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Intensive care nurses' encounters with multicultural families in Norway: An exploratory study

Sevald Høye, Department of Nursing, Hedmark University College

Elisabeth Severinsson, Department of Health Studies, Faculty of Social Sciences, University of Stavanger

Summary

The aim of this study was to explore nurses' perceptions of their encounters with multicultural families in intensive care units in Norwegian hospitals. Immigrants from non-Western countries make up 6.1% of the population in Norway. When a person suffers an acute and critical illness the person's family may experience crises. Nurses' previous experiences of caring for culturally diverse patients and families is challenging due to linguistic differences, and contextual factors. Family members should be near their critically ill spouse to reduce the impact from a frightening environment.

The study had a descriptive exploratory qualitative design with a retrospective focus. Three multistage focus groups consisting of 16 nurses were set up in intensive care units. The data were analysed by interpretive content analysis. The theme 'Cultural diversity and workplace stressors' emerged. This theme was characterised by four categories: 'impact on work patterns'; 'communication challenges'; 'responses to crises' and 'professional status and gender issues'. In conclusion, nurses' perception of their encounters with multicultural families in intensive care units seem to be ambiguous with challenges in interaction, and the nurses' stressors emanating from linguistic, cultural and ethnic differentness. To diminish cultural diversity the nurses strive for increased knowledge of different cultures and religions.

Introduction

In Norway, as in other West-European countries, there has been immigration from all over the world during recent decades. People come to Norway especially from countries such as Pakistan, Iraq, Vietnam, Somalia, Bosnia and Herzegovina, Iran, Turkey, Serbia, Sri Lanka and Poland. Immigrants from non-Western countries make up 6.1% of the population in Norway (Statistics Norway, 2006). As a result Norwegian society has become more multicultural than ever before in the sense that different ethnic groups are a natural part of the same society. For this reason there will be an ongoing need for nurses and other health professionals to have knowledge of different cultures in order to meet potential patients' and families' needs when entering hospital (*cf.* Leininger, 2002).

Barth (1994) states that if ethnicity is the social organisation of cultural diversity we have to understand culture in order to understand ethnicity. Culture is an integrated dynamic system of values, beliefs and practices shaped by interactions from conception and throughout the lifespan (Willis, 1999). The increase in global mobility creates populations that are ethnically diverse in almost all countries. Multicultural societies (Parekh, 2007) are made up of several types of ethnic-national minorities, the similarity of the term minority background, who are more or less immigrants or successors of immigrants, aborigine or their progeny. Minorities

and ethnic groups are protected by Human Rights allowing them the right to enjoy their own culture, to practice their own religion, and to use their own language. Equal rights are stated in Norwegian legislation which enable immigrants and asylum seekers to access health care and medical treatment. In the present study multicultural families focuses on families from a minority and a different ethnic background, except those from other Scandinavian countries, either living in the country as immigrants or having a migrant family. Traditionally the term family is used to refer to people who are linked together by blood or marriage. Another way to describe a family is to focus on the emotional bond that exists between family members. Wright and Leahey (2000, p. 70) state that a family: "*is who they say they are*".

When a person suffers an acute and critical illness the family network may experience crises. Tracy and Ceronsky (2001) found that stress affects the family's ability to cope with the situation and their ability to process information about complex matters. Some patients in intensive care units (ICU) and their families need assistance from health care professionals in order to cope with the hospital admission. In cases of multicultural families both patient and family members may experience additional stress, because their encounter with the strange hospital milieu could reflect earlier unpleasant experiences as immigrants (Robertson et al., 2006). According to Lazarus and Folkman (1984) psychological stress is a relationship between the person and the environment, where the person's resources are exceeded and their well-being endangered. Positive appraisals of stress occur when challenged stimuli mobilises development towards coping efforts. In an investigation of everyday practice in intensive care Wickström and Larsson (2003) found that ICU staff's routine work was largely connected to technology, emphasising that technology has an impact on the welfare of human beings.

Up to now studies have shown challenges in nurses' and physicians' encounters with patients and families in ICU in general, but also with culturally diverse families. For example Anthonypillai (1993) reported disruption in effective communication in intensive therapy units when patients did not speak the native language. To facilitate cross-cultural communication she suggested that nurses can be guided to develop their role as interpreter, to provide a specially designed booklet and to be more supportive. In Waters' (1999) study of African American, Hispanic and White family members' perception of professional support expected of critical care nurses, there were significant differences in responses. For example African American family members had higher expectations for the critical care nurses to be concerned about their comfort in the waiting room. However generally, expectations were generally universal, suggesting equitable care, dignity and respect. Moreover, Cioffi (2005) concluded that nurses are informally acquiring cultural knowledge and that some nurses use stereotypical views of the patient's cultural group, while others use the perspective of the individual patient and family. Chenoweth et al. (2006) also suggest strategies to achieve cultural competence in nursing by respecting the health consumer's culture, value system and ways of being.

Nurses' experiences of caring for culturally diverse clients is reported as complex and challenging due to the interrelatedness of multiple personal and contextual factors like the setting of health care, the support of colleagues, the institutional climate, the foundation of education, and the presence of racism (Kirkham, 1998). Nailon (2006) pointed out central factors to promote communication more effectively when linguistic differences occur, such as: nurses' skills working with interpreters, interpreter availability, and accuracy. Engström and Söderström (2004) concluded that it was important for family members to be near their critically ill spouse even if the environment was frightening. However, there are few

investigations that focus on encounters between multicultural patients and their family members, and nurses in ICU.

The aim of this study was to explore the perception of intensive care nurses in regard to their encounters with families of patients with multicultural background. The research question was: What are the nurses' perceptions of their encounters with multicultural families in ICU?

Methods

Design and approach

This descriptive exploratory study had a qualitative design that focused on intensive care nurses' retrospective perceptions of their encounters with multicultural families.

Ethical approval

Ethical approval for the study was obtained from the Regional Committee for Medical Research Ethics in Norway (No.518-04198) which accepted the research protocol and strategies for informed consent. The study was announced to the Norwegian Social Science Data Services, who gave their receipt to fulfil the project (No.11753). All nurses who participated received oral and written information and gave their written consent to participate.

Participants

The inclusion criteria for the study were: registered nurses with at least 2 years of intensive and critical care experience, and experience with multicultural patients and families, especially within the preceding 3 months. A total of 16 intensive care nurses fulfilled the criteria to participate. They were all educated in intensive care nursing. The participants comprised 15 females and 1 male, and their ages ranged from 27 to 64 with the majority (11) between 30 and 50 years. The participants had worked as intensive care nurses between 2 and 32 years (mean = 7.6) and all nurses were of Norwegian ethnic background. Eleven of the participants reported that they were Christian, two were humanists and three were atheists or non-religious. The sample consisted of three groups of nurses recruited from three different ICUs, which were chosen for practical reasons, such as sampling a population of nurses who were broadly based and representative. There were both male and female nurses in the units, although the majority were female, which is representative of Norwegian nurses with respect to gender.

Data collection

Data were collected by means of multistage focus group interview (Morgan, 1997), a method which is based on the advantage that the participants form a homogeneous group (Maunsbach and Dehlholm-Lambertsen, 1997). Unlike the usual one meeting focus group concept, multistage focus groups imply that reflections shared and developed within a particular group over several meetings, lead to a deeper understanding of a theme (Thornton, 2002). A second advantage is sharing experiences and thoughts about a specific topic created through the interactive group process. The expressions of the group opinion are presented in consensus at consecutive group meetings. According to Hummelvoll (2007) the multistage focus group explores experiences by using dialogue and by lifting the discussion to a higher level in order

to detect potential utilitarian value. On the other hand, ordinary focus groups seek to clarify opinions within a group created by dialogue itself. The utilitarian factor is more or less subordinated in ordinary focus groups. When using multistage focus groups in this study, the purpose was to stimulate the intensive care nurses' reflections on the communication processes and the consequences for nursing practice.

In this study three focus groups were held in three different ICUs (at university hospitals; A, B and C) in Norway. Two of the focus groups met on three occasions, while the third held two meetings. The reason for two meetings in one group is that the reflections and discussions had reached a repetitive and exhaustive level of the subject by completion of the second meeting. With regard to group size, one consisted of five nurses, another group four and the third group consisted of seven participants. However, due to free time and reports of sickness among the nurses, there was variation in subsequent group meetings, ranging from three to seven participants. Notwithstanding the group size, there was always more than half the original number which enabled continuity of discussion. In total eight focus group interviews took place, each was recorded and lasted approximately 1.5 h. The time-span between the different focus group meetings was from 1 month to 6 weeks. All the interviews were moderated by the first author (S.H.). A co-moderator participated at the second and third meeting in the focus groups in hospital A and another co-moderator participated at the first meeting in hospital C. The reason for using co-moderators in a restricted number of the meetings was to make some observations of the interaction between the group participants and the moderator. They were also able to provide feedback at various stages regarding their perceived appropriateness and direction of questions and discussion.

Each initial focus group interview began with the following question: how would you describe your experiences with multicultural families? Subsequent questions, clarification and further exploration centred on the resultant discussion, for example the families' interaction with nurses, and the role of the families in nursing care activities. The nurses were encouraged to speak openly and honestly about their experiences with any multicultural family, and at the conclusion of each meeting the main points were clarified and summarised. Each subsequent meeting began with a reiteration of the previous one and focused on in-depth discussion of the issues.

Data analysis

The data were analysed by the process of interpretative content analysis as described by Graneheim and Lundman (2004) and Berg (2007). This process was created through several steps. Firstly, transcribed data from all eight focus group interviews were read several times. The reading resulted in different meaning units from the transcribed text, which comprise sentences containing aspects related to each other through their content. The meaning units were then transformed into condensed meaning units, which are characterised by a process of shortening while preserving the core of the text. Further on codes, categories and themes were created as a result of abstraction of the condensed meaning units. An example is given in Table 1. Some of the codes, in the sense of a label of the meaning units, fitted into more than one category.

Table 1.

An example of interpretative content analysis: meaning units, condensed meaning units, code, category, theme

Meaning units	Condensed meaning units	Codes	Categories	Theme
<i>Words, sentences or paragraphs containing aspects related to each other through their content</i>	<i>Reference to a process of shortening the meaning unit while still preserving the core</i>	<i>The label of a meaning unit</i>	<i>A group of content that shares a commonality</i>	<i>A recurring regularity developed within categories or cutting across categories</i>
It can be said that they (<i>multicultural persons</i>) have much more pain after surgery or they express their pain more than the people from the Northern countries	Different pain experiences			
It is demanding that they are yelling and making a noise with each other, and acting out. They express their pain more often than Norwegians	Strong expressions of pain	Loud expressions of emotions	Responses to crises	Cultural diversity and workplace stressors

To establish rigor in qualitative research, such as collecting and analysing data from these focus groups, the researcher needs to maintain transparency. In a naturalistic (qualitative) paradigm different criteria are intended to maintain trustworthiness as an expression of rigor (Lincoln and Guba, 1985). Morse et al. (2002) have argued that rigor should be attained through the use of verification techniques. In the current study rigor is maintained in different ways, for example by the described procedure for recruiting participants, by presenting summaries from previous meetings for all focus groups, by peer-debriefing of data analysis by both authors, and by following the prescribed steps in data analysis. The analysis focused on both manifest and latent content in the transcribed text (Graneheim and Lundman, 2004), especially because the purpose was to interpret what was lying between the lines and in the interaction.

Results

The nurses' main perceptions of their encounters with multicultural families in ICU in Norwegian hospitals were described by the theme *Cultural diversity and workplace stressors*. This theme was characterised by four main categories, which represent difficulties and concerns in the nurses' job situation. The categories are: *impact on work patterns; communication challenges; responses to crises; and professional status and gender issues* (Table 2).

Table 2.

Description of theme, the different categories and codes

Theme	Cultural diversity and workplace stressors			
Category	Impact on work patterns	Communication challenges	Responses to crisis	Professional status and gender issues
Code	Crowded rooms for family members	Assisted communication with tape and pictures	Emotional interpretation by family members	Patriarchal opinion of women
	Many visitors disrupt procedures	Linguistic differences lead to insecurity	The family promotes emotional adaptation to crisis and grief	Men as spokesmen
	Restrict the number of visitors	Clarify by asking	Expanded families	Contrasts between gender
	Different routines for visiting hours	Uncertainty of received information	Religious and practical orders when grieving	Reserved and expectant role as a nurse
	Non-respect for visiting hours	Adjusted information in relocation	Expressions of pain and grief	Nurses as inferior
	Limited participation in practical care	Employees as interpreter	Loud expressions of emotions	Lack of respect for ethnic groups

Theme	Cultural diversity and workplace stressors			
Category	Impact on work patterns	Communication challenges	Responses to crisis	Professional status and gender issues
	Discomfort when exposing	Seeking knowledge	Confidence in symbols which is healing	Positive attitude
	Planning of relocation		Periods with rest and restitution	Reliance on the nurses
			Previous trauma may be intensified	Respectful appearance
			Supportive climate within the families	

Impact on work patterns was described by nurses as emotional distress both in the sense of encounters with multicultural families and in the structural and occupational demands. The multicultural families seemed to be expanded compared to Norwegian families. The situations that produced stress were characterised by rooms crowded with family members and great numbers of visitors, which can hinder nursing procedures in the patient's room. For example, the Norwegian families usually confine visitors in ICU to immediate family only, while many multicultural families also include aunts, uncles, cousins and close friends. Nurses were forced to restrict the number of visitors several times in order to maintain care routines.

“It was very difficult, because the ward was crowded and approximately 30 people arrived. They were on the wall and in the corridor, so that other family members did not get any space at all. We tried to tell them to restrict their stay in the room or in the corridor”.

Non-respect for visiting hours and different routines, and differing opinions of the staff when organising visiting hours and numbers of visitors in ICU was reported. Also, the nurses felt a level of uncertainty regarding patient exposure. They were ambivalent for example, about fulfilling cultural expectations to respectfully cover the patient or to uncover the febrile patient to prevent increased body temperature.

“For a woman who is known as a Muslim we cover the shoulders and we may take for granted to cover the hair. Otherwise, one may presume that the family sees her as naked”.

The nurses experienced some stress due to relocating the patients and informing the family.

“We often try to contact the ward so they (the nurses) could visit the ICU, but because of increased activity both they and we have no time left to think of the patient before he leaves the unit and goes to the ward”.

Overall, the impact on work patterns was one of stressful situations and difficulty adjusting to differing needs and demands.

Communication challenges were linked to linguistic difficulties between the nurses and multicultural families, who did not speak Norwegian very well, or not at all. The ICNs became insecure, but they acknowledged the importance of clarifying special needs and wishes in the families by asking them, and by using additional resources as necessary.

“We have to involve interpreters in order to give information to the family member. But we need to be with the patient all the time and then we are forced to involve the family member as interpreters in daily caring”.

In some cases the nurses engaged employees as interpreters. They also reflected upon the use of linguistic aids to facilitate nurse–family interaction.

“When the patient was woken after being on the ventilator the interpreter read the information to a tape-recorder. Every time she appeared to be distressed we played the tape; ‘you are at the hospital’, ‘you are breathing with the help of a machine’. It worked”.

Although the nurses were focused on informing the patient and family according to Norwegian legislation, they reflected uncertainty about whether the families had actually understood the information or not.

“We often say that they speak fluent Norwegian, but our experience is that families who seem to speak fluently don’t catch the differences in our language when we talk to the patient. It may be misunderstandings that can’t be captured”.

Another challenge in communicating with multicultural families for the nurses was to discover their own lack of knowledge about cultural and religious values.

“I can’t free my self from thinking that there ought to be some general matters which we can learn. All religions have a framework in one way or another”.

Challenges to communication were also stressful for the nurses, although they were resourceful and, to some extent, insightful.

Responses to crises occurred in the form of anxiety and distress within multicultural families. The nurses expressed both challenging behaviour and communication in the families, and challenges in how to prevent more confusion and distress. The processes within such families when they are in crisis were characterised by loud expressions of emotions especially among

the women, religious and practical orders when grieving and confidence in different symbols which may appear as curing and healing.

“Family members stayed in the room after she died and talked very loudly. We had to shut the doors, in order to prevent the voices being heard in the corridor, because other patients were really scared”.

The nurses’ perceptions of different expressions of pain and grief among multicultural family members were described in different ways.

“When the patient died the wife was crawling into the bed, and she was screaming and refused to remove herself. Foreigners tended to be a little more dramatic when expressing their feelings”.

Such behaviours impacted on the way some nurses dealt with the situation.

“As nurses we are engaged in, or we are used to helping grieving persons. But I didn’t find this consolatory role in the unit with all those family members”.

In regard to current emotional difficulties the previous traumas of some patients and family members origins may be recalled and intensified.

“It could be people who have been tortured, who have had traumatic experiences ... and they have to monitor their own people to prevent harassment”.

Despite the difficulties mentioned above, the nurses’ perception was that multicultural families promote emotional adaptation to crisis and grief within themselves. Further on it seems the nurses created a supporting climate and that the families allowed themselves periods with rest.

“We offer some advice and say what they ought to do, but they have to decide themselves. We have said; ‘your son needs you even more when he's more awake. Now you can spend some days to rehabilitate yourself”.

Professional status and gender issues refer to the sense of pride of occupation as a nurse, threats to identity as a woman and confirmation/non-confirmation of professional identity. These are linked together and reflect both positive and negative perceptions. Men are often the spokesperson in multicultural families and the patriarchal opinion of women in some cultures is reflected in their attitudes toward nurses, most of whom are women and seen to be doing menial work.

“Her husband was the interpreter and before discharge he wanted a talk with the chief. I came, because I was the ward sister. He refused to talk to me, because I was a woman”.

This view was reinforced when nurses reflected upon some of the multicultural physicians who rejected female staff in ICU, and seen as a threat to their identity as a nurse and a woman. They felt they were in an inferior role in relation to the patriarchal families and physicians. At times the nurses perceived a lack of respect from diverse ethnic groups. All of these reflections support the feelings among many nurses in ICU, who interact with multicultural families, that their role as a nurses is characterised as subordinate.

“We have many bad encounters with..., lack of respect for us as health care workers. They refused to move and did as they wanted to do....we had to call the police, but they hid themselves and appeared when the police had gone”.

In contrast to the observation above some of the nurses' encountered multicultural families who were distinctly positive. This included their overt reliance on the nurses, and the families and other colleagues' respectful demeanour.

“They (the multicultural families) often have confidence in us. They are well satisfied. They have confidence and express that it's safe to let their nearest stay in the ICU”.

Discussion

The present study explored intensive care nurses' perceptions of their encounters with multicultural families in ICU in Norwegian hospitals. The main results were described by the theme *cultural diversity and workplace stressors*. This theme was characterised by four main categories, which represent the nurses' perception: *impact on work patterns, communication challenges, responses to crises and professional status and gender issues*.

The main perception among ICNs, described in the theme *cultural diversity and workplace stressors*, can be understood by lack of adequate knowledge of cultural behaviour in diverse ethno-cultural groups. Similarly, Boi (2000) reported that nurses perceived difficulties when caring for culturally different patients, such as poor communication and lack of knowledge of their culture. In contrast, the same study showed that nurses had an attitude of cultural flexibility and acceptance of each patient as an individual.

