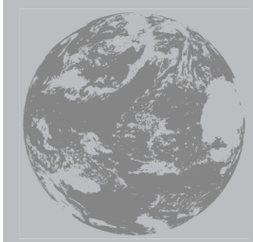

Introduction: Cultural Competence and Nutrition Counseling

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In the book, *We Are What We Eat: Ethnic Food and the Making of Americans,* historian Donna Gabaccia asserts, "Food and language are the cultural habits humans learn first and the ones they change with the greatest reluctance" (1). As health care professionals working with people with diabetes, we are quite familiar with this sentiment. We ask our clients:

- "What did you eat?"
- "How much did you eat?"
- "How did the meal affect your blood glucose level?"
- "How was the food prepared?"

The answers inevitably reveal our clients' attachment to the foods of their cultures. In addition to gathering data about eating habits and patterns, we learn about our clients, their views on food, and their devotion to their culture. For example, we learn what kind of meals they enjoyed as children, the foods they share at holidays, and their favorite family recipes.

Understanding the cultural significance of diet not only helps us relate better to our clients, it also helps us be more effective. We can make culturally appropriate recommendations that will resonate with clients much more than a "one-size-fits-all" plan. Then, because the plan fits into their lives, they may be more likely to comply with medical nutrition therapy (MNT).

Diabetes has reached epidemic proportions in the United States, and people from some ethnic and racial groups are disproportionately affected. For many of us in the nutrition profession, an increasing number of our clients have cultural backgrounds different from our own. For this reason, the American Dietetic Association, American Diabetes Association, and American Association of Diabetes Educators support and encourage practitioners' efforts to develop cultural competence and provide culturally sensitive MNT (2-4). Furthermore, the Commission on Accreditation for Dietetics Education requires that future registered dietitians (RDs) develop their cultural competence and dietetics programs integrate cultural studies into their curricula (5).

In this book, you'll find the tools to help you on your journey toward cultural competence. Written by RDs who are experts in culture and food, as well as in diabetes care, this guide presents traditional and contemporary health beliefs and food patterns for 15 cultural and religious groups. To put this information into the context of MNT, we discuss the importance of courtesy, respect, communication skills, and family dynamics when collaborating with clients. Furthermore, in acknowledgment of the rising popularity of complementary and alternative medicine (CAM), we present commonly used CAM therapies for each group.

The Relationship of Culture to Food and Disease

Culture can be defined as the accumulation of a group's learned and shared behaviors in everyday life. It is the lens we use to view and understand people's beliefs, customs, and knowledge. As we become more familiar with our clients, we gain a deeper understanding of how their cultures create a sense of identity, order, and security in their lives. Through our formal and informal client interactions we see how culture can define social structure, decision-making, and communication styles. We also come to better understand that every culture defines its eating occasions in unique ways (6). This information provides a rich opportunity to employ culturally appropriate behavior, etiquette, and protocol in a way that respects each client.

To understand culture, we first must define ethnicity and race in the context of our professional lives and the world at large. There are no universally accepted definitions of "ethnicity" or "race." Ethnicity is a historically complex concept that typically refers to identity generated within and between social groups. Ethnicity is often referred to as a common ancestry, which may include shared language, nationality, social customs, and/or religion. "Race" is generally used to categorize individuals who share particular physical characteristics, such as skin color, facial features, and hair. Racial categories include African American, American Indian, Asian, and others (7).

RDs are well versed in the science of food and nutrition, but we must also understand that the cultural significance of food goes well beyond daily sustenance (8). Culture influences each person's choices about what to eat, when to eat, how, and with whom. 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 frequently play an integral role in religious ceremonies and social events. As individuals from other cultures become acculturated to US society, their food practices may change. At the same time, however, they may continue to observe many traditions of their original culture.

Culture also influences everyone's attitudes, beliefs, practices, and values about good health and disease prevention. For example, there are cultural practices regarding the care and treatment of the sick; culture helps individuals decide whom to consult when they are ill; and cultural assumptions affect how both clients and health care professionals see their roles (9). By recognizing that culture shapes how a person defines health, perceives illness, and seeks treatment, we are positioned to provide well-informed MNT that integrates both our scientific understanding of disease and sensitivity to the culturally specific expectations and desires of our clients (10).

As outcomes-driven professionals, RDs must leverage and apply the growing evidence of a positive correlation between understanding a patient's culture, on the one hand, and improved health outcomes (such as client satisfaction and adherence), on the other. Diabetes outcomes may improve when health care providers offer long-term, supportive follow-up that empowers the client, his or her family, and the community at large (11). As members of a helping profession, we are dedicated to the care of individuals. Building on this notion, we are poised for cultural engagement, an active, developmental learning process that requires long-term commitment (7,12).

The Impact of Diabetes on Ethnic and Racial Groups

Dynamic population shifts in the United States and the changing health status of various cultural, ethnic, and racial groups impact the diabetes landscape. Data from the 2000 US Census indicate that non-Hispanic whites were approximately 70% of the total population, whereas individuals identifying themselves as black, Asian, Hispanic, or other comprised 30%. By 2050 the Census Bureau estimates that more than 50% of the population in the United States will identify themselves in a racial or ethnic category other than non-Hispanic white (13).

Approximately 23.6 million children and adults in the United States (7.8% of the population) have diabetes (14). This includes 17.9 million people who have been diagnosed and 5.7 million who are unaware they have the disease (14). In 2007, 1.6 million US residents age 20 years or older were diagnosed with diabetes (14). If present trends continue, one in

three people in the United States who were born in 2000 will develop diabetes in their lifetime (15).

Certain ethnic and racial groups are disproportionately diagnosed with diabetes. For example, it is estimated that 13% of African Americans; 10% of Hispanics, and 16.3% of American Indians and Alaska Natives have diabetes, compared with 8.7% of non-Hispanic whites (15,16).

Landmark research has demonstrated creative ways to deliver diabetes care and education. The Diabetes Prevention Program (DPP) was a randomized clinical trial to assess the safety and efficacy of interventions that may delay or prevent development of diabetes in people at increased risk for type 2 diabetes. It included more than 3,200 participants without diabetes who had elevated fasting and postload plasma glucose concentrations. These participants were from diverse backgrounds (55% self-identified as white, 20% were African American, 16% were Hispanic, 5% were American Indian, and 4% were Asian American), and they were randomly assigned to one of three groups: placebo, metformin (850 mg twice daily), or a lifestyle-modification program (17). The lifestyle interventions were culturally tailored to the participants' ethnic groups, and these interventions effectively reduced the incidence of diabetes in participants of all racial and ethnic groups (18). 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 and Diabetes Care and Education

As nutrition professionals, one of our greatest strengths is our ability to establish rapport with clients when providing education. We can complement this strength by understanding the influence of culture on health care practices (19). By integrating cultural constructs into diabetes care and education, we may improve diabetes outcomes (19) and better satisfy clients (20). The development of cultural competence is thus essential for every health care provider (21,22).

To effectively encourage clients to make healthier food choices and improve health outcomes, we must understand the food habits, preferences, and practices (eg, holidays, celebrations, and fasting) of the ethnic and racial groups we treat. The result: clients feel that they have been understood and that we respect their beliefs, behaviors, and values.

Cultural competence has been described as a set of congruent attitudes, behaviors, and policies (23). Situated in a system or 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 (23). These themes are present in the classic Campinha-Bacote model (12) and others, which define cultural competence in terms of recognizing and forming one's attitudes, beliefs, skills, values, and levels of awareness to provide culturally appropriate, respectful, and relevant care and education. Such models emphasize the ability of health care professionals to ask questions, listen carefully, speak simply and respectfully, and involve clients in their own treatment plans (24–26).

Applying the Campinha-Bacote Model of Cultural Competence

As a group of professionals dedicated to food and nutrition, we appreciate and value individuals, families, and communities, and this appreciation is the cornerstone of developing one's cultural competence. When we successfully bridge the differences between our own culture and the cultures of others, we demonstrate and achieve mutual understanding and meet unique needs. Campinha-Bacote's model treats cultural competence as a process, rather than a result, and has five interdependent constructs (12). The following sections describe the components of the model and how health care professionals may apply them when delivering diabetes care and education.

Cultural Awareness

As a first step toward cultural competence, the health care provider examines her own cultural background and asks herself questions about her own values, beliefs, and practices. After all, it is not just the client who has a culture. The health care provider must reflect on her own culture in order to extend beyond it during client outreach. Questions you might ask yourself include the following:

- What assumptions do you make about ethnic and racial groups?
- How might your assumptions and comments make counseling more difficult or less effective?
- Are any of your health-related values, beliefs, and practices related to diabetes? How might they affect the way you provide diabetes care and education?

At the same time that he investigates his personal cultural perspectives, the health care professional also aims to learn about each client's culture, including its effects on values, beliefs, practices, and problem-solving strategies. Asking clients the following questions may help in this process:

- In addition to the questions I have already asked you, is there anything more you like me to know about your diabetes?
- What are some of your health-related values, beliefs, and practices?

Cultural Knowledge

A culturally competent health care professional has broad cultural knowledge, including understanding of the following:

- Relevant cultural norms, values, world views, and practicalities of everyday life
- Cultural variations in family relationships
- Culturally specific health beliefs and practices
- Sociodemographic factors
- Cultural food habits
- Cultural attitudes about health care professionals and when to consult them
- Physical, biological, physiological, and psychological differences among ethnic and racial groups

To acquire cultural knowledge, health care professionals may review research for insight into the following questions:

- What is the prevalence of diabetes in various ethnic and racial cultural groups?
- To what extent does the biomedical model for the causation of diabetes agree or conflict with the client's cultural perspective? Does the client's culture describe or approach diabetes in ways that could affect an individual's reception of 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

Progressing from awareness and knowledge, we are prepared to more fully develop cultural skill—the ability to collect culturally relevant information from clients and perform culturally based assessments and interventions. The keys to developing cultural skill are asking open-ended questions and listening to the client's answers. The following are some questions to ask:

- What languages do you speak?
- Would you like us to use an interpreter when we meet?

- What kinds of foods do you like to eat when you feel well? How about when you are not feeling well?
- Which foods do you avoid when you are ill?
- Do you avoid any foods for cultural or religious reasons? Which ones?
- In your opinion, what causes your diabetes?
- How do you think we should manage and treat your diabetes?

Cultural Encounter

A cultural encounter (which may occur in any client interaction) is a process of actively seeking and engaging 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 nonjudgmental questions. Individuals 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.
- Observe whether clients make eye contact and understand how to interpret their gaze (eg, in some cultures, direct eye contact is considered rude or confrontational).
- Note how clients use silence.
- Ask open-ended questions; then truly listen to the client's answers (rather than simply waiting for your turn to talk).

Cultural encounters are opportunities to explore cultural food behavior. Encourage clients to bring food labels from home to counseling/education sessions. Also ask them to show you supermarket flyers that advertise ethnic foods and take cell-phone or digital photographs of their meals so you can help them ascertain portion sizes.

The following questions may help you understand the client's food habits and complete 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?

Food and Health

- Which foods do you eat to be healthy?
- Which foods do you avoid because you have diabetes?
- Which foods do you eat more of because you have diabetes?
- Have you seen other practitioners to treat your diabetes or conditions related to it? Please describe any treatments or remedies you use.
- We all have favorite remedies that we use when we are sick. Which home remedies do you use?

New Foods

- What foods have you recently eaten for the first time? Why did you start eating them?
- Do you regularly try new foods?
- Which new foods did you dislike? What about them did you not like?

Food Acquisition and Availability

- What foods do you typically buy?
- Where do you buy 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 this meal?
- How is this food/dish cooked?
- What recipes do you use?
- What do you usually eat with this food/dish?
- Do you have enough time and equipment to prepare the foods you like?

Food and Socialization

- Who eats meals with you?
- Who do you share holidays with?

Cultural Desire

Cultural desire means we want to be actively involved in cross-cultural encounters and seek greater cultural competence. To succeed in diabetes care and education, health care professionals must acknowledge similarities and differences among cultures and be prepared for interactions unlike those that are typical in their own cultures. For example, you may be more accustomed to asking job-related questions and feel hesitant about "prying" into personal matters, but your clients may be more comfortable if you ask about their families rather than their work. Similarly, you may be trained to measure outcomes in terms of the individual, but your client may be more receptive to knowing how diabetes affects the family. As a general rule of thumb, try to demonstrate a genuine interest in the client first and diabetes second.

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This book is one tool that can help you on the road to cultural competence. This journey promises many rewards. In particular, as you become more culturally competent, you and your clients will likely reap the benefits of improved communication and more effective counseling. Enjoy your cultural nutrition exploration!

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Contents

Tips for Healthy Meal Planning

General Tips

- Use measuring cups and spoons to control portions. Measure each serving to be sure you are eating the amount of food given in your meal plan.
- Tortillas, rice, beans, and corn are the main sources of carbohydrate in most traditional Mexican diets. Be sure to stay within your meal plan when eating these and other foods.
- Whole grain foods, nonstarchy vegetables, and fruits are good sources of fiber and other nutrients. Include them in your daily meal plan.
- Eat less fat and fewer fried foods.
- Have sweets, pastries, donuts, muffins, cake, and candy only occasionally and in small portions.

