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Comparisons of Specific Illness Beliefs of Rural and Urban Blacks and Whites

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ABSTRACT

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To provide quality care, health care providers must understand the beliefs and cultural perspectives of clients, for these perspectives affect clients and caregivers in both overt and subtle ways. Nursing and health care leaders have noted the urgent need for developing culturally competent care and for studies that consider the context of patients' lives and power relationships between providers and patients. To date, most studies on cultural context have focused on general health perspectives, but these are not always applicable to particular illnesses. The concepts of explanatory model and illness guided this study. The purpose of this descriptive study was to determine specific health beliefs of individuals with cardiovascular illness from two racial groups residing in rural and urban areas. Semi-structured interviews

were conducted with 126 patients (51 Blacks, 75 White adults) admitted to a medical center hospital for invasive cardiovascular procedures or surgery. The interview consisted of questions about specific illness beliefs and cultural perspectives based on a cultural assessment. Data were content analyzed using Folioviews software. Results indicated many similarities in all four subgroups. Differences were observed in 1) expectations for types of treatment and self-care; 2) understanding of physiological processes; 3) use of medical terminology; 4) focus on quality of life; 5) financial concerns; 6) and feeling “entitled” vs. “grateful.” Results of this study reinforce the importance of determining individual client’s explanatory model of illness, versus the tendency to make assumptions about client’s perspectives based on observable characteristics or demographic variables.

Key Words: Black Adults, Cardiovascular Diseases, Cultural Competence, Health Beliefs, Rural Health, Urban Health, White Adults

Introduction

Significant health disparities exist among various racial and ethnic groups in the U.S.^{1,2} For example, life expectancies of Black and White Americans vary dramatically: White males, 73.2 years; Black males 64.9 years; White females 79.6 years; Black females 74.1 years.³ Health disparities among racial and ethnic groups are particularly evident in age-adjusted death rates from heart disease.⁴ More women than men are disabled and die of cardiovascular disease,⁵ and racial differences are also evident, with the death rate among White women at 99 per 100,000, while among Black women the rate is 164 per 100,000.⁶ The Agency for Health Care Policy and Research⁷ notes that in the U.S., women have poorer health status than men, and Hispanic and Black adults have nearly twice the rates of poor health as White adults, much of it attributable to cardiovascular disease.⁸ Decreasing rates of coronary heart disease in White men and increasing rates of the disease among Black men have also been noted.⁹

Racial, gender, and cultural factors are important in the likelihood of developing and receiving treatment for

¹U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

²N.I.H. (1999). *Women of color health data book*. Bethesda, MD: Office of the Director, Office of Research on Women's Health, National Institutes of Health, Department of Health and Human Services.

³Ibid.

⁴ Anderson, N. (1996, March). *Why do African Americans suffer illness and die at a higher rate than other Americans?* Paper presented at the 27th meeting of the Association for Applied Psychophysiology and Biofeedback, Albuquerque, NM.

⁵Wallis, D. (1999). Heart disease in women.

Cardiovascular Nursing Newsletter, Spring, 6-11.

⁶NIH, 1999

⁷Kass, B.I., Weinick, R.M., & Monheit, A.C. (1999). Racial and ethnic differences in health. Rockville, MD. *Report from the Agency for Health Care Policy and Research*.

⁸Wallis, 1999

⁹Hames, C.G. & Greenlund, K.J. (1996). Ethnicity and cardiovascular disease. The Evans County heart study. *American Journal of Medical Science*, 311, (3),130-134

specific health problems. Thus, with the growing proportion of minority groups in the U.S. population,^{10,11} health care professionals are challenged to incorporate cultural perspectives into the care they provide. Cultural perspectives influence patients and caregivers in both overt and subtle ways, affecting attitudes toward illness and beliefs about proper care by self and others.¹²⁻¹⁴ A lack of awareness of cultural differences means that health care providers will not be able to overcome common barriers that emerge from different life experiences.¹⁵ Even the most basic aspects of care, such as the meaning of symptoms, are filtered through the worldview of the client and cannot be assumed to fit the typical biomedical model of the health care provider.¹⁶ One aspect in overcoming health disparities is to improve abilities of health professionals to offer culturally competent care that respects and values differences in approaches to daily life, often seen among racial and ethnic minorities. This may be particularly important in rural communities, when strong traditions and the culture of rural life influence decisions to seek health care and its acceptability.^{17,18} Also, minority status, with its different cultural

¹⁰Department of Commerce (1994). *Current population reports*. Washington, D.C. Division of the Census.

¹¹Spector, R. (1991). *Cultural Diversity in Health and Illness*, (3rd. ed.) Norwalk, CT: Appleton and Lange Publishers.

¹²Larson, C.O., Colangelo, M., & Goods, K. (1998). Black and white differences in health perceptions among the indigent. *Journal of Ambulatory Care Management*, 21, (2), 35-43.

¹³Campinha-Bacote, J. (1995). The quest for cultural competence in nursing care. *Nursing Forum*, 30, (4), 19-25.

¹⁴Leininger, M. (1985). Southern rural black and white American lifeways with focus on care and health practitioners. In *Qualitative Research Methods in Nursing*. New York: Grune and Stratton Publishers.

¹⁵Meleis, A., Isenberg, M., Koerner, J.E., Lacey, B., & Stern, P. (1995). *Diversity marginalization and culturally competent health care: Issues in knowledge development*. New York: American Academy of Nursing Press.

¹⁶Wenger, A.F. (1993). Cultural meaning of symptoms. *Holistic Nursing Practice*, 7 (2), 22-35.

¹⁷Ramsey, P.W. & Glenn, L.L. (1998). Risk factors for heart disease in rural Appalachia. *Family & Community Health*, 20 (4), 71-82.

¹⁸Wilson, M., Hinton, I. & Merwin, E. (2000). *Race, culture, mental health services and family well-*

being. Proceedings from a conference held in 1999, sponsored by the Faculty of Arts and Sciences, the Southeastern Rural Mental Health Research Center, and the Center for Children Families and the Law, University of Virginia.

traditions may interact with rural life to create a complex interplay of factors that affect health status and the ability to benefit from care.

Culturally competent care has been defined by the National Academy of Nursing expert panel as:

“...care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender and sexual orientation. This care is guided by nursing theories, models and/or research principles.... It is also care that is provided within the historical and ‘dailiness’ context of clients.”¹⁹

¹⁹Meleis, A.I. (1996). Culturally competent scholarship substance and rigor. *Image: the Journal of Nursing Scholarship*, 19, (2), 1-16.

Nurses need to develop approaches to caring for individuals with cardiovascular disease in ways that reflect cultural competence. As a first step in this process, the study reported here examined the health beliefs of a sample of adults with cardiovascular disease. Some of the participants lived in an urban area and some in a rural area. In order to practice culturally competent care, health care providers must try to elicit individuals’ explanatory model of illness, their worldview and their illness experience.^{20,21} This study was therefore guided by Kleinman’s concept of the explanatory model of a disease, i.e., an individual’s explanation of the cause, onset, course and treatment of

²⁰McSweeney, J.C., Allan, J.D., & Mayo, K. (1997). Exploring the use of explanatory models in nursing research and practice. *Image: Journal of Nursing Scholarship*, 29 (3), 243-248.

²¹Luyas, G.T. (1991). An explanatory model of

diabetes. *Western Journal of Nursing Research*, 13 (6), 681-697.

²²Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California.

²³Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care: Clinical lessons from anthropologic and cross culture research. *Annals of Internal Medicine*, 88, (2), 251-258.

a disease and an individual's experience of it as an illness.^{22, 23} The theoretical framework (see [Figure 1](#)) demonstrates the relationship between the individual's explanatory model (EM) of an illness and the health care professional's exhibiting cultural competence through developing an understanding of the person's EM.

Each person comes to the health care encounter with perspectives and ideas about the illness. It is only through inviting the person to share his/her EM that the health care professional is able to understand the client's perspective, honor the meanings, and care for the person in a way that respects his/her way of living.^{24, 25}

²⁴McSweeney, et al, 1997

²⁵Cohen, M.Z., Tripp-Reimer, T., Smith, C., Sorofman, B. & Lively, S. (1994). Explanatory models of diabetes: Patient-Practitioner variation. *Social Science in Medicine*, 38 (1), 59-66.

Methods

In this descriptive exploratory study, semi-structured interviews were conducted with 126 informants admitted to cardiovascular units of a medical center hospital that serves mostly rural areas in Central Virginia. The study was part of a larger study of health

status and preferences for who should make decisions about treatment. The study was approved by the Institutional Review Board. Informants were included if they were over 18 years of age, self-described as Black or White adults, living in a rural or urban community (determined by zip code, reflecting population density), in stable mental and physical condition, recovering from an invasive procedure for cardiovascular disease, and able to speak English and provide informed consent. Efforts were made to recruit equal numbers of Black and White and urban and rural participants. Interviews ended when data saturation was achieved and subject groups were nearly equal in numbers. Informants were paid \$10 for the interview; however, some participants refused the payment, stating that they wished to “help others.” Confidentiality was protected in the taped interviews by addressing informants as “Mr. R” or “Mrs. M.” Written data sheets and tapes were numbered but were not linked with any identifying information.

The nine interview questions were based on the work of Kleinman, Eisenberg and Good,²⁶ and were designed

²⁶Kleinman, et al, 1978

to explore the informant's culturally based explanations for the current illness and appropriate treatments (see [Table 1](#) for specific interview questions).

Audio taped interviews took approximately 30 minutes and were conducted in hospital rooms by researchers dressed in casual business clothes to distinguish them from care providers. Efforts were made to develop rapport with informants by first engaging in social conversation, asking where the person was born, where the family lived, and how long they had been in the region. There were four experienced nurses, both Black and White, who conducted interviews. Nurses of the same race as the informant conducted most interviews.

The race of the 126 participants was determined by self-report from admission data. There were 51 Black and 75 White adults; 71 were males and 55 females (see [Table 2](#) for breakdown by gender and race).

The vast majority were older adults, with an average age of 67 (SD = 10.7). Eighty-one percent had completed high school (SD = 3.2 years completed); 38% (n=46) were employed, 40% (n=49) were retired, and 22%

(n=26) disabled. Of those who were employed, most worked in blue-collar occupations such as factory worker, truck driver and clerk; many of the women were homemakers. Household incomes ranged from \$2,000 to \$110,000, with 50% of participants making \$19,000 or less. While a variety of religious faiths were reported, the highest percentage indicated that they were Baptist (49%, n=62) (see [Table 3](#) for detailed sample demographics). The most frequent cardiovascular diseases for which participants were hospitalized were coronary artery disease, peripheral vascular disease, and valve disease. Fifteen participants had both diabetes and hypertension.

Data Analysis

Interviews were transcribed from tapes into Folioviews software²⁷ for content analysis by a research team member who had expertise in this methodology. The unit of analysis was the phrase. Responses were content analyzed from the taped interviews and phrases coded according to the interview questions from Kleinman et al.²⁸ In addition the entire text was

²⁷Folio Corporation (1994). Folioviews 3.1 Infobase Management Software. Provo, UT. Folio Corporation.

²⁸Kleinman, et al, 1978

searched for key words derived from Kleinman's questions such as "cause," "sickness," "treatment," etc. Color-coding of the text was used to aid in sorting content that fit particular questions, regardless of where the topic arose in the interview so that similar responses were grouped together. The responses for each question were then grouped together for the four subgroups of informants (by race and gender). Themes from each group were then compared.

Methods for establishing trustworthiness were based on the recommendations of Lincoln and Guba.²⁹

²⁹Lincoln, Y., Guba, E. (1985). *Naturalistic Inquiry*. Newbury Park. Sage Publications

Credibility was established by using the research team and a consultant as peer debriefers. Member checking was accomplished by clarification during interviews by the four trained interviewers. There were a sufficient number of interviews to identify common themes. The analysis was completed by the principal investigator in collaboration with a research assistant. Confirmability and dependability were addressed by the use of an audit trail, which included transcripts, a record of coding from the Folioviews software, and notes from research team meetings where results were presented and

discussed at regular intervals.

Results

Similarities

Similarities were found among the four groups of participants in the significance of symptoms, the importance of functional status, the causes of illness, the treatments needed, and fears related to the illness. The *importance of symptoms* was the predominant theme. Symptoms were mentioned in response to questions about their sickness, problems that it had caused, and the desired results from treatment (i.e., relief from symptoms). When asked what their sickness did to them, informants in all four subgroups listed specific symptoms including pain, shortness of breath, swelling, loss of feeling, chest pain, and weakness. Participants also mentioned symptoms when asked about the problems their illness had caused. Symptoms mentioned most often were pain and weakness. In addition, informants in all subgroups mentioned relief of symptoms as one of the primary outcomes desired.

Functional status was the second most common theme

mentioned by participants in all four groups. They described loss of function as one of the main problems their sickness had caused, and said return to function was one of the most important results they hoped for with treatment. All informants defined loss of functional status as inability to walk, work, and generally care for one's self. Being a burden to others was a frequent concern. A Black urban informant who desired to improve functional status said his goal was:

"To have no more shortness of breath. Be able to walk and do like I used to. 'Cause I used to walk every day. I walked with a friend of mine and we'd just walk across town and get a cab back."

Informants in the four subgroups gave similar responses to questions about *what caused their health problem* and *why it started when it did*. Some had no idea about causation and some had definite ideas about causation. Those informants who identified a cause mentioned lifestyle factors, such as smoking, drinking, diet, stress, and high cholesterol. Informants from the Black rural subgroup tended to attribute their health problem to a general state of "not taking care of myself" ([Table 4](#) summarizes these findings).

Informants from the White rural and Black urban subgroups said that *health care providers had told them lifestyle factors were the cause* of their illness.

But as the following quote from a Black urban informant illustrates, participants were not sure they accepted these explanations.

"...they [health professionals] say cigarettes [caused PVD] and, by me sitting in driving a truck day in and day out is one of the major causes. So...I can't say that they're right and I can't say that they're wrong, you know, I don't know..."

Urban Blacks and rural Whites mentioned heredity as a factor causing their illness, noting multiple family members with the same problems.

Many people in all four subgroups had *no explanation when asked about why the illness started when it did*. People in both the White and Black urban groups said that their present problem could have been caused by a pre-existing problem such as high blood pressure, diabetes, or a problem with a heart valve. The White rural and Black urban subgroups explicitly stated they had been told by their health care provider that their current problem was caused by a pre-existing health problem. Again, however, they expressed uncertainty

about this, as illustrated by the following quote from a Black urban informant:

“You know they [health care professionals] claim [the cause is] sugar, they say sugar....so diabetes...so. That's the only thing I have to go by, you know ...cause I never was sick in my life. So.... I got the diabetes so...they [“they” is emphasized here] claim that's it.....”

When asked how their illness worked, the predominant response in all four subgroups was, “I don't know.”

Informants in the White rural group mentioned "plaques build up," "it hurts so bad it takes your breath away," "your heart is overworked," and "not getting enough oxygen." One Black rural informant said “lack of circulation.” Black urban informants mentioned "sugar makes the blood sticky and makes the vessels get clogged up," and "the body was starving and not getting enough oxygen from heart disease." White urban informants mentioned "fluid building up," "blood supply cut off to the brain," "blood supply cut off," and "my heart couldn't handle the unusual beat."

Informants in all four groups responded similarly to the question about *what sort of treatment they should receive*. Most people interpreted the question as “how are you being treated here?” and their responses

included "they are treating me fine" and "everyone has been very nice to me." Informants clearly trusted their health care providers. Responses such as "they are doing everything they can" or "the doctor is doing what needs to be done" were common. One informant from the Black urban subgroup expressed thankfulness for his treatment:

"I guess I'm receiving more than most people...and lucky to be receiving it, you know I...I'm glad to get what... help I can get. I don't have no insurance, I don't have a...um...hospital relation...or anything like that."

A final question asked participants *whether they had fears related to their illness*. Some responses seemed defensive, while others were noncommittal: "No, not really.... can't say that I fear anything now." Black urban informants mentioned fear of death, a heart attack, stroke, or kidney failure. Black rural informants gave more general responses such as "not getting well" or "not being able to work." Fears mentioned by White urban informants included death, stroke, organ rejection, heart attack, and loss of family, while White rural informants mentioned "death" and "loss of functional ability" as their greatest fears.

Differences

Differences in the four groups were observed in the specificity with which they labeled symptoms, the severity and duration of illness, problems caused by the illness, why the illness started when it did, and the treatment needed.

While informants were generally very specific about symptoms, Black rural informants often listed nonspecific symptoms such as a "feeling of sickness" or a general feeling of illness, as in the following example:

"Something was wrong with me. I just had a bad feeling. It felt like a sickness. I was just bored and upset, couldn't get myself together to do nothing. Yea, I really didn't know why I needed to go. It was just the way I felt. I didn't know...I called the rescue squad."

Another difference noted among the groups was in *whether they assigned a label* (often a diagnosis) to their symptoms and the explanation they gave (if any). Most of the Black rural subgroup did not mention a label or diagnosis for their symptoms. Informants in the other three subgroups often did attach a label to their symptoms such as a "heart attack" or "stroke," or stated that they were in the hospital for a procedure or an

operation such as an arteriogram or an amputation, or "I'm here for surgery on my foot." Informants in both the Black rural and urban subgroups indicated that they had received a label for their symptoms from health care providers. These groups often referred to health care providers as "they," as in this example:

"I don't know. They thinking I got poor circulation. My legs, they just start hurting. And they be weak and stiff. I can't walk and they say it's from [poor] circulation."

In both rural subgroups, informants were *unsure about their acceptance of the diagnosis* or the label given by health care providers. For example, a Black rural informant talked about his health care problem thus:

"And I woke up and I was dizzy, swimmy headed. My sister was sitting out on the porch. She said something's wrong with you and she went in straight and called the rescue squad. The rescue squad said that I had high blood. They brought me over here to the hospital. And they said I had a stroke. That's what I heard here. I don't know whether I did or not."

Financial problems related to their illness, was a theme only for the Black rural and White urban groups. The following quote is from a White urban informant:

"Well, uh, it changed our whole lifestyle really, from the time I went on disability...it has changed it tremendously. I had to completely liquidate my business and face the uncertainties of how you're going to live.... that's a stress in itself. But, everything

has just worked out beautifully."

The groups also differed in their responses to the question about *why the illness started when it did*. Informants from the White rural and Black urban subgroups suggested that the illness was predetermined: "it was just time for it to happen" or "it was just my time for it to happen." Others were less clear.

Questions about the *severity and duration of the illness* brought mixed responses from informants in all four groups. Although the predominant response was, "I don't know," there was a variety of responses. Black urban informants thought their illness was very severe and could be either short or stay with them the rest of their lives. Informants from the Black rural subgroup saw their health problems as "moderate" to "very severe," and generally thought the problem would be with them the rest of their lives. White rural informants described their condition as moderate to severe, and the duration as either short or long. The White urban subgroup saw the illness as severe and the duration as short without future problems.

Ideas about treatments also differed among the groups. The Black rural subgroup mentioned using sprays and salves, dressings, antibiotics, and protection. Some informants defined treatment as protection, meaning assistance from staff or equipment such as wheelchairs. Another example of protection was relief from stress and agitation. White urban informants described treatments needed as therapy (unspecified), exercise, medications, and diet. White rural informants mentioned medications, physical therapy, monitoring, and respiratory treatments. One Black urban informant expressed a belief in the central role he played in his treatment:

"It's not what they should do, it's me. They've done their part by replacing your bad parts and now it's up to me to get in shape. I had a guy come in today when I took my first walk. He give me a pamphlet with some exercises to do that'll really help. You know to get me into shape, slow but sure."

Discussion

The semi-structured interview, developed by Kleinman et al,³⁰ was useful in eliciting patients' perspectives on cardiovascular illness. The fact that there were **both**

³⁰Kleinman et al, 1978

similarities and differences in the responses of groups living in different areas and belonging to different racial groups suggests that individual perspectives cannot be predicted by group membership alone. The significance of symptoms, the importance of functional status, the causes of illness, the treatments needed, and fears related to illness were similar in all four subgroups. However, the different subgroups had differing perspectives on applying labels to symptoms, the severity and duration of illness, the kinds of problems caused by the illness, why the illness began, and the type of treatment needed.

While data from this study cannot support this conclusion, the many similarities in the four groups may reflect the tendency of participants to “parrot” information they had received from health care providers, whom they referred to as “they.” Similarly, in her study of cardiac rehabilitation patients, Hoeman³¹ found that nurses’ own cultural perspectives usually determined the assumptions used as a basis for the plan of care.

³¹ Hoeman, S. P. (1989). Cultural assessment in rehabilitation nursing practice. *Nursing Clinics of North America*, 24, (1), 277-289.

This tendency of participants in the current study to refer to health care providers as “they” or “them” appears to reflect differences in knowledge, social status, and power between patients and providers in the hospital setting. Patients who used the phrase “they say...” were reporting what professionals said, implying that the patients did not “own” that point of view.^{32,33} At the same time, however, many participants expressed gratitude for the care they received and thus they seemed to accept a certain “closeness” to the providers who were so different from them. Feeling themselves ill and vulnerable, perhaps patients must emphasize their gratitude and trust rather than their differences from providers. Care providers need to be aware of the power they hold and strive to earn and maintain the trust given them by patients.

³² Hansen, M. & Resick, L. (1990) Health beliefs, health care, and rural Appalachian subcultures from an ethnographic perspective. *Family and Community Health, 13*, (1), 1-10.

³³ Lacey, K., Meier, G., & Krumholtz, R. (1995). Outcomes after major vascular surgery: the patient’s perspective. *Journal of Vascular Nursing, 13*, (1), 8-13.

The findings of the present study are a reminder that, in spite of widespread public awareness about cardiovascular disease and public campaigns for heart healthy behaviors, individuals hold a variety of beliefs about the cause and treatment of their illness ^{34,35}. To bridge gaps in understanding and effectively promote

³⁴ Fleury, J. (1996). Wellness motivation theory: An exploration of theoretical relevance. *Nursing Research, 45* (5), 277-283.

³⁵ Price, J.L., & Cordell, B.

(1994). Cultural diversity and patient teaching. *The Journal of Continuing Education in Nursing*, 25, (4), 163-166.

self-care for cardiovascular illness, nurses and other providers need to elicit the patient's beliefs and build the plan of care congruent with the individual's perspective. Clearly health care providers cannot take for granted that they know the perspectives of their clients simply based on visible characteristics or demographic variables, and thus must instead explore patients' explanatory models in order to approach them in culturally competent ways.

This study contributes to the ability of nurses and other providers to understand how clients' perspectives affect their decisions about self care in the context of a cardiovascular illness. Although the pace of health care in acute care settings makes culturally competent care more difficult to achieve, the necessity of offering care consistent with individuals' beliefs is reaffirmed by the present study.

Table 1. Interview Questions: Assessment of Cultural Perspectives on Illness

- What do you think has caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you; how does it work?
- How severe is your sickness?
- Will it have a short or long duration?
- What kind of treatment should you receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused you?
- What do you fear about your sickness?

(Kleinman, Eisenberg, & Good, 1978)

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Table 2. Race, Residence and Gender Characteristics of Study Sample

	Black Rural	Black Urban	White Rural	White Urban
Male	18	11	26	16
Female	16	6	17	16

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Table 3. Demographic Characteristics of Participants (n=126)

	F	%	\bar{X}	SD
Age (range 38-88)				
38-50	14	11	46	3.7
51-60	14	11	56	2.6
61-70	41	32.5	65.7	3.1
71 & >	57	45.2	76	4.4
	—			
	126			
Education (years of schooling completed)				
8 or <	35	27.7	6.7	1.3
8.1 to 12	67	53.1	11	1.2
12.1 or >	24	19.0	14.9	1.95
	—			
	126			
Employment				
Employed	46	38		
Retired	49	40.5		
Disabled	25	20.7		
Unemployed	1	.5		
Missing Cases	5			
	—			
	126			
Annual Household Incomes (range \$1,920-\$110,000)				
\$10,300 or less	28	22	\$6,624	\$2,195
\$10,400 - \$20,000	20	15.9	\$15,992	\$3,072
\$21,000 - \$30,000	10	7.9	\$27,036	\$2,777
\$31,000 - \$40,000	11	8.7	\$35,427	\$3,157
\$40,000 & >	16	12.7	\$68,281	\$20,420
Missing Cases	41			
	—			
	126			

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Table 4. Beliefs About Causation of Illness by Group Membership

	Urban	Rural
Black Informants	Lifestyle: Smoking, sedentary (etc)	Lifestyle: diet, stress, hi choles.
	Heredity	Don't Know
	Pre-Existing Condition	
	Don't Know	
	Fate	
White Informants	Lifestyle: smoking, diet (etc.)	Lifestyle: smoking, diet, stress
	Heredity	Heredity
	Pre-Existing Condition	Don't Know
	Don't Know	Fate

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Figure 1. The Link Between the Individual's Explanatory Model and Cultural Competence by Health Care Professional (HCP)



*Kleinman, 1980

*Kleinman, Eisenberg & Good, 1978

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