Reflections

# Doing Transcultural Nursing Research

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Nurses' involvement in international and transcultural Nursing research reflects their growing awareness of the importance of different cultures in the profession (Andruskiw, 1985). Nurse researchers such as de Chesnay (1983), Meleis (1989), Morse (1987; 1986), Munet-Vilaro (1988), Norbeck & Tilden (1988) and O'Brien (1981) have identified challenges, advantages/disadvantages and problems while conducting transcultural Nursing research. Some of the problems identified included negotiating entry, data collection (Morse, 1986), communication (de Chesnay, 1983; Morse, 1986; Munet-Vilaro, 1988), objectivity (de Chesnay, 1983; Munet-Vilaro, 1988), gaining entry, issues related to the concept of equivalency measurement as well as the need for developing and testing internationally sensitive methods of data collection. Morse (1987) stated that the type of difficulties/problems that emerge while doing transcultural research depends on the level of development of the country, politics, climate, geography, social structure as well as the study setting (urban vs. rural; hospital, community or clinic). Further, Anthropologist/Psychiatrist Kleinman (1987) addressed the issues of translation in cross-cultural studies in addition to exploring certain anthropological questions such as the extent of differences of psychiatric disorders in different societies.

In this paper I will relate some of the methodological issues relating to negotiating entry, gaining entry, and preparation for data collection, analysis, reliability, validity and bias issues while conducting a transcultural Nursing research study in Madurai, India. I conducted a qualitative study in Madurai to identify and describe the social and cultural factors in depression in a sample south-east Asian Indian women as well as the influence of these reported factors on their treatment-seeking behaviour. A sample of thirty depressed Indian women was obtained from a south-eastern hospital in Madurai for purposes of exploring answers to the following research questions: (1) What socio-cultural factors do adult depressed Indian women report as factors influencing their depression? and (b) How do these reported factors influence their treatment-seeking behaviour? A semi-structured taped interview was completed with each of the thirty respondents. In addition, demographic data were obtained to describe the sample population in terms of their socio-economic status, education, marriage, occupation, family and kinship, dwelling, migration, and caste systems.

## Negotiating Entry

O'Brien (1981) states that many of the methodological difficulties like gaining entrance to the study population, and communication with a different cultural group may be avoided or minimized through anticipating well in advance of entering the actual setting as well as prior communication and consultation with experts in the culture of the research study. I initiated the process of gaining entrance two years prior to the field study being conducted in India. Through recommendation of a Psychiatrist at the All India Institute of Medical Science (AIIMS) in New Delhi, the city of Madurai was chosen as the setting to conduct the study since it was one of five research centres in India where research on depression was ongoing. Further, the Chief Psychiatric Officer (CPO) of the Madurai Re-

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search Center (located in Madurai Government Hospital) was the former Director of the Indian Council of Medical Research (ICMR), the granting agency for permission for conducting research studies in India. Obtaining permission was a lengthy and arduous task as delineated in a subsequent part of this paper.

One of the five elements of research that Scheinfel (1987) considers essential is to develop a rapport and good working relationship with the people in power positions. I went to Madurai to meet the CPO in person in order to establish rapport and to explain the nature of my study. The latter was done to explore the feasibility of the study from the perspective of the cultural context and if I would be able to obtain additional information on the topic of study. Thus contacts with the CPO of the government hospital were established in person two years prior to conducting the study and was continued by phone calls and correspondence from the United States of America (USA) through the actual period of formal data collection. The problems related to negotiating entry and gaining access, common in field studies, were therefore minimized by having the support of and maintaining continuous contact with the gatekeeper, in this case, the CPO of the government hospital, even prior to the onset of the study. I also established contacts with friends in Madurai in anticipation to help with the necessary accommodations during data collection.

Although verbal approval of promise of support and cooperation were provided by the CPO, a written formal approval to conduct the study was needed for the protection of human subjects. Therefore, prior to data collection a copy of the proposal was mailed to the CPO to obtain a written formal approval granting permission to conduct the study. This permission, further, was contingent upon approval by the Indian Council of Medical Research (ICMR), the granting agency, as this study was conducted in India, since according to Morse (1987) governments of host countries feel responsible to protect the cultural ethos from exposure to outsiders. Further contacts and formal approval from the Government of India's ICMR were obtained, but not without difficulty. It took five months to obtain the permission to conduct the research study. de Chesnay (1983) states that local and government officials can facilitate entry into the system. Since the CPO was the former director if ICMR, his approval of the study made it easier to obtain approval from the ICMR, along with knowing a top ranking official from the ministry of health.

## Gaining Entry and Preparation for Data Collection

Qualitative research is usually conducted in a naturalistic setting, so that the context and the phenomenon are considered as parts of each other (Field & Morse, 1985). This study was conducted in the naturalistic setting of Madurai in south-eastern India, to gain an understanding of the context in which the phenomenon of depression occurred in Indian women. The city of Madurai had a population of approximately 400,000, most of whom were of the Hindu religion and spoke the Tamil language, one of the common languages in south-eastern India. The setting was conducive for the conduct of the study given my knowledge base and communication skills in the Tamil language.

The study was conducted in a 1,200-bed government hospital which included a 60-bed psychiatric department, and an outpatient department. The hospital also included a research center, "The Centre for Advanced Research and Behaviour" (CARB), consisting of a research staff involved in studies on depression. I again felt the need to develop a rapport and good working relationship with the people in power positions, as well as work with an already established group.

I was introduced by the CPO (the person in power) to the research staff of CARB (the established group), which included a team of psychiatrists, psychologists, psychiatric social workers, and clerical staff. The study including sample selections, criteria for selection and the methodology was then presented to the research staff. The purpose of the briefing was to facilitate cooperation for the study (gain more cultural information from staff members) and to select key informants who are knowledgeable about and have rapport with members of the cultural group

(O'Brien, 1981). Copies of the study proposal were distributed for those who needed further clarification.

I was granted access to all areas of the hospital, particularly the Psychiatric Unit and the research areas. Permission was obtained from the CPO to utilize staff records of subjects (who were under treatment) who were included in the sample in order to obtain objective data in addition to the interview data. I was also given a separate quiet room in the research centre to conduct my interviews.

Prior to entering the field, I had not intended to use any particular diagnostic criteria like the DSM - III for sample selection because of reports of cross-cultural variations in studies that had utilized specific diagnostic (WHO, 1983; Marsella, Sartorious, Jablensky & