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Ethnocultural Gerontological Nursing: An Integrative Literature Review

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Abstract

The aging population is growing increasingly more diverse, with one in four older adults from an ethnic minority group by 2050, while the nursing force will largely remain members of a single race White population. The purpose of this review is to appraise the state of nursing knowledge in relationship to meeting the needs of elders in unique racial/ethnic groups using two approaches: evaluating the efficacy of current knowledge and evaluating the state of nursing knowledge about ethnocultural gerontological nursing based on an integrative review of nursing literature. Thirty-four articles were reviewed. Most articles used qualitative methodology focused on a single ethnic group, with several articles focused on health promotion/prevention. Cultural perspectives were better addressed than aging concepts and few articles integrated ethnocultural and gerontological nursing concepts. This evaluation indicates many gaps in the knowledge base about ethnocultural gerontological nursing. Specific areas for future knowledge development are identified.

Keywords

ethnocultural nursing, integrative review, gerontological nursing

Rapid aging of ethnocultural minority populations is a significant concern for academicians, policy makers and health care providers. By 2050, for the first time in U.S. history, the non-Latino, single-race White population will be in the minority (46%; U.S. Bureau of Census, 2010). By 2050, those older than 65 years will constitute 25% of the total U.S. population; the 65 years and older population will double; and the 85 years and older population will triple (U.S. Bureau of Census, 2010). Mirroring trends for the general population, nearly half of all elders will be from minority groups (U.S. Bureau of Census, 2010).

These projections confirm that soon one quarter of all persons for whom nurses provide care will be 65 years and older, which underscores the importance of *all* nurses having gerontological nursing skills and competencies. The projections also suggest that the aging population is becoming more ethnoculturally diverse. Important to note, the increase in population diversity is occurring at a time when the "typical" nurse is still a member of the "single-race, white population" (Health Resource Service Administration, 2010), which is unlikely to change substantially any time soon. As a consequence, nurses will likely be unable to intuit how best to provide care based on their ethnic and cultural similarities to clients. Rather, responding to client needs in 2050 will require a mature, efficacious knowledge base in ethnocultural gerontological nursing that integrates knowledge from gerontological and transcultural nursing. This article has two purposes: (1) to examine the efficacy of our current knowledge about ethnocultural gerontological nursing and (2) to examine the state of nursing knowledge about ethnocultural gerontological nursing based on an integrative review of nursing literature. Knowledge gaps critical to future knowledge development will be considered in the discussion.

Efficacy of Current Knowledge

One way to assess the efficacy of our current knowledge of ethnocultural nursing is to apply recognized standards to quality indicators described in nationally available databases and documents. In this assessment, quality indicators identified by the National Quality Forum (NQF, 2004) are applied to data available in the Agency for Healthcare Research and Quality (AHRQ, 2008-2012) National Healthcare Disparities Reports 2007-2011.

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Table 1. Disparities in Nurse-Sensitive Outcomes Identified in AHRQ Health Disparities Reports.

Indicator	Finding
Use of restraints among nursing home residents (2008)	Significantly higher among Asian or Pacific Islander compared with White elders and Latino elders compared with non-Latino White elders
Prevalence of pressure sores (2008; high-risk, long-stay)	Significantly higher among Black elders, American Indian/Alaska Native elders and compared with White elders and Latino compared with non-Latino White elders; significantly higher for males compared with females
Prevalence of pressure sores (2008; short-stay)	Significantly higher among Black, Asian or Pacific Islander, compared with White elders and Latino compared with non-Latino White elders; significantly higher for males compared with females
Acute care hospitalization of home health patients (2008)	Significantly higher among Black and American Indian/Alaska Native elders and significantly lower among Asian elders compared with White elders; significantly higher among Latino elders compared with non-Latino White elders
Pain management in hospice (2008)	Significantly worse for Black elders and Asian or Pacific Islander elders compared with White elders and among Latino elders compared with non-Latino White elders
Timeliness of hospice referrals (2008)	Significantly worse for American Indian/Alaska Native elders and significantly better for Black elders compared with White elders
Received end-of-life care consistent with wishes (2007)	Significantly worse for Black, Asian or Pacific Islander and American Indian/Alaskan Natives compared with White elders, Significantly worse for Latino compared with non-Latino White elders
Appropriately timed antibiotics for wound infections (2007)	Significantly lower for Asian or Pacific islander compared with White elders; significantly lower for Latino versus non-Latino White elders
Medication-related adverse events (2008)	Significantly higher among Black compared with White elders for low-molecular weight heparin and warfarin
Use of potentially inappropriate medications (2008)	Significantly more frequent among Asian compared with White elders, non-Latino white elders compared with Latino elders; older women compared with older men.
Having recommended care for pneumonia (2008)	Significantly lower for Black, Latino, and Asian elders compared with White elders

Note. AHRQ = Agency for Healthcare Research and Quality. The date following the indicator represents the year in which the data were reported. Retrieved from http://archive.ahrq.gov/qual/nhdr05/fullreport/Index.htm and http://archive.ahrq.gov/qual/nhdr06/report/Index.htm

Quality Indicators

In 2004, the NQF identified standards for "nurse-sensitive outcomes," which are outcomes for which nurses have primary responsibility and for which nursing has a measureable effect. Examples include deaths among surgical inpatients with treatable serious conditions, pressure ulcer prevalence, falls prevalence, restraint use, catheter-associated urinary tract infection, medication errors (NQF, 2004), and patient satisfaction with various aspects of care such as pain management and end-of life care (Savitz, Jones, & Bernard, 2005).