When nurses are exposed to the external differences, which are addressed in the *impact on work patterns*, some respond as if they were unaware of Human rights and national legislation. According to the ICN Code of Ethics (ICN, 2000) nurses should facilitate these values when encountering patients and families with ethnic diversity. Another interpretation of workplace stressors is that the nurses did not recognise their integrated role as comforter in dealing with patients' and families' pain and grief. The nurses expressed their feelings in terms of being rather frustrated, and they strove to dispel some of the non-acceptable behaviour themselves, for instance by making clear the restrictions and by limiting the number of visitors in the unit. In some way they also felt themselves superfluous in nursing actions, due to the fact that the family members and patients met their own emotional needs within the expanded multicultural family. Not surprisingly, the nurses' reflections represent an outside perspective based on cultural behaviour, clothes, and familial interactions. Solvang (2002) also argues that the differentness experienced by one ethnic group compared to another may underline the fact that people look upon themselves as normal and therefore others become deviants. The nurses in this study could be seen as representatives of the majority group. On the other hand the minority group members' vulnerability is not necessarily linked to these dimensions alone. The loud expressions of pain and grief in some multicultural families may be the result of learned behaviour, which strengthens their connection to that group. The impact on nurses' work patterns when dealing with multicultural families seems to be based on the expressed differences, with which the nurses are unfamiliar. It might also be a result of great demands which nurses put on themselves, especially when meeting new challenges. The impact on work patterns which creates stress for the nurses is linked to a lack of appropriate facilities for visitors, interruptions in nursing procedures, and different visiting routines. Moreover, job stress related to multicultural families may lead to a feeling of

shortcomings, or looking upon groups in a stereotypical way. The perception may be influenced by the dichotomy of normality and differences, and the concept 'us and the others'.

The nurses' perceptions in this study highlight the lack of a full review to assess the needs of multicultural families. The nurses also show deference to the fact that ethnicity is an unknown area in their professional competence and that they need to improve their understanding of other cultures. The recognition of the gap between the nurses' real knowledge and their need for prospective knowledge corresponds with the professional attitude described in The Code of Ethics for Nurses (ICN 2000). Consequently, to prevent a negative impact on work patterns the nurses could acquire more knowledge about diverse cultures, as suggested by participants. The increased knowledge could lead to mutual respect of multicultural families' ethnicity.

Communication challenges arise from the differences in language. It was diminished by involving professional interpreters and by practical and technical methods to promote understanding for patients and families. Eriksen and Breivik (2006) launch the linguistic phenomenon 'ethnolect' as an expression of dialects linked to diverse groups, which further expresses an ethnic identity. However the nurses in the present study referred to linguistic difficulties as both frustrating and unpredictable. The use of family members as interpreters often arose because the ICNs were obliged to find a quick solution in acute situations. They also engaged employees with the same cultural background as the actual families to solve linguistic problems. The ICNs highlighted additional related dilemmas such as the possible contradistinction of whether to engage the nearest family member or not in interpreting, especially when health professionals are informing about a grave prognosis or therapy. Dilemmas occur when children become interpreters if their parents need linguistic assistance. The latter was reported by the participants in some unfortunate cases. Doubt in using employees from the hospital as interpreters was presented by the ICNs as a possible threat to anonymity and professional codes. Nailon (2006) maintains that lack of interpreters and nurses' shortcomings in collaboration with interpreters may impair nurses' abilities to gather applicable clinical and cultural information about the patients and their families.

