Using Cultural Competence Constructs to Understand Food Practices and Provide Diabetes Care and Education

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Abstract

By 2050, > 50% of the U.S. population will consist of people from different cultural backgrounds. The dynamic, growing population shifts in the United States and the changing health status of various cultural, ethnic, and racial groups create exciting challenges for health care professionals. Increasing evidence about culture and health emphasizes the importance of understanding and applying cultural constructs as a part of diabetes care and education. To understand the connections between cultural food practices and diabetes among ethnic and racial groups, cultural competence first must be gained. This article presents a discussion about applying the Campinha-Bacote Model of cultural competency to the task of understanding the relationship between cultural food practices and diabetes.

Culture, food, and diabetes converge at different points to promote and affect an individual's health and well-being. As a part of the provision of diabetes care and education, the questions that may be posed by health care providers to people with diabetes may include, "What did you eat?" "How much did you eat?" "How did it affect your blood glucose level?" and "How was the food prepared?" Understanding the answers to these questions and investigating why people eat what they do requires an awareness of their culture. Once understood, such knowledge may be applied to develop appropriate interventions.

The American Dietetic Association, American Diabetes Association, and American Association of Diabetes Educators support and encourage health care professionals to develop their cultural competence to provide culturally sensitive medical nutrition therapy as well as care and education to people with diabetes.[1–3] Cultural competence is now part of the Commission on Accreditation for Dietetics Education standards. Students will learn and discuss diverse cultures as part of their studies.[4]

Relationship of Culture to Food and Disease

Every culture defines its eating occasions.[5] Culture is an accumulation of a group's learned and shared behaviors. Acquired by people living their everyday lives, culture offers beliefs, customs, and knowledge, as well as a sense of identity, order, and security. It defines social structure, decision-making practices, and communication styles. Transmitted formally and informally from one generation to the next, culture dictates behavior, etiquette, and protocol.

As a starting point for discussing culture, ethnicity and race merit definition and reflection. No universally accepted definition of ethnicity exists. This complex concept typically refers to identity generated within and between social groups. Ethnicity is often referred to as a common ancestry that may include shared language, nationality, social customs, and religion. Race generally refers to particular physical char-

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acteristics of individuals, including skin color, facial features, and hair, delineating to race categories such as African American, American Indian, Asian, and others.[6]

According to Gabaccia,[7] "food and language are the cultural habits humans learn first and the ones they change with the greatest reluctance." As a powerful symbol of cultural identity, food is more than an object or product to be purchased for routine inclusion in daily life.[8] Food fulfills the human race both culturally and physiologically. The meaning of food for different cultural groups goes beyond providing sustenance. Cultural food patterns are defined by what, when, how, and with whom foods are eaten. Ethnic and racial groups differ in how they identify foods and how they prepare them, the condiments they use, and the timing and frequency of meals. Foods are frequently used in symbolic ways, playing an integral role in religious ceremonies and social events. Cultural food practices are dynamic and ever-changing, with many traditions persisting with acculturation.

Ethnic groups maintain their cultural identities with their food practices, values, and beliefs. Culture determines how a person defines health, recognizes illness, and seeks treatment. Each culture has attitudes, beliefs, practices, and values about good health and disease prevention; the care and treatment of the sick; whom to consult when ill; and the social roles between the client or patient and health care professionals.[9]

Disease refers to physiological and psychological processes. Illness refers to the psychosocial meaning and experience of the perceived disease for the individual, the family, and those associated with the individual.[10] Health care professionals have been trained to manage disease, whereas patients seek care to manage their illness. A cultural discordance occurs when the management of illness differs from the management of disease. Successful cross-cultural communication and understanding occurs when health care professionals address clients' perceptions of illness, treatment, and outcome.

Growing evidence supports a connection between understanding a client's culture and health outcomes, particularly as it relates to client satisfaction and adherence. Long-term supportive follow-up with an emphasis on client-family-community empowerment can improve diabetes outcomes.[11] Understanding culture is an active, developmental learning process requiring a long-term commitment.[12,13]

Impact of Diabetes on Ethnic and Racial Groups

The dynamic population shifts in the United States and the changing health status of various cultural, ethnic, and racial groups create exciting challenges for health care professionals. Census 2000 data indicate that individuals of either different races or Hispanic origin comprise > 30% of the total population in the United States. This trend will continue, and by 2050, > 50% of the population in the United States will consist of people from different cultural backgrounds.[14]

Diabetes has reached epidemic proportions in the United States, affecting an increasing number of adults, with people from ethnic and racial groups disproportionately affected. Approximately 23.6 million children and adults in the United States, or 7.8% of the population, have diabetes.[15] An estimated 17.9 million have been diagnosed, and 5.7 million people are unaware they have the disease.[15] In 2007, 1.6 million new cases of diabetes were diagnosed in people ≥ 20 years of age.[15] If present trends continue, one in three people in the United States who were born in 2000 will develop diabetes in their lifetime.[16]

A disproportionate number of people from different ethnic and racial groups are diagnosed with diabetes. Insufficient data exist to determine the prevalence of both diagnosed and undiagnosed diabetes for all racial and ethnic groups.[15] Approximately 13% of African Americans, 10% of Hispanics, and 16.3% of American Indians and Alaska Natives have diabetes, compared to 8.7% of non-Hispanic whites.[16,17]

The prevalence of diabetes in an increasingly diverse population will challenge health care providers to seek creative ways to deliver diabetes care and education. Results from the landmark work by the Diabetes Prevention Program (DPP) showed that lifestyle intervention effectively reduced the incidence of diabetes in participants in all racial and ethnic groups.[18] More than 45% of participants in the DPP were from diverse backgrounds.[19] Of this number, by self-identification, 55% were Caucasian, 20% were African American, 16% were Hispanic, 5% were American Indian, and 4% were Asian American.[19] Each ethnic group involved in the DPP received culturally appropriate lifestyle interventions. Based on the outcomes from this research, DPP researchers encourage health care professionals to develop therapies to meet the needs of ethnic groups with diabetes.

Cultural Competence: Integrating Cultural Food Practices Into Diabetes Care and Education

Increasing evidence suggests that understanding the influence of culture on health care practices may improve diabetes outcomes.[20] Integrating cultural constructs into diabetes care and education that targets ethnic groups may result in greater patient satisfaction.[21] The members of many ethnic and racial groups possess attitudes, beliefs, and values related to health, making the development of cultural competence essential for every health care provider.[22,23]

To be effective in encouraging clients to make healthier food choices and improving health outcomes, health care professionals must possess specific knowledge about food habits, preferences, and practices (e.g., holidays, celebrations, and fasting practices) for the ethnic and racial groups they see in their practice. In this way, clients feel as if they have been understood and their beliefs, behaviors, and values have been respected. Before providing any type of intervention to a diverse clientele, health care professionals will benefit from knowing about cultural

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competence and how it may fit into their scope of diabetes practice.

According to the classic Campinha-Bacote Model, cultural competence means recognizing and forming one's attitudes, beliefs, skills, values, and levels of awareness to provide culturally appropriate, respectful, and relevant care and education.[12] To complement and add to this definition, cultural competence is also described as a set of congruent attitudes, behaviors, and policies.[24] Situated in a system, agency, or among integrated patterns of human behavior, cultural competence constructs include understanding the language, thoughts, communications, actions, customs, beliefs, values, and institutions of ethnic, racial, religious, or social groups.[24] Many cultural competence models exist, and the premises of each are similar: developing cultural awareness, knowledge, skills, desire to engage with others, and interactions. Such models rely on the ability of health care professionals to ask questions, listen carefully, speak simply and respectfully, and involve clients in their own treatment plans.[25–27]

Applying the Campinha-Bacote Model

Cultural competence begins with the individual and continues at the family and community levels. It is the successful integration of one's own cultural background with that of people from different cultures to achieve mutual understanding and meet unique needs. Campinha-Bacote's model of cultural competency is a process rather than an end result and has five interdependent constructs.[12] The section below describes the components of the model and how health care professionals may apply them when delivering diabetes care and education.

Cultural awareness

Cultural awareness arises from gaining an appreciation for a client's culture and its effect on values, beliefs, practices, and problem-solving strategies. Health care professionals must examine their own cultural backgrounds and ask themselves and their clients questions related to values, beliefs, and practices. Examples include:

Health care professional:

- What assumptions do you make about ethnic and racial groups? How might your assumptions and comments contribute to difficulties?
- What are some of your health-related values, beliefs, and practices related to diabetes and how might they affect the way you provide diabetes care and education?

Client:

- What, if anything, would you like me to know about your diabetes that I have not asked?
- What are some of your health-related values, beliefs, and practices?

Beyond this fundamental level, cultural awareness also means having a willingness to extend oneself to the client.