In addition, AHRQ has published yearly comparisons of care processes and quality indicators for unique ethnocultural groups. The reports target six national priorities which include patient safety; patient centeredness; care coordination, care effectiveness in prevention of mortality and morbidity; effectiveness in promoting best practices for healthy living; and access to health care (AHRQ, 2012). Data in reports are drawn from a variety of sources and in different years, although the priorities remain the same, different populations, health care practices, and quality indicators are considered.

Results

Table 1 shows some quality indicators in multiple disparities reports applicable to older adults that fit the definition of being "nurse-sensitive." The 2008 report indicated that since 2003 there had been improvements in several areas, but significant differences based on ethnocultural group membership persisted such as those related to restraint use, pain management and prevalence of pressure ulcers. The report in 2011 indicated that disparities remain such that adults older than 65 years receive worse care than younger individuals; and individuals in all ethnocultural groups receive worse care for between 30% and 41% of all quality indicators, depending on group, compared with non-Latino White individuals. The indicators in Table 1 do not represent all data in the disparities reports, nor do they represent of the *entire scope* of nursing practice. However, they do suggest that nurses could do better with regard to "nurse-sensitive" outcomes for elders in unique ethnocultural groups. Many gerontological nursing texts (e.g., Meiner, 2010; Miller, 2011) indicate that the path to improving care to elders in unique ethnocultural groups is through acquiring skills in "cultural competence" which is translated to mean approaching clients in unique groups in an

accepting way and communicating with them in a sensitive manner. These data suggest, however, that there may be large gaps in our knowledge that are linked to neither communication nor approach or that the knowledge that is currently available is not being translated into practice. Discerning which is the case requires a systematic examination of the literature in order to determine the state of nursing knowledge with a particular eye to identifying what is being studied and how new knowledge is being used to undergird interventions for elders in unique ethnocultural groups.

State of Nursing Knowledge About Ethnocultural Gerontological Nursing

The integrative review method (Whittemore & Knafl, 2005) was chosen to examine the current state of nursing knowledge regarding ethnocultural gerontological nursing. This method is one of several recognized and legitimate strategies available for systematically examining and evaluating literature (Whittemore, Chao, Jang, Minges, & Park, 2014). Whittemore and Knafl (2005) assert that while each literature review strategy is unique with its own goals and targeted literature base, the integrative review method is most comprehensive in that it not only targets literature reporting the results of empirical research but also includes consideration of theoretical literature. The integrative review method was chosen because empirical research on the needs of elders in unique ethnocultural groups is both qualitative and quantitative and some additional and important theoretical knowledge is found in nonempirical sources such as concept or theory analyses. In addition, the method is systematic and comprehensive, involving a series of defined steps and processes designed to increase the scientific rigor of the review. The discrete steps identified by Whittemore and Knafl (2005) guide the presentation that follows.

Problem Identification

The first stage involves identifying the problem of interest, the purpose of the review, and the variables to be considered. The problem identified was based on some data that suggest the need for nursing to improve the efficacy of interventions targeting the health problems of elders in unique ethnocultural groups. The purpose of the review was to determine the breadth, depth, and strength of ethnocultural nursing knowledge currently available.

Literature Search

The second stage involves identifying primary literature sources using two or more search strategies. The strategies used in this search included comprehensive computerized database searches using key terms and citation index searches from retrieved articles as described by Conn et al. (2003). Only published literature in peer-reviewed journals was included since these constitute the literature base most readily accessible to clinicians. The comprehensive computerized database search was conducted using PubMed (1966-2014) and CINAHL (1994-2014) databases with the key terms *transcultural nursing theory, transcultural care in old age, gerontological nursing theory*, and *health disparities*. Combined search terms were as follows: *gerontological nursing and nursing theory and culture, gerontological nursing and health disparities, gerontological nursing and transcultural nursing, ethnic diversity and nursing and aging, health disparities and 65+*, and *transcultural nursing theory and 65+*. The related article feature found in PubMed and citation index searches was applied to increase our article yield (total yield = 895). In addition, PROQUEST, the dissertation database, was searched to find current nursing dissertations that have published results. Of 50 citations, two articles were added for a total yield of 897 articles. After eliminating duplicates and excluding articles focused exclusively on prevalence of disparities, instrument testing, editorials, reviews, studies of health care providers, articles that did not include persons in unique ethnocultural groups or sample persons aged 65 years and older, 218 English language articles were included. After retrieval, data from these articles were abstracted into a table of evidence for closer review by two authors (JCM, NS), who established consistency in inclusion of the articles through consensus. This reduced the number of articles to 38, with articles excluded because they focused more on the disease condition versus cultural and aging aspects, or caregiving as opposed to aging.

Data Evaluation

A review rubric developed by an author (JCM) for critical appraisal of the literature was used to evaluate methodological rigor. The rubric can be used to evaluate both quantitative and qualitative studies and includes evaluation of key elements such as description of purpose, research questions or aims, sampling adequacy, and strength of methodology, which are based on elements recommended by Whittemore et al. (2014). Scores range from 0 to 11, with articles receiving a 6 or higher included in the review. Two authors (JCM, LRP) reviewed the articles and reached consensus on the scores. This reduced the articles for analysis to 34.

Data Analysis

Data were analyzed in two phases. In Phase 1, each article was content analyzed based on identified variables including (1) study topic, (2) cultures and cultural concepts, (3) age and aging concepts, (4) theory or model used, and (5) integration of cultural and aging concepts (Table 2). In Phase 2, the body of literature was considered as a whole and evaluated for the breadth and depth.

Table 2. Table of Evidence.

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
1. Agurs-Collins, Ten Have, Kumaniyika, and Adams-Campbell (1997)	Randomized controlled trial To evaluate a weight loss and exercise program to improve diabetes control in older African Americans	Disease management: Diabetes	Cultural dietary preferences Instructional material depicting African Americans Culturally tailored intervention	Aging issues considered in educational material and sessions	Social action theory
2. Bohman, van Wyk, and Ekman (2011)	Ethnography To understand South African's experiences of being old and of caring and being cared for in a transitional period	Perceptions of aging	Ubuntu belief, African concept of humanity, dignity, respect and compassion for others, both living and dead	Reflection on life/life review	Authors stated that findings supported the theory of gerotranscendence
3. Chen (1996)	Qualitative grounded theory To describe and explain beliefs and behaviors regarding health promotion and illness prevention among Chinese elders in the United States	Health promotion	Collectivism Exercise to guide (*Xingi*) and activate (*Qi*) Yin/Yang Food for flavor, energies, movement, common and organic actions	Aging concepts are not considered	Theory of conformity with nature was developed by author to guide health promotion within Chinese American elders
4. Chiang and Sun (2009)	Two-group quasi-experimental design To examine the effects of a walking program, with and without cultural components, on hypertension among Chinese American immigrants	Disease management: Hypertension	Chinese cultural values of authority, harmony, balance and family involvement (The culturally specific intervention did not work)	Aging concepts are not considered	Leininger's cultural care theory and Prochaska's stages of change model
5. Crist (2005)	Prepost test designs	Use of services: Homecare	*Familism, personalismo*	Aging concepts are not considered	No nursing/or other model

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
	To pilot test the effect of cafecitos and telenovelas in changing attitudes of Mexican Americans toward use of home health services				
6. Crist, Garcia-Smith, and Phillips (2006)	Qualitative, grounded theory methodology	Use of services: Homecare	Anima: a sense of pride and self-sufficiency; taking care of our own	Intergenerational relationships	No nursing theory at outset
	To explicate the personal, cultural/ethnic, and attitudinal factors that influence decisions of Mexican American elders and caregivers about use of home care services		*Familismo*; respect		Linked to Goffman and social exchange in discussion
			Controldarse (control of oneself) and *aguantarse* (ability to withstand stress)		Linked to Miner's positive reciprocal relationship theory in gerontology
7. Crist, Woo, and Choi (2007)	Correlational descriptive study	Use of services: Homecare	Familismo, experiences with discrimination, acculturation, culture-bound consensus beliefs about appropriate responses to "need"	Functional status, health status	No nursing/or other theory
	To compare the effect of cultural/ethnic, contextual, and social structural variables on use of home care services among Anglo and Mexican American elders				
8. D. K. Davis and Cannava (1995)	Qualitative descriptive	Meaning of age-related role change: Retirement	Cultural concepts relate to those of performing artists. For example, unburdening lightness was related to esthetic connections in the past and opportunities for new ways of being. In some ways the citing of the study in Italy was accidental and no "Italian cultural" concepts were incorporated	Leaving a legacy	Parse strongly rooted in three principles: structuring meaning multidimensionally; paradoxical unity; and powering in the process of transformation
	To explore the meaning of retirement among performing artists in Milan Italy				

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
9. R. Davis (2010)	Qualitative design using ethnonursing method and thematic analysis	Perceptions of aging	Native Hawaiian themes including: *pono* (harmony and doing right); *mana* (strength and spirituality); *'ohana* (family); *ha'aha'a* (humility and respect); role of elders in and toward the family; Hawaiian healing practices and conflict with Western medicine; valuing of the "talking story;" ethnic identity with regard to cultural heritage and genealogy; long-standing alienation and discrimination	No aging concepts, but role of elder in the family (cultural theme) is relevant	Leininger's sunrise model
	To describe "meanings, experiences and perceptions of care focusing on Native Hawaiians—interviewed elders and health care providers				
10. Degazon (1994)	Descriptive cross-sectional study	Perceptions of aging	Ethnic practices such as differences in religion and languages based on geographical location—United States, Barbados, Haiti	Life-course and historical perspective	Lazarus and Folkman theory of social support
	To explore coping strategies as influenced by ethnic and social identity among African Americans, Afro-Barbadians, and Afro-Haitians		Family support		Ethnic identity based on slave experience and opportunity for social support from one's ethnic group influences coping and may determine differences between Afro subgroups
			History of victimization		
11. Duffy, Jackson, Schim, Ronis, and Fowler (2006)	Qualitative methodology using focus groups	End of life	Explored religious/spiritual issues; gendered differences, perceptions of discrimination, family relationships, and role expectations	Aging concepts are not considered	No nursing/or other model
	To identify within cultural preferences for end-of-life and make cross cultural comparisons in 5 groups—Anglo, Latino, Black, Arab Christian, Arab Muslim				

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
12. Eun, Lee, Kim, and Fogg (2009)	Cross-sectional telephone survey, quantitative methodology	Health promotion: Breast health	No cultural beliefs specified although some questions on the Health Belief Scale were modified or added to include beliefs in, for example, family harmony, reluctance to discuss disease (self-fulfilling notion)	No age concepts or explanation of observed differences: Older women's propensity to have mammograms was predicted by perceived seriousness, benefits, and barriers whereas younger women's propensity was only predicted by barriers	Health belief model
	To identify differences in health beliefs about breast cancer among younger and older Korean women and determine how health beliefs contribute to mammography				
13. Fleury (1996)	Qualitative grounded theory	Health promotion	Spirituality	Aging concepts are not considered	Wellness motivation theory (author developed)
	To identify, describe, and provide an analysis of the psychological and social processes used by older, rural African Americans to initiate and sustain health-related behaviors		Community Family		
14. Fowler (2006)	Grounded theory methodology	Health promotion: Breast health	Spirituality; women's strength, sisterhood and fellowship; communal kinship values; indigenous beliefs about cancer, cancer fears; fatalism	Aging: strongly rooted in life-course perspective in terms of perceptions of discriminatory behavior and unequal treatment; shared experiences from slavery; differential cohort effects	Theory of claiming health (author developed)
	To generate a theory to explain decisions of younger and older African American women about mammography				