Responses to crises were especially expressed in pain and grief. The nurses were to some extent, unprepared for the families' behavioural and emotional multiplicity, which may be derived from the families' ethnic background. None of the nurses related the behaviour to the families' cultural characteristics. Omeri et al. (2006) recommend empowering, improving interpreter services and promoting understanding of religious practices to improve the health of refugees entering Australia, which would be appropriate for nurses and multicultural families in other countries as well. The nurses perceive the Norwegian people as cool and emotionally non-expressive compared to culturally different families. If non-Scandinavians openly express emotions as a typical behaviour, these differences might play an active role in coping with chaos and crisis. The emotional differences between multicultural families and Norwegians have to be preserved, because the behaviour in grieving and pain often promotes well-being and acceptance of being in an unknown hospital situation. Participants seem to be aware of actions that could lead to improved nursing care for different families, for example by asking for their wishes, adjusting routines for visiting hours, and using visiting rooms. Furthermore, Snyder and Niska (2003) maintain that nurses should be aware of health practices in other cultures. This knowledge could promote health and well-being if judiciously incorporated into the plan of care. In other words, understanding responses to crisis could lead to acceptance of such behaviour.

Professional status and gender issues are related to a sense of pride of occupation as a nurse, preserving dignity for the patients, and confirmation of professional identity. These seemed to be goals for nurses in this study. Threats to identity as nurses and women are explicitly expressed by patriarchal attitudes from the multicultural families. The nurses experienced these unexpected behaviours as somewhat frustrating. On the other hand models of positive identity development for oppressed groups exist, especially designed for nurses to pass from acceptance and finally into a renewed identity as professionals (Roberts, 2000).

According to gender issues in this study, Bourdieu (2001) argues that the sociological dichotomy based on gender legitimates a masculine domination, which is embedded in a biological nature that is a naturalised social construction. The challenges for nurses are how to meet the special needs of multicultural families. Blackford and Street (2002) found that the effort of feminist nurses to treat all patients the same, focusing on equity in order to meet the gendered and racial needs of women of different cultural backgrounds, did not always have the desired outcome. Constructive efforts could be worked up to support professional identity of nurses by consequently linking their role to caring values, and by adjusting experiences with ethnically different patients and families into nurses' socialisation and education. Besides, to fulfil the recommendation of "more knowledge about cultures" as argued by the participants, it might be more appropriate to increase the recruitment of ICU nurses that have different ethnic backgrounds and cultural traditions.

Limitations of the study

The authors acknowledge that the instability in group membership may have impaired the discussion and free association in the groups. However, Morgan (1997) points out that unsettled membership in multistage focus groups may strengthen the discussion by bringing out more contrasts. Finally, one of the focus groups consisted of both ordinary ICNs and one head nurse. This resulted in a tendency for group members to listen to the head nurse before expressing their own views. From a critical perspective this may have blocked free associations. At the last group meeting several members were uninhibited when talking about their encounters with multicultural families, which dispelled the possible dominance of the head nurse. It is possible that the head nurse's statements in the first group meeting may have generated multiple associations among group members.

Conclusion

Dealing with multicultural families in the context of ICU presents particular difficulties for nurses working in these areas. Their perceptions reveal issues that contribute to workplace stress such as overcrowding, the extended nature and diversity of demands of such families and the cultural characteristics associated with expressions of pain and grief. The nurses' perception was ambiguous with many challenges in interaction, in which deficits occurred. However recognition and flexible use of appropriate resources helped to deal with the problems. The concept of self and professional identity was challenged by the fact that some people have patriarchal attitudes, supported may be by traditions and beliefs in their cultures. The linguistic, cultural and ethnic differentness between Norwegians and multicultural families presented challenges to ICU nurses.

The results from this study have implications for practice for example by diminishing stressors for nurses through a more appropriate adjustment of the ward in order to accommodate visiting families. An explicit awareness of cultural diversity among intensive

care nurses may be reached by increased knowledge of different cultures and religions in education and throughout hospital courses. Furthermore, ICUs need to be equipped with helping aids to promote different communication challenges.

To address the issue more fully further investigations are needed to explore multicultural families' own perceptions of their preferences and obligations when entering Norwegian hospitals.

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