Assignment # 2: Delivering Culturally Competent Care to Older Adults

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1. What are the selected ethnic group’s unique cultural beliefs?

According to Lynda Konecny (2012), the “older population in the United States (U.S.) are becoming increasingly diverse in terms of race and ethnicity” (Konecny, 2012, slide 7). It is expected that by the year 2050, “there will be a dramatic growth among Hispanic older adults, who will represent nearly 20% of the older population” (Eliopoulos, 2014, p. 24). They will include a variety of people from different Spanish-speaking countries, such as Mexico, Cuba, South America, and Central America (Konecny, 2012, slide 62). Therefore, it is continually becoming more imperative that as nurses, we “realize the importance of … the need to understand and value their health beliefs and practices” (Strunk, Townsend-Rocchiccioli, & Sanford, 2013, p. 46).

According to Eliopoulos, “many Hispanic people view states of health and illness as the actions of God (Eliopoulos, 2014, p. 25),” which also demonstrates a belief in a higher power and the existence of spiritual relationships. With that being said, it has been reported that “Hispanic belief that physical and mental illness results from an imbalance between the person and environment, and between hotand cold” (Strunk et al., 2013, p. 47). Old age is of importance and is held in high regard in the Hispanic culture; this is apparent by the mere 7% rate of nursing home usage, which corroborates the idea that the caretaker responsibility will normally be with the children of the older adult (Eliopoulos, 2014, p. 25). Occasionally, “direct eye contact is seen as rude and disrespectful” amongst Hispanic Americans (Konecny, 2012, slide 31). In regards to truth-telling, it has been found that many “Mexican American clients are unlikely to want to be told they are dying” and choose to opt out of making any decisions with their end-of-care (Konecny, 2012, slide 60). Studies suggest that South American and Mexican cultures believe “that speaking about death can bring it closer” (Konecny, 2012, p. 60).

2. What are the selected ethnic group’s unique cultural values?

Hispanic cultural values promote a “high emphasis on family closeness, close interpersonal family relations, respect from adults, and traditional gender roles” (Lorenzo-Blanco, Unger, & Baezconde-Garbanati, 2012, p. 1352). The following cultural values have been identified by Hispanic Americans: *familisimo*, which “emphasizes trust between family members, loyalty to the family, and a general orientation to the family,” *respeto*, “governs positive reciprocal interpersonal relations and dictates deferential behavior towards family, thereby maintaining family harmony,” and *fatalisimo*, which “encompasses the belief that one is powerless in altering negative life circumstances” and “has been described as promoting social support and belonging” (Lorenzo-Blanco, et al., 2012, p. 1352).

3. What are the selected ethnic group’s unique traditions and/or practices?

As per Eliopoulos (2014), many Hispanic Americans choose to utilize “traditional practitioners” such as Curanderos, Sobadoras, Espiritualistas, Brujos, and Senoras in place of or in conjunction with traditional Western medicine and its providers (p. 25). Therefore, there are “more than one fourth of Hispanic adults in the United States lack[ing] a usual health care provider” (Livingston, Minushkin, & Cohn, 2008, p. 4). In response to the belief that God can reward a person with good health, many Hispanics may wear “medals and crosses…to facilitate wellbeing, and prayer plays an important part in the healing process” (Eliopoulos, 2014, p. 25). Many of the subgroups believe that illness results from a “body imbalance between caliente (hot) and frio (cold) or “wet” and “dry,”” with Cubans believing that “good health results from prevention and good nutrition” (Estes, 2010, p. 137). As per Estes (2010), it is also common practice for Hispanics to “prevent and treat illness with “hot” and “cold” food prescriptions and prohibitions” (p. 135).

During living years, older Hispanic adults are usually practicing Roman Catholics who believe in both and afterlife and possibility of resurrection after death (Konecny, 2012, slide 83). As previously noted, it is highly likely that family members will become caretakers and be responsible in making decisions on behalf of the older adult (Konecny, 2012, slide 83). Although people of this culture usually have “an expressive style, there can be an expectation of stoicism in the face of suffering” amongst older adult clients typically due to a fear of becoming addicted to pain relievers that may be administered (Konecny, 2012, slide 56). In accordance with this, family members of the deceased older Hispanic adult may exhibit an “open display of emotion” and “extended grieving” (Konecny, 2012, slide 83). Also, it is not uncommon for these family members to “want to prepare [the] body” and host “prolonged wakes” (Konecny, 2012, slide 83).

In a brief description of the individual subcultures, Estes notes that Mexicans are mostly bilingual, “consider prolonged eye contact disrespectful,” and have a “relaxed concept of time” in regards to relationships, including work (Estes, 2010, p. 135). Whether or not Puerto Ricans speak Spanish or English depends on the length of time spent in America; the longer time they have been in the United States the more likely they are to speak English or be bilingual versus strictly Spanish-speaking, whereas Cuban Americans are more likely to be bilingual upon arrival (Estes, 2010, p. 136). Amongst this “paternalistic” subgroup, “personal and family privacy [is] valued, and they “tend to have a relaxed sense of time” in relation to their communication styles (Estes, 2010, p. 136).

4. What are the selected ethnic group’s unique health-related needs/problems?

Hispanic Americans are faced with several health-related needs and problems. According to Livingston et al. (2013), many Hispanics are overweight, a finding that is likely to increase the prevalence of diabetes in this population (p. 4). A potential problem is that approximately 83 percent of the Hispanic receives health information (that has an effect on their current health practices) from a form of media, most significantly from television (Livingston, 2013, p. 27) in place of visiting a practitioner at an actual healthcare facility. This can in fact have an effect on level of knowledge regarding prevalent diseases in this population, such as diabetes. Livingston et al. (2013), reports that in conjunction with healthcare access, language, and education level, “nativity and assimilation are associated with higher levels of diabetes knowledge” (p. 36). Lastly, it is important to address a possibly problematic health issue: alcohol consumption by Hispanic Americans. It has been found that Hispanic Americans consume less alcohol, in general, than non-Hispanic whites, however, “Hispanics who choose to drink are more likely to consume higher volumes of alcohol than non-Hispanic whites” (National Institute on Alcohol Abuse and Alcoholism, 2013).

5. What are the selected ethnic group’s health-related experiences?

Hispanic Americans health-related experiences are affected by numerous challenges presented during care, such as “numerous health issues, language difficulties, differences in cultural beliefs and practices, and the loss of social supports” (Strunk et al., 2013, p. 46). According to Livingston, et al., “more than three-quarters of Hispanics who have had medical care within the past year rate it as good to excellent: 32 percent say it was excellent, and 46 percent say it was good” (p. 22). Nonetheless, there were approximately 17 percent who rated their care as being “fair” and about 4 percent that found it to be “poor” (Livingston et al., 2013, p. 23). Of those who reported perceived poor care, reasons included “inability to pay…their race or ethnicity…[and] their accent or how they speak English” (Livingston et al., 2013, p. 24). It has been found that, “although access to health care does not account for disparities in their entirety, physicians and health care workers do contribute to a portion of disparity problems” along with “institutionalized discrimination, where policies and procedures make it harder for health care professional to provide equal care to disenfranchised individuals” (Strunk et al., 2013, p. 46). The lack of legal employment provided to Hispanic immigrants is often indicative of their access to healthcare and high poverty level compared to non-Hispanic whites, which in turn will leave older Hispanic adults (65 years and over) with few resources post-retirement, increasing their likelihood of becoming or remaining poor and without access to proper healthcare. (Strunk et al., 2013).

6. What are the selected ethnic group’s health risks?

As per Livingston, et al., Hispanics “have a lower prevalence of many chronic health conditions that the U.S. adult population as a whole,” however, “they have a higher prevalence of diabetes than do non-Hispanic white adults, and they are more likely to be overweight” (2013, p. 4). It is also found that Hispanics are more genetically predisposed to cleft lips or palates, hypertension (Mexican American, Latino, Chicano) and malignant osteoporosis (Costa Rican) (Estes, 2010, p. 126).

7. What are the selected marginalized group’s unique lifestyles?

As per Eliopoulos (2014), we have become more conscious of the gay community and its growing population, and approximately 10 percent of the population currently identifies as being part of the LGBT community. Older adults within this population were once subjected to severe prejudices causing many of them to remain enigmatic about their sexual orientations (Eliopoulos, 2014, p. 30-31). According to Konecny (2012), gay people often “age feeling socially isolated, fearing discrimination from healthcare practitioners, living alone, and do not have children to help in their care” (slide 58).

8. What are the selected marginalized group’s health-related needs/problems?

Eliopoulos (2014) reports that recent years have shown some progression in dealing with the needs of gay individuals and the gay community with the creation of many associations, programs, and networks that work to advocate for the equality and other needs of this population (p. 31). According to the School of Medicine at Vanderbilt University (2012), “men who have sex with men and gay men are at increased risk for certain types of chronic diseases, cancers, and mental health problems.” There also exists a higher prevalence of smoking and drinking when compared to the heterosexual population. Reports of victimization, denial of or receipt of inferior care, and the feelings of having to conceal their sexual identity continue to propagate amongst the older adult gay population (p. 31). The prevalence of HIV/AIDS among gay men continues to be of epidemic proportions, and they “should get regular HIV tests and appropriate risk-based counseling about safe sex practices” (Vanderbilt School of Medicine, 2012). Furthermore, vaccines for HPV and hepatitis C are available for gay men; they can prevent transmission of these viruses, however, screenings for STDs should be done routinely and consistent safe sex practices should be implemented (Vanderbilt School of Medicine, 2012). Lastly, it has been found that men who have sex with men have a tendency to have body image disorders, use anabolic steroids, and be obese; it is important to screen gay men for each of these, and provide them with guidance and education about healthy lifestyle habits (Vanderbilt School of Medicine, 2012).

9. What healthcare disparities/discriminatory practices may the selected marginalized group encounter?

Healthy People 2020 (2013) report that:

Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals.

Several of the disparities that Healthy People 2020 (2013) suggest healthcare personnel immediately and consistently address include the increased likelihood of suicide attempts and homelessness, risks of HIV/AIDS and other STDs, and rates of those within the gay community that smoke, drink alcohol excessively, and use other drugs that are detrimental to their health and wellbeing. It should also be noted that “studies have found that LGBT older adults in community and long-term care settings reported being fearful of rejection and neglect by other caregivers, not being accepted by other residents, and being forced to hide their sexual orientation (Eliopoulos, 2014, p. 31).

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