the medical center, and often still elected to receive their care at the long-term care facility.

Kelch (2015) conducted a translational research project in Haiti, implementing a chronic disease management program based on the provision of culturally congruent care for health workers and ancillary staff with hypertension or Type 2 diabetes employed at a remote primary care clinic. He was able to bring the technology of HgbA1C testing to this remote tropical area despite not having the necessary climate-controlled storage or work spaces

where blood sample testing took place (Kelch, Wehbe-Alamah, and McFarland, 2015). This challenge was addressed by storing blood samples in a portable cooler filled with reusable ice packs and a thermometer from the clinic to monitor temperatures. Thus, a climate-controlled environment was created for storing blood samples for testing. However, healthcare workers who were diagnosed with Type 2 diabetes were treated with oral medications only, given that insulin rapidly degraded in the excessive heat and most Haitians living in remote areas lacked the technologies of refrigeration or air conditioning.

Religious, Spiritual, and Philosophical Factors

Strang and Mixer (2015) discovered that spiritual factors among the Kenyan Maasai were important influencers on malaria care. The Maasai often prayed to God for healing before taking medicine offered by professional care providers. Gunn and Davis (2011) in their study about healing botanicals used by elderly African Americans in the Mississippi delta region reported that their caring practices in modern times were rooted in healing from God rather than depending on herbs, roots, and plants as was done in by-gone eras. Morris (2012) in her study of urban adolescent gang members discovered spiritual and religious beliefs were a means for them to ameliorate the harsh realities of the urban environment and to promote personal, group, and community wellbeing.

Kinship and Social Factors

Wolf et al. (2014) in their study of Minnesotan Somali immigrant refugees discovered that tribe and family involvement in care influenced their healthcare access and experiences. One informant described that female family members were never left alone in the hospital; she stated that Somalis would like nurses to understand that practice and allow extended family visits. Wehbe-Alamah (2006, 2015) discovered in her studies with Lebanese and Syrian Muslims in the Midwestern United States that both groups relied on community members as extended caregivers and that husbands took on a more active role in the caregiving process due to the absence of immediate and extended family members.

Cultural Values, Beliefs, and Lifeways

Cultural values, beliefs, and lifeways as a factor has been studied extensively by transcultural nurse researchers using the CCT as a guide to discover how this factor influences and is influenced by the provision of culturally congruent care and health and wellbeing. This central placement of this factor in the enabler reflects its importance as a key influencer upon the other factors (rays of the sun) and culture care expressions, patterns, and practices, which in turn affect the provision of culturally congruent care, and thereby health and wellbeing. The discovery of cultural values, beliefs, and practices by diverse cultural groups were central to finding out how to provide culturally congruent care to rural Dominicans (Shumacher, 2010); African Americans in the Mississippi delta region (Gunn & Davis, 2011); urban African American gang members (Morris, 2012); homeless urban and rural

Appalachian women and their children (Lee, 2012); bereaved Tanzanian relatives of homicide victims (Outwater et al., 2014); breast cancer survivors in northern Thailand (Wanchai et al., 2015); Somali refugee immigrants in Minnesota (Wolf et al., 2014); rural *mestizo* Ecuadorians (Moss, 2014); the Kimana Maasai of Kenya (Strang & Mixer, 2015); and rural healthcare workers in Haiti (Kelch et al., 2015).

Biological Factors

Biological factors are a developing construct—first referred to by Leininger (2002b, p. 53)—that emerged from studies guided by the CCT where physical conditions, illnesses, and syndromes were a major care focus of the cultural group under study. Among the more recent studies where biological factors were identified as key influencers on care were Strang and Mixer (2015) who studied malaria care with the Kenyan Maasai; Wolf et al. (2014) who studied immigrant Somalis in Minnesota and mental health; and Kelch et al. (2015) who studied hypertension and diabetes among multicultural healthcare workers in Haiti. *Biological factors* has been added as a central construct to the Sunrise Enabler under *Cultural and Social Structure Dimensions* and above *Care Expressions, Patterns, and Practices* to emphasize the importance of assessing hereditary and genetic illnesses as well as culture-bound syndromes. This placement was done in recognition of the fact that biological factors influence and are influenced by cultural and social structure dimensions and the other factors depicted within the rays of the sun in the Sunrise Enabler, all of which thereby influence and are influenced by generic and professional care expressions, patterns, and practices (H. B. Wehbe-Alamah, personal communication, October 2015).

Political and Legal Factors

Political and legal factors exert influence through regulatory and legislative actions that affect access to and the professional provision of care at both the social structure and individual levels (Miller, 2002). Outwater et al. (2012) studied the care practices of bereaved relatives of homicide victims in Tanzania and found that care practices differed in rural areas compared to modern urban areas. If a person was murdered in a village without police, the assailant would be followed and the murder solved by the cooperative efforts of the local people as an expression of care. In her study of rural and urban families [women with children] who were homeless in Appalachia, Lee (2012) recommended that nurses move their advocacy efforts beyond the scope of providing direct care services to advocacy in the public policy arena seeking more substantive and lasting solutions to issues such as housing and employment reforms.

Economic Factors

Many transcultural nursing research studies guided by the CCT documented the importance of economic factors and their influences on the quality of generic and professional care provided to diverse cultural groups. Gunn and Davis (2011) addressed the economic woes of

African Americans living in a rural county in the Mississippi delta region where the majority of households earn an income well below the poverty line, placing the population at greater risk for poor health outcomes. Kelch et al. (2015) discussed poor health outcomes for rural Haitians who chew on sugar cane stalks and eat cookies made with mud [dirt] and salt to alleviate their hunger. Morris (2012) discovered that senior African American adolescent gang members in a large Midwestern city in the United States encouraged younger children to become gang members as a means to earn a living.

Educational Factors

Educational factors have influenced care and caring through nursing education and encouraging young people to enter into healthcare professions (Leininger, 1995b). Educational levels also influence health literacy, which affects patients' ability to understand and navigate the healthcare system, and thereby has a direct bearing on health outcomes (Schumacher, 2010). Gunn and Davis (2011) discussed the uneducated workforce in the Mississippi delta as one reason for the high unemployment rate in the local community; industries were not willing to locate where there was not a population with skilled potential employees. Kelch et al. (2015) discussed educating local healthcare workers about nutrition and healthy local foods such as the indigenous fruits and vegetables available to Haitians. Such educated healthcare workers knowledgeable about the Haitian culture could provide nutritional information for patients in a culturally congruent and acceptable way. Mixer (2011) focused her research on how nursing faculty educated nursing students to become culturally competent to provide care to clients from diverse backgrounds.

SUMMARY/CONCLUSION

In reviewing studies for this chapter, it came to this author's attention that there were gaps in the extant knowledge base of the discipline that provide opportunities for future ethnonursing research using the Culture Care Theory. Such studies could address the culture care needs of immigrant and refugee populations; how technology is used in and/or affects the ways cultures seek or use health care; and the healthcare needs of people in developed and developing regions of the world experiencing local or globally occurring healthcare crises, disparities, or communicable disease epidemics.

The Theory of Culture Care Diversity and Universality has increasingly become used by transcultural nurses as a guide to study diverse cultures worldwide. Practicing nurses can use culturally-based research findings to provide culturally congruent care for clients from diverse and similar cultures. In addition, the theory can be used as a cultural guide to study current health issues related to problems in diverse communities in the world facing serious health challenges. Examples of this include animal-borne diseases that have been passed to humans and become epidemic such as the Ebola virus in West Africa and Zika virus in Puerto Rico and Florida in the United States (U. S. Department of Health and Human Services [USDHHS], 2015; Freiden, Schuchat, & Peterson, 2016).

In addition, forced displacement of persons has increased (34,000 people every day) to the extent that by the end of 2015, 65.3 million individuals were forcibly displaced worldwide (refugee or stateless persons), with more than half of these people coming from just three countries—the Syrian Arab Republic, Afghanistan, and Somalia (United Nations Refugee Agency [UNHRC], 2016). Among the displaced are nearly 21.3 million refugees (persons forced to flee their homes or homelands because of conflict or persecution), over half of whom are under the age of 18 (UNHRC, 2016). There are also 10 million stateless people being denied a nationality and access to basic human rights such as education, health care, employment, and freedom of movement (UNHRC, 2016). At the end of 2015, UNHRC reported that the world was poised to experience its highest recorded level of displaced persons known in history (UNHRC, 2015).

Many displaced people dwell in 'temporary' refugee camps where multiple urgent and often serious (life altering and/or life-threatening) healthcare needs are endured while they wait for durable solutions to their refugee status (UNHCR, 2014). Effective prevention, treatment, and eventual eradication of such easily transmittable communicable diseases and attending to the myriad health challenges faced by refugees will require transculturally-prepared nurses and other healthcare professionals to integratively address the influencing cultural and social factors at individual, community, institutional, and national levels (Leininger, 2002d).

One of the strategies used to control the spread of Ebola in West Africa has been to remove infected people from their communities where traditionally *family care* is provided for the sick (USDHHS, 2015). "…A CDC staffer discovered *30 unreported cases* [emphasis added] in one remote village in Sierra Leone; the health official in the village thought Ebola was witchcraft and intentionally kept their outbreak a secret" (USDHHS, 2015). It seems evident that shifting from treating the physiological or physical disease to integrating major social structure dimensions about cultures, caring, and health-and-illness values, beliefs, and practices would provide the broad cultural perspective essential to providing care/caring for and serving these individuals (Leininger 2002d). The study of culturally congruent and specific care beliefs and practices is *key* to prevent further illness, promote healing, maintain health, and be of help in the recovery from this and other epidemic illnesses (Leininger, 2002d, p. 73).

The sexual transmission of Zika, a mosquito-borne virus associated with human birth defects, has been reported in 60 countries or territories including Puerto Rico and the state of Florida in the United States (Freiden et al., 2016). Access to contraceptives and sensitive counseling for women who have had confirmed positive laboratory tests for the Zika virus is a pressing, imperative need. Further, active engagement with the people in the affected or at-risk communities is also urgently needed to promote understanding and gain support for interventions such as travel limitations, mosquito protections, and vector eradication programs (Freiden et al., 2016).

Using the three culture care modes of decisions and actions (*culture care preservation and/or maintenance*; *culture care accommodation and/or negotiation*; and *culture care repatterning and/or restructuring*) to engage people to participate in requisite strategies that will effect changes for healthy outcomes is vital for meaningful and lasting health and

satisfying cultural lifeways. Co-participative and collaborative care decisions and actions are essential to effectively prevent, treat, and eradicate disease as well as to meet the evolving healthcare needs of cultures worldwide (Eipperle, 2015; Leininger, 2002a, 2015b).

DEDICATION

This chapter is dedicated to Madeleine M. Leininger, my teacher, mentor, colleague, and friend.

DISCUSSION QUESTIONS

1. Review the constructs of *culture*, *care and caring*, and *culture care*. Reflect upon and discuss what your beliefs and perceptions about them were before reading the chapter compared to what your perceptions are now. How will this affect your interactions with patients?
2. Discuss how you can integrate (not add) culturally congruent care into your practices.
3. Discuss how the Theory of Culture Care Diversity and Universality is applicable to health care in the context of current national and global events.
4. Drawing from your own professional experiences, discuss how you might apply the three modes of culture care decisions and actions to past, present, or future client situations. How would the outcomes have been or be different?
5. Discuss how the Theory of Culture Care Diversity and Universality, the Sunrise Enabler, the three modes of culture care decisions and actions, and the Ethnonursing Research Method can be used by transcultural nurses and other healthcare providers to influence how governments and nongovernmental agencies could more effectively address prevention, intervention, and treatment for current and emerging global communicable disease crises and other healthcare issues worldwide.

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