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
15. Garroutte, Sarkasian, and Karamnov (2012)	Quantitative study testing logit models	Provider to elder communication	Intercultural communication; provider and elder ethnic identification; intercultural relationship building; culturally prescribed behavioral manifestations of respect, empathy and rapport; role of social inequality in interactions; bicultural identification; degree of ethnic discordance	Aging concepts: None actually except perhaps status of elder within the culture (communication with older adults)	Orthogonal ethnic identity theory; cultural health capital theory
	To examine the effect of ethnicity on interpretation of provider behavior among older American Indians				
16. Grandbois and Sanders (2012)	Qualitative descriptive focusing on interpretation of meaning	Perceptions of aging	Cultural preservation; family; personal and cultural identity; cultural traditions and practices; traditional values; cultural bridging (living in two worlds); unity with natural world/ spiritualism; discrimination (including liberal racism); cultural pride; cultural cohesion; cultural resilience; storytelling; acculturation/enculturation	Strongly rooted in life-course perspective; life-long chronic stress; internalized stereotyping; evolving resilience; intergenerational relationships and role of elder as transmitter of heritage; legacy of survival and strength	No nursing/or other model
	To explore the lived experience of Native American elders related to the effects of stereotyping and resilience				
17. Hikoyeda and Wallace (2002)	Qualitative grounded theory	Residential preferences	Generational Japanese immigrant concepts: *Issei, Nisei, Sansei, Yonsei, Gosei*. Nikkei (Japanese Americans)	Aging concept of autonomy, boredom (in the living facility), not having meaningful activity	Suggests that findings support continuity theory in that residents seek "normal living" within the home setting

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Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
	To evaluate whether ethnic-specific RCFEs meet the needs and preferences of Japanese American residents and families better than mainstream facilities and do ethnic-specific facilities enhance QOL		For characteristics of homes		Cultural congruence
			Respect for elders, cleanliness, food preferences, harmonious relationships, *enryo* defer to authority, avoid confrontations with staff and other residents, and hold back from expressing true feelings		
18. Holkup, Salois, Tripp-Reimer, and Weinert (2007)	Community-based participatory action developed pilot project	Mental health: Elder abuse	Harmony and restoration of harmony; indigenous heath workers; traditional beliefs and values about elders, family and community; traditional decision making and mediation; spiritual beliefs and interconnectedness; "Communitarianism;" Beliefs about status differences and intergenerational norms (tribal and clan structure); norm of gracious hospitality; language preference and facility; outside acknowledgment of strengths (acknowledgment by the family is culturally inappropriate); cultural values of interdependence and reciprocity	Aging concepts: Role of elders—this is an elder-focused intervention focused on elder welfare and safety but elders are not included	Participatory action model
	To evaluate the potential of the Family Care Conference as a strategy for preventing and mitigation of elder abuse among Native Americans				
19. Johnson, Tripp-Reimer, and Schwiebert (2000)	Qualitative	Residential preferences	Cultural concepts not considered	More aging concepts than cultural:	No nursing/or other model
	To explicate views of elderly African Americans about their residential preferences and nursing homes as residential alternatives			Overarching concept "not to be a burden to children"	

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
				Nursing homes as "bad places" Intergenerational differences in lifestyle Family-elder reciprocity in elder care	
20. Jonas (1992)	Qualitative descriptive methodology	Perceptions of aging	Theme: Cherishing necessities for survival and cherishing celebration with important others—is linked to Nepalese culture through traditional religious and cultural events in Nepal Other two themes were not specifically related to Nepalese culture although the last one (changing customs . . .) reflected on modernization in what was a strongly rural and isolated area	Aging is considered to the degree that world changes have influenced older adults	Rooted in Parse's theoretical perspective
	To explore the meaning of being an elder in Nepal		Discussion focused on "paradoxical rhythms" that characterized their aging experience. Cross-cultural comparisons predominately to aging in Western culture		
21. Kataoka-Yahiro, Ceria, and Yoder (2004)	Focus group study (one group) with thematic analysis	Age-related role change: Grandparenting	Intergenerational relationships, family unity, mutual reciprocity, authoritarianism	Grandparenting as a normative role of older adults, intergenerational conflict rooted in cultural values about aging and aging status, and reality of treatment by younger generation; legacy/ transcendence; health dimensions	No nursing/or other theory
	To explore the cultural context of grandparenting and perceived effects on health in Filipino American families				

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
22. Keller, Fleury, Perez, Belyea, and Castro (2011)	Clinical trial	Health promotion: Physical activity	Collectivism envisioned as social support/community	Aging concepts are not considered	*Mujeres en accion* culturally driven theoretical model to support the intervention to increase physical activity
	To evaluate the effectiveness of a social support activity intervention for midlife and older Hispanic women		Promotoras		
23. Lim, Waters, Froelicher and Kayser-Jones (2008)	Theory evaluation based on Fitzpatrick and Whall criteria	Health promotion: Physical activity	Cultural identity with a focus on collectivism as appropriate for Korean culture; aging transitions as rooted in Buddhist philosophy (transpersonal/transcendence); balance (yin/yang) as directing views of health; compatibility SCT are strongly substantiated	Aging concepts are not considered	Social cognitive theory; Pender's nurse promotion model
	To analyze the potential of social-cognitive theory in relation to providing culture specific direction in gerontological nursing, specifically to design physical activity interventions for unique groups, that is, older Korean Americans				
24. Liu (2012)	Systematic review	Disease management: Diabetes	Of the four antecedents to self-efficacy (relevant knowledge, personal experience, role modeling, and family support), family support was seen as rooted strongly in the strong family ties and filial piety characteristic of Chinese culture	Aging concepts are not considered	Self-efficacy as a middle-range nursing theory and basis of a nursing diagnosis describing an evaluation of the patient's perception of his or her capacity to self-manage chronic illness or change behavior in the face of chronic illness
	Avant and Walker methodology concept analysis To analyze the relationship between self-efficacy and self-management of older adults with diabetes mellitus with special emphasis on Chinese older adults.				

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
25. McCarthy, Ruiz, Gale, Karam, and Moore (2004)	Qualitative grounded dimensional analysis To understand the meaning of health in older Anglo and Latino women	Healthy aging	Collectivism, individualism acculturation	Functional health, however, the focus was more on culture than aging	Theory developed describes and explains differences between older Latino and Anglo women's view of health and day-to-day functioning
26. McFarland (1997)	Ethnocultural nursing qualitative method To identify traditional generic and professional care practices that promote health among older African American and Anglo Americans living in institutional settings	Health promotion	Tension between traditional cultural practices (e.g., food; religion) and nursing home culture was part of the discussion on cultural care. Desire for family involvement and caring for others were cultural concepts described as relevant to both groups. Difficulty of maintaining life practices in the nursing home (as opposed to apartments) was also discussed	Aging concepts are not considered	Leinger's cultural care theory
27. Pope, Wallhagen, and Davis (2010)	Qualitative grounded theory methodology To explore social processes contributing to illicit drug use in older African Americans	Mental health/ substance abuse	Social (family history of drug abuse), environmental (racial residential segregation), political and historical (slavery, research issues; Tuskegee) determinants of health in African Americans	Generational effects	Winick's sociological theory for the genesis of drug dependence Dubois's concept of double consciousness
28. Rendon, Sales, Leal, and Pique (1995)	Phenomenological study (Van Kaam) To uncover the meaning of aging among residents of Valencia, Spain	Perceptions of aging	This study does not focus on cultural concepts. Rather its focus is on the aging experience and its sample is "accidental"	Aging experience in relationship to death anticipation	Strongly rooted in Parse's theory of human becoming

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
29. Romo et al. (2013)	Qualitative descriptive with grounded theory method used for analysis To explore the meaning of successful aging among African American, White, Spanish-speaking Latino and Cantonese-speaking Chinese older adults with disabilities	Successful aging	Family and relationships; perceptions of aging within culture; spirituality; independence versus burden/dependence; acculturation	Aging concepts: Life continuity; accepting/ adapting/compensating; contributing to the next generation; minimizing constraints; cohort effects	No nursing/or other model
30. Swinney and Dobal (2011)	Qualitative focus group methodology and thematic analysis To explore health beliefs of older African American women about breast health practices	Health promotion: Breast health	Spiritual beliefs, particularly those related to God as source of disease and healing (external health locus of control/fatalism), indigenous health beliefs related to cancer, surgery for cancer, cancer as a death sentence, body as symbol of womanhood, fears of disfigurement; pre-eminence of family; women's role as family protector and strength	Notes that these beliefs are found in the literature to increase with age, but no explanation and no aging concepts "per se"	Health belief model
31. Tashiro (2006)	Qualitative descriptive using narrative analysis To describe, within the context of ethnic identity, the health beliefs and practices of older mixed ancestry Asian Americans	Health beliefs/health promotion	Ethnic identity; acculturation and immigration experience, traditional health practices; culturally prescribed role enactment; distrust of Western medicine/practitioners	No aging concepts, per se, but findings are strongly rooted in life-course perspective, hence an emphasis on cohort effects, social-historical context of the life lived and issues related to power dynamics (with the dominant group), racial violence and discrimination; class dominance with and between groups; and heterogeneity	Gordon's classic model of assimilation—hence analysis focused on generation since immigration

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Table 2. (continued)

Authors	Method/purpose	Focus	Cultural concepts	Aging concepts	Nursing theory/model
32. Troutman-Jordan, Nies, and Davis (2013)	Qualitative descriptive sing focus group methodology and thematic analysis	Successful aging	Black/White differences noted but cultural explanations were not provided—for example, Black elders talked about church in terms of social affiliation/fellowship and White elders talked about church in terms of connection to God, but no cultural explanation discussed; similarly data showed Black elders spoke of their relationships with family in emotional terms whereas White elder spoke more in terms of roles. No cultural explanations were offered	Aging concepts: connecting and relating (God/church family/ activities; friends and social life); temporality (impressions of past, family and history; future generations)	No nursing/or other model
	To identify key components of successful aging among older adults living in North Carolina and described differences between Black and White older adults				
33. Weiler and Crist (2009)	Qualitative descriptive using grounded theory methodology	Disease management: Diabetes	Collectivism and family; indigenous health beliefs about diabetes include cultural stigma; culture values related to food and celebration and cultural expectations in social gathering toward food	Aging concepts are not considered	No nursing/or other theory
	To explore the sociocultural context of living with type 2 diabetes among migrant Latino adults. Age range on this is from 46 to 65 years				
34. Wenzel et al. (2012)	Focus group methodology with thematic analysis	Disease management: Cancer	This study was not organized around cultural concepts; rather the focus was on SES and access disparities. However, results showed spirituality, and the resources of family and community support as important. Health literacy part of the discussion	Aging concepts are not considered	No nursing/or other theory
	To describe older African American cancer survivors' perceptions of cancer diagnosis and treatment experiences				

Note. RCFE = residential care facility for the elderly; QOL = quality of life; SES = socioeconomic status; SCT = social cognitive theory.

Results

The types of studies varied from concept/theory analysis ($n = 2$) to qualitative ($n = 24$) and quantitative studies ($n = 8$). Most studies used qualitative methodologies (grounded theory, ethnography, or phenomenology) to describe the experiences of a single ethnocultural group of elders. The quantitative articles were largely descriptive-correlational ($n = 4$), with one quasi-experimental study, one pilot study, and two clinical trials.

Phase I Analysis

Study Topics. Health promotion/prevention accounted for most articles ($n = 9$) and focused on general health promotion activities such as encouraging physical activity (e.g., Chen, 1996; Fleury, 1996; Keller, Fleury, Perez, Belyea, & Castro, 2011; McFarland, 1997), or more targeted activities such as promoting mammography (Eun, Lee, Kim, & Fogg, 2009; Fowler, 2006; Swinney & Dobal, 2011). Most of these articles focused on women. A second group focused on disease management ($n = 6$), including management of diabetes (Agurs-Collins, Ten Have, Kamanyika, & Adams-Campbell, 1997; Liu, 2012; Weiler & Crist, 2009), hypertension (Chiang & Sun, 2009), and cancer (Wenzel et al., 2012). Other topics included perceptions of aging (Bohman, van Wyk, & Ekman, 2011; D. K. Davis & Cannava, 1995; R. Davis, 2010; Degazon, 1994; Grandbois & Sanders, 2012; Jonas, 1992), residential preferences/service use (Crist, 2005; Crist, Garcia-Smith, & Phillips, 2006; Crist, Woo, & Choi, 2007; Hikoyeda & Wallace, 2002; Johnson, Tripp-Reimer, & Schwiebert, 2000), healthy/successful aging (McCarthy, Ruiz, Gale, Karam, & Moore, 2004; Romo et al., 2013; Troutman-Jordan, Nies, & Davis, 2013), end-of-life care (Duffy, Jackson, Schim, Ronis, & Fowler, 2006), age-related role change (D. K. Davis & Cannava, 1995; Kataoka-Yahiro, Ceria, & Yoder, 2004), mental health/substance abuse (Holkup, Salois, Tripp-Reimer, & Weinert, 2007; Pope, Wallhagen, & Davis, 2010), and elder–provider communication (Garroutte, Sarkasian, & Karamnov, 2012).

Culture and Cultural Concepts. The ethnocultural groups considered were African/African American ($n = 14$), Afro-Caribbean ($n = 1$), Asian American ($n = 1$), Arab ($n = 1$), Chinese ($n = 5$), Filipino ($n = 1$), Italian ($n = 1$), Latino/Hispanic ($n = 8$), Korean ($n = 2$), Japanese ($n = 1$), Native Americans/American Indians ($n = 3$), Native Hawaiians ($n = 1$), Nepalese ($n = 1$), and Spanish ($n = 1$). In 26 (79%) articles a single cultural group was studied. Seven involved cross-cultural comparisons of Mexican American and Anglo elders (Crist et al., 2007; McCarthy et al., 2004); African American and Anglo elders (McFarland, 1997; Troutman-Jordan et al., 2013) Anglo, Latino, Black, Arab Christian, and Arab Muslim elders (Duffy et al., 2006); African American, Anglo, and Chinese elders (Romo et al., 2013) and African American, Afro-Barbadians, and Afro-Haitian elders (Degazon, 1994).

Some cultural concepts framed studies. For example, the study by Chiang and Sun (2009) on management of hypertension was framed by the Chinese cultural values of authority, harmony, balance, and family involvement. Similarly, the study of use of in-home services by Mexican American older adults by Crist (2005) was framed by the Latino values of *familismo* and *personalismo*. Several studies described culturally tailored interventions (e.g., Agurs-Collins et al., 1997; Chiang & Sun, 2009; Crist et al., 2007; Keller et al., 2011). The interventions were culturally tailored through strategies such as including culturally appropriate foods in the intervention (Agurs-Collins et al., 1997). Since most studies were qualitative, identification of cultural concepts was done in the analysis or discussion. Cultural concepts varied by ethnocultural groups. For example, in studies of Chinese elders, common cultural concepts included: filial piety, family involvement, spiritual beliefs and practices, yin/yang, role of food in health, and collectivism (Chen, 1996). For studies of African American elders, common cultural concepts included: spirituality, community and communal kinship values, family, fatalism, value of caring for others, gender roles (Fleury, 1996; Fowler, 2006; McFarland, 1997; Swinney & Dobal, 2011; Wenzel et al., 2012). For studies of Latino elders, cultural concepts included: *familismo, personalismo*, respect, self-control and ability to withstand stress, collectivism, acculturation, cultural values related to food and indigenous health beliefs (Crist et al., 2006; McCarthy et al., 2004; Weiler & Crist, 2009). While unique values were identified for many of the groups, to some of degree, many of the ideas behind the concepts were similar, for example, familism/filial piety/family involvement.

A few studies did not consider cultural concepts at all even though they focused on unique ethnocultural groups. In these studies the sampling frames provided cultural background but beyond that, no cultural concepts were included. For example, the Rendon, Sales, Leal, and Pique (1995) study sampled older adults living in Valencia Spain, but no cultural concepts were identified. Similarly, in the Troutman-Jordan et al. (2013) study of perceptions of successful aging, differences between Anglo and African Elders were noted, but no cultural explanations were provided.

Age and Aging Concepts. In many studies, being an older adult was the extent of the researcher's perspective on aging. In other words, the chronological variable of years since birth (e.g., 65 years or older) was a sampling criterion but aging was not a study concept. For studies that considered the effect of aging, the most common aging concepts were roles for older adults (R. Davis, 2010; Holkup et al., 2007; Kataoka-Yahiro et al., 2004), intergenerational relations (Crist et al., 2006; Grandbois & Sanders, 2012; Johnson et al., 2000), life-course perspective/cohort effect (Degazon, 1994; Fowler, 2006; Grandbois & Sanders, 2012; Jonas, 1992; Romo et al., 2013; Tashiro, 2006; Troutman-Jordan et al., 2013), and leaving a legacy (D. K. Davis & Cannava, 1995; Grandbois & Sanders, 2012; Kataoka-Yahiro et al., 2004;

Romo et al., 2013). In the discussion sections of several studies, specific gerontological theories were identified as being supported by the results, including continuity theory (Hikoyeda & Wallace, 2002), gerotranscendence (Bohman et al., 2011), and positive reciprocal relationship theory (Crist et al., 2006). In one of the quantitative studies (Agurs-Collins et al., 1997) attention to age involved accommodating to older research participants' needs as a part of the research process; for example, by providing materials in large print.

Theory or Model Used. Several nursing models guided the research. Only one nursing model was based in culture, specifically, Leininger's cultural care theory/sunrise model which was used in three articles (Chiang & Sun, 2009; R. Davis, 2010; McFarland, 1997). Other nursing theories or nursing models used were Parse's theoretical perspective (D. K. Davis & Cannava, 1995; Jonas, 1992; Rendon et al., 1995) and Pender's nurse promotion model (Lim, Waters, Froelicher, & Kayser-Jones, 2008).

Two studies used theories from anthropology as frames: Garroutte et al. (2012) who used the orthogonal ethnic identity theory and cultural health capital theory and Tashiro (2006) who used Gordon's model of assimilation. Many other studies applied majority culture theoretical models developed in sociology or psychology, such as the health belief model (Eun et al., 2009; Swinney & Dobal, 2011), social action theory (Agurs-Collins et al., 1997), Lazarus and Folkman's transactional model of stress and coping (Degazon, 1994), and Prochaska's stages of change (Chiang & Sun, 2009). One study, a concept analysis, was conducted specifically to examine the cultural congruence of the concept of self-efficacy as it related to self-management of diabetes in Chinese elders (Liu, 2012). The purpose of several of the qualitative studies was to develop theory about a health concern in an ethnic population. The studies using grounded theory methodology produced several theories: theory of conformity with nature to guide health promotion with Chinese American elders (Chen, 1996), wellness motivation theory to guide older African Americans to initiate and sustain health behaviors (Fleury, 1996), and theory of claiming health to explain decisions about mammography in African American women (Fowler, 2006). *Mujeures en accion* (Women in action for health) was a theory developed from a community-based participatory approach for the purpose of designing a culturally appropriate intervention with older Hispanic women to increase physical activity (Keller et al., 2011).

Integration of Cultural and Aging Concepts. Although most studies did not integrate cultural and aging concepts, several did. Of particular note are the following. Fowler (2006) used grounded theory to generate theoretical explanations for the decisions of younger and older African American women to obtain mammograms. Findings integrated culture concepts (women's strength, sisterhood and fellowship, and indigenous beliefs about cancer) with aging concepts rooted in the life-course perspective (perceptions of discriminatory behavior and shared experiences from slavery) to produce the theory of claiming health to explain decisions about mammography. Similarly, Grandbois and Sanders (2012) used a qualitative methodology to study perceptions of aging among Native American elders. Culture concepts (cultural preservation, cultural bridging, unity with natural world, and cultural resilience) were integrated with aging concepts rooted in life-course perspective (life-long chronic stress, internalized stereotyping, and intergenerational relationships) to describe the lived experience of aging of Native Americans. Finally, Pope et al. (2010) framed their research in an aging cohort (baby boomers) and examined the social determinants of poverty, racism, and environmental issues as they perpetuated substance abuse among older African Americans.

Phase 2 Literature Evaluation

Breadth and Depth of the Literature Base. Taken as a whole, Table 2 suggests that this literature base has some breadth in that many different ethnocultural groups have been studied and studies have a variety of foci. However, the literature base has little depth. Some groups are little studied and some studies do not consider the nuanced differences between ethnocultural subgroups (e.g., studying "Hispanics" as a single group). In general, this is a patchwork of studies, looking at individual cultures, but not usually across cultures, to begin to understand common concepts that would help move nursing science and practice forward. The qualitative studies on cultural groups, specifically those with a focus on health promotion/prevention demonstrate many similar findings but we found no meta-syntheses that unify this body of knowledge. The literature base also lacks depth in that although it is rich in descriptions of ethnocultural groups through qualitative research, there is little follow-up on these findings through the implementation of intervention studies. There are exceptions (e.g., Keller and Crist), but in general, most authors/teams appear to have published only one study with little evidence of sustained research productivity in the area. While there are a variety of foci, the number of studies focused in any particular area is small. Although the issue of health disparities within an ethnocultural group is often the impetus for designing the study, with so few interventions studies, the knowledge needed to ameliorate particular disparities is scant. Only one (Duffy et al., 2006) of the reviewed studies focused on a nurse-sensitive health disparity identified in Table 1.

In general, the literature base is also conceptually and theoretically shallow. Although age is a sampling criterion, most studies do not view aging conceptually and chronological age alone seems to serve as a proxy for the aging experience. Little special consideration is given to life experiences,

roles, or special needs of older adults either in the design of studies or in the discussion. The view of culture, in many instances is also shallow. Some studies do not link the study of ethnocultural groups to cultural concepts. In some studies, the selection of the cultural group appears to be based on convenience rather than as a strategy for providing insight into cultural variation. Thus, the sampling plans appear to lack theoretical depth as well. Generally, the studies focused more on culture than aging and, with some exceptions; few address both aging *and* culture resulting in the lack of integration of aging and cultural concepts. Some studies are based on nursing models, but those selected do not include consideration of aging. Some studies are based on theories from psychology or sociology with little or no discussion about the appropriateness of the theory/model to the ethnocultural or age group being studied.

Discussion and Future Directions

Currently, our ethnocultural gerontological nursing knowledge base is evolving, but still quite sparse. Based on these results, the following activities are needed to equip nurses to provide care to elders in 2050. First, we need to revise our view of aging in transcultural nursing research. Studies need to be designed that focus on aging as a conceptual and not merely a chronological issue. Researchers (Cherubini et al., 2011; Gurwitz & Goldberg, 2011; Heiat, Gross, & Krumholz, 2002) point out that the static variable of chronological age is a poor proxy for more relevant variables (e.g., functional status) and that electing samples based solely on chronological age reinforces preexisting stereotypes and leads to erroneous conclusions. In addition, research (Geronimus, Colen, Shochet, Ingber, & James, 2006; Geronimus, Hicken, Keene, & Bound, 2006) has shown that individuals in ethnocultural groups "age" at different rates, that is, functional changes occur at different points in the lifespan, which seriously effects the ability to make meaningful cross-cultural comparisons.

Second, we need to better represent cultural concepts in the research. Many current studies seem to be based on the premise that recognizing and appreciating cultural uniquenesses, that is, developing cultural sensitivity, is sufficient for knowing what differences these uniquenesses make for nursing practice and research. Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) defined cultural sensitivity as "the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population, as well as relevant historical, environmental, and social forces are incorporated into the design, delivery and evaluation of targeted [research interventions]" (p. 11). Resnicow et al. (1999) proposed two dimensions of cultural sensitivity: surface structure and deep structure. Some reviewed studies attended to surface structure (considering superficial aspects of culture in the research, such as tailored recruitment materials in the language of the proposed participants, or including culturally appropriate foods, etc.; Resnicow et al., 1999). This is in contrast to deep structure that focuses on incorporating a life-course perspective that is cognizant of the historical, cultural, social, environmental and psychologic forces that may contribute to an individual's health and illness (Resnicow et al., 1999). Designing studies that attend to deep structure is an imperative for building nursing knowledge for the future.

Third, we need to integrate our current knowledge. There are two targets for integration. The first is integrating knowledge from studies of single ethnic groups into models that embrace concepts common across cultures. This needs to be done carefully so as not to disguise the natural heterogeneity within and across groups. The second is the integration of concepts from transcultural and gerontological nursing so our approach to older adults in unique groups takes into account the unique social, environmental, psychological world views, and experiences of these elders. The health of older adults in unique groups is strongly influenced by socioeconomic disadvantages, differential exposure to life-long health risks, past life experiences, inequities in access to health care and health care information, institutional discrimination, and genetics. The complexities of these social determinants need to be reflected in the knowledge we build for the future.

Fourth, we have a strong need to carefully evaluate the appropriateness of the theories being used in the research. Although it may be expedient and appealing to apply a model of behavior change, for example, to a study involving behavior change in a unique group, clear evidence that the application is age- and culturally appropriate is needed.

Fifth, moving the theory from descriptive to explanatory and the research from description to intervention are imperative. Currently, we have an evolving theory base that describes basic within-group and between-group similarities and differences. However, we lack theoretical understandings about how and why these differences occur. In other words, we are sorely lacking explanatory theories. In addition, the number of intervention studies in the literature is scant and many interventions are not rooted in explanatory theory, probably because so little exists. Moving the science of ethnogerontological nursing forward requires carefully designed intervention studies rooted in explanatory theory to inform the actions nurses use to improve health of aging individuals in unique ethnocultural groups.

Finally, nursing research needs to be designed to meaningfully address health disparities. Currently, the most common way nurses use health disparities is to justify the significance of the study. However, ameliorating the disparity is not the focus of the study. Clark (2014) suggests this approach has pitfalls in that health disparities, which are of concern at a population level, can obscure and stigmatize what is happening at an individual level. To put health disparities into a meaningful context one needs to consider the social determinants of disparities, rather than just the cultural

background in which the disparities are manifested. In addition, nursing has a responsibility to address the disparities for which it is responsible (i.e., "nurse-sensitive disparities"). There are many gaps in our knowledge about resolving nurse-sensitive disparities for those in unique ethnocultural groups. We still have little understanding of why, for example, individuals in certain groups have more pressure ulcers, falls, restraints, and catheter-associated urinary tract infections than non-Latino White individuals. The studies identified on disease management and on health promotion activities are a good start, but our knowledge base is still in its infancy in many areas. Expanding both breadth and depth of the knowledge base is an imperative for the future.

Conclusion

While we have a strong knowledge base in transcultural nursing and gerontological nursing, we have failed to marry the two. By 2050, nearly half of all elders will be in ethnocultural groups. Now is the time for building the knowledge and theory base to help nurses meet the needs of individuals in these unique groups.

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