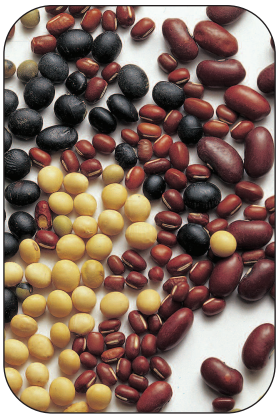
Tortillas

- If you make flour tortillas by hand, cut back on the fat or lard (manteca). Just a teaspoon of lard adds a lot of flavor.
- Also, try making flour tortillas with canola oil instead of lard or pork fat. You'll need less oil than fat to make the dough the right texture.
- When making enchiladas, brush one side of the tortillas with canola oil. Then stack them and warm the stack in the microwave. The small amount of oil keeps the tortilla from getting mushy in the sauce.

Rice

- Limit the fat in Spanish rice to just a tablespoon of canola oil.
- Instead of frying rice in oil, toast it in a warm pan and then add the cooking liquid.
- Avoid adding salt to rice dishes while cooking or at the table. Season with herbs and spices instead.
- Limit the use of consommé because it is high in salt.
- If you use canned products in rice dishes, choose salt-free or low-sodium types.

Beans



- Boil beans instead of frying them.
- Mash boiled beans and add milk or vegetable broth to give them the texture of fried beans.
- When cooking beans, limit salt to 1 to 2 teaspoons per pound of beans.
- If you use canned beans, choose low-sodium or salt-free types, or rinse them in water to remove some of the added salt.

Starchy Vegetables

- Types of starchy vegetables include potatoes, yams, sweet potatoes, peas, and corn.
- Boil and bake vegetables instead of frying.
- You can also pan-fry vegetables in nonstick cooking spray.
- Season dishes with onions, garlic, peppers, herbs, and spices instead of salt.

Fruits

- Enjoy fresh or frozen fruits, or have canned fruits packed in juice or extra-light syrup. Avoid fruit canned in heavy syrup.
- Eat fruit more often and drink fruit juices less often.
- If you drink juice, choose 100% fruit juice in small amounts. The portion size for fruit juice is ⅓ to ½ cup.

Nonstarchy Vegetables

- Choose low-fat and no-fat ways of cooking vegetables, such as steaming them in water or microwaving them.
- To cut calories and fat, limit or avoid vegetable dishes made with cheese or creamy sauces.
- Add lemon or lime juice to raw vegetables for flavor.
- Limit the amount of regular salad dressings that you eat. They add more calories, fat, and salt.

Milk and Milk Products

- All types of milk have the same amount of carbohydrate. For less fat and fewer calories, choose nonfat (skim) or 1% milk instead of whole or 2% milk.
- Enjoy low-fat or fat-free yogurt or sour cream instead of regular types.
- Try nonfat condensed milk or fat-free half-and-half in coffee and puddings. They add rich flavor but no fat!
- Limit cheese to small amounts and choose types that are low in fat, like part-skim mozzarella.
- If you grate cheese instead of slicing it, you probably will use less.

Meats and Meat Substitutes

- Cut off all visible fat from beef, pork, and other meats. Remove skin from chicken.
- Bake, broil, or stew beef, pork, fish, seafood, or chicken.
- Pan-fry meats, fish, and chicken with non-stick vegetable spray instead of frying in oil.
- Use chorizo only occasionally because it is high in fat, salt, and calories. Cook a small amount and drain it on paper towels before adding it to eggs or other dishes.
- Limit egg yolks to three a week. Use two egg whites instead of a whole egg with the yolk. (The yolk contains all the cholesterol in the egg.)

Fats and Oils

- All types of fat and oil are high in calories. Limit them to small amounts. Choose heart-healthy fats more often.
- Avocados and nuts have heart-healthy fats. Eat them in small amounts.
- Replace lard, drippings, butter, and stick margarine with small amounts of heart-healthy olive or canola oil.
- Avoid *trans* fats. Foods made with hydrogenated oils (like stick margarine and many packaged snack foods) have *trans* fat.

Holiday Foods

- Many holiday foods, like tamales, hot chocolate, pan dulce, and atoles, are high in carbohydrates and calories. Enjoy these foods in small amounts.