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What is This?
The Giger and Davidhizar Transcultural Assessment Model

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The Giger and Davidhizar Transcultural Assessment Model was developed in 1988 in response to the need for nursing students in an undergraduate program to assess and provide care for patients that were culturally diverse. The model includes six cultural phenomena: communication, time, space, social organization, environmental control, and biological variations. These provide a framework for patient assessment and from which culturally sensitive care can be designed.

Communication. Communication embraces the entire world of human interaction and behavior. Communication is the means by which culture is transmitted and preserved. Both verbal and nonverbal communication are learned in one’s culture. Communication often presents the most significant problem in working with clients from diverse cultural backgrounds.

Space. Space refers to the distance between individuals when they interact. All communication occurs in the context of space. According to Hall (1966), there are four distinct zones of interpersonal space: intimate, personal, social and consultative, and public. Rules concerning personal distance vary from culture to culture. Territoriality refers to feelings or an attitude toward one’s personal area. Each person has their own territorial behavior. Feelings of territoriality or violation of the client’s personal and intimate space can cause discomfort and may result in a client’s refusing treatment or not returning for further care.

Social organization. Social organization refers to the manner in which a cultural group organizes itself around the family group. Family structure and organization, religious values and beliefs, and role assignments may all relate to ethnicity and culture.

Time. Time is an important aspect of interpersonal communication. Cultural groups can be past, present, or future oriented. Preventive health care requires some future time orientation because preventive actions are motivated by a future reward.

Environmental control. Environmental control refers to the ability of the person to control nature and to plan and direct factors in the environment that affect them. Many
Americans believe they control nature to meet their needs and thus are more likely to seek health care when needed. If persons come from a cultural group in which there is less belief in internal control and more in external control, there may be a fatalistic view in which seeking health care is viewed as useless.
Biological variations. Biological differences, especially genetic variations, exist between individuals in different racial groups. It is a well-known fact that people differ culturally. Less recognized and understood are the biological differences that exist among people in various racial groups. Although there is as much diversity within cultural and racial groups as there is across and among cultural and racial groups, knowledge of general baseline data relative to the specific cultural group is an excellent starting point to provide culturally appropriate care.

There is some evidence suggesting that different races metabolize drugs in different ways and at different rates (Echizen, Horari, & Ishizaki, 1989). For example, Chinese people are more sensitive to the cardiovascular effects of Propranolol than are White people. Primaquine is metabolized by oxidation and is used in the treatment of malaria. Although Primaquine is given to individuals who lack the enzymes necessary for glucose metabolism or the red blood cells, hemolysis of the red blood cells occurs. Approximately 100 million people in the world are affected by this particular enzyme deficiency and thus are unable to ingest Primaquine. Approximately 35% of African Americans have this particular enzyme deficiency. Antihypertensives are another category of drugs that are metabolized differently depending on race. For example, African Americans tend to need higher doses of beta-adrenergic blocking agents such as Inderal. Chinese men tend to need only about half as much Inderal as compared to White American males.

One category of differences between racial groups is susceptibility to disease. The increased or decreased incidence may be genetically, environmentally, or gene-environmentally induced. American Indians have a tuberculosis incidence that is 7 to 15 times that of non-Indians. African Americans have a tuberculosis incidence three times that of White Americans. Urban American Jews have been the most resistant to tuberculosis. Ethnic minorities now account for more than two thirds of all the reported cases of tuberculosis in the United States, partly as a result of the increased incidence of tuberculosis among ethnic minorities affected with HIV (Centers for Disease Control, 1998). Diabetes is quite rare among American Eskimos. Diabetes has a high incidence within certain American Indian tribes, including the Seminole, Pima, and Papago. NIDDM, or Type 2 diabetes, is a major health problem for Native American Indians, occurring as early as the teens or early twenties. Age-specific death rates for diabetes appear to be 2.6 higher for Native Americans between 25 and 54 years of age, compared with the rest of the general population. The incidence of hypertension is higher in African Americans than Whites. The onset by age is earlier in African Americans, and the hypertension is more severe and associated with the higher mortality in African Americans. It is important to remember that susceptibility to disease may also be environmental or a combination of both genetic and environmental factors.
cultural nursing, Dr. Madeleine Leininger (1985); the work of Dr. Rachel Spector (1996); the classic work of Orque, Bloch, and Monrroy (1983); and the classic work of Hall (1966) and others in space phenomena, communication, and anthropology.

APPLICATION TO THEORY, RESEARCH, AND PRACTICE

Giger and Strickland (1995) received $750,000 to test the usefulness of the model to identify behavioral risk reduction strategies and chronic genetic indicators for premenopausal, African American women with high-risk indices of coronary heart disease. In 1998, Linda Smith, DSN, completed a pilot study using the model. The primary purpose of the study was to describe the relationship among the scores and subscores on scales measuring concepts of cultural competency. Three scales were used: the cultural attitude scale originally developed by Bonaparte (1977, 1979) and modified by Rooda (1990, 1992), the cultural self-efficacy scale developed by Bernal and Froman (1987), and the knowledge-based questions on cultural competencies developed by Rooda (1990). In this study, the model served as the theoretical foundation, and the three scales served as the instruments. In 1998, Dr. Sharon Mullen and Dr. Carla G. Phillips at Ohio University’s School of Nursing also used the model as the overarching theoretical framework to explore the cultural beliefs of southeastern Ohio Appalachians. The primary purpose of the qualitative ethnographic study was to identify cultural beliefs of southeastern Ohio Appalachians as a means of providing culturally competent care. Giger and Davidhizar’s model was used to identify cultural beliefs from the six cultural phenomena previously described by Giger and Davidhizar (1990, 1995, 1998, 1999). Subjects were 14 adults who had resided in the area their entire lives. The Giger and Davidhizar Transcultural Assessment Model, which also included interview questions and observational guidelines, was used for structural interviews. Findings from this study suggested that these individuals were more socially inclined, communicated more openly, had more of an internal locus of control, had fewer personal space needs, were more future oriented, used no significant home remedies, tended to be conscientious about getting to appointments on time, and were more likely to follow medical protocols than Appalachians in general.

AREAS OF FUTURE DEVELOPMENT

Work relative to biological variation specifically regarding genetic variations continues to undergo refinement with additional research by various researchers, including Giger and Strickland.

REFERENCES


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