Cultural knowledge

Gaining cultural knowledge means familiarizing oneself with the cultural variations in families, health beliefs, and sociodemographics among various cultural groups. Cultural knowledge also involves developing an understanding of and educational base about different cultures' health practices, food habits, and notions about obtaining assistance from health care professionals. It also involves knowing the physical, biological, physiological, and psychological differences among cultural groups. Knowledge about another ethnic and racial group includes assessments about the relevant norms, values, world views, and practicalities of everyday life.

To acquire cultural knowledge, health care professionals may investigate the literature and ask themselves the following questions:

- What is the prevalence of diabetes among various ethnic and racial cultural groups?
- To what extent does the biomedical model for the causation of diabetes agree with the client's cultural perspective? What other culturally based theories affect or conflict with the biomedical model?
- What is the client's perspective about who is responsible for his or her diabetes management?
- How does the client perceive a visit with the health care professional to receive diabetes care and education?
- How do food habits and preferences affect the client's ability and willingness to manage his or her diabetes?

Cultural skill

Cultural skill is adeptness in collecting culturally relevant information from clients to perform culturally based assessments and interventions. The key to developing cultural skill lies in the approach to listening and asking questions. The approach to querying clients involves asking open-ended questions. To develop cultural skill, health care professionals may consider asking clients the following questions:

- What languages do you speak?
- Do you prefer an interpreter?
- What kinds of foods do you like to consume when you feel well and when you are not feeling well?
- What, if any, foods do you avoid when you are ill?
- Do you avoid any foods for cultural or religious reasons?
- What do you think are the causes of your diabetes?
- How do you think we should manage and treat your diabetes?

Cultural encounter

This is the process whereby health care professionals actively seek and engage in cross-cultural exchanges. This process involves obtaining a variety of responses from clients and providing culturally appropriate verbal and nonverbal responses to them. This type of interaction requires a balance of listening, observing, and asking nonjudging questions. Clients see, hear, and feel only what has meaning to them. Nonverbal gestures are relatively easy to observe and understand. The following are suggestions for interacting with clients from different cultures.

- Let clients determine their personal space.

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- Observe clients' type of eye contact.
- Note how clients use silence.
- Ask clients questions.
- Listen to their answers.

Cultural encounters are opportunities to explore cultural food behavior. Encourage patients to bring food labels from home. Ask them to bring supermarket flyers that contain ethnic foods. Encourage clients to take pictures of their meals using cell phones with cameras or digital cameras to ascertain portion sizes.

The following questions may aid in the understanding of food habits and assist in completing the nutrition assessment.

Traditional foods:
- What foods do you commonly eat?
- What are your favorite foods?
- How often do you eat them?
- Which foods do you eat on holidays or special occasions?

Foods and health:
- Which foods do you eat to be healthy?
- Which foods do you avoid now that you have diabetes?
- Which foods do you eat more of now that you have diabetes?
- Have you seen other practitioners for the treatment of diabetes and its related conditions? If yes, what treatments or remedies are you taking?
- We all have favorite remedies that we use when we are sick. Which home remedies do you use?

New foods:
- What new foods have you recently eaten? What prompted you to eat them?
- Do you regularly eat new foods?
- Which new foods did you dislike? What about them did you not like?

Food acquisition:
- What foods do you typically purchase?
- Where do you purchase food?

Amount and quality of food:
- Do you have enough food to eat each day?
- Are you able to get the types of food you need?

Food preparation:
- How do you prepare the meal? How is it cooked?
- What recipes are used?
- What is it usually accompanied with?
- Do you have enough time and equipment to prepare the foods you like?

Family interaction with food:
- With whom do you eat meals? Every day? On special occasions?

Cultural desire

Cultural desire means that health care professionals want to be actively involved in cross-cultural encounters and seek greater understanding about cultural competence. An integral part of the client-professional relationship means understanding how the interactions with others may be unlike the ones we are accustomed to in our own cultures. If successful diabetes care and education is to occur, then similarities and differences among cultures must be acknowledged. This may mean first asking clients about their families rather than their work, knowing how diabetes affects the family rather than the individual, and demonstrating a genuine interest in the client first and diabetes second.

Summary

Culture influences values, beliefs, and practices related to food and diabetes. Differences between racial and ethnic groups provide a context for examining cultural food practices and their impact on diabetes practices. To best serve the health care needs of racial and ethnic groups with diabetes, health care professionals must acknowledge each group's attitudes, beliefs, values, and ways of being. Recognizing these cultural constructs may better prepare health care professionals to understand their clients' feelings and thoughts about diabetes. By applying the cultural competence constructs presented here, health care professionals may be better prepared to interact with a diverse population requiring diabetes care and education.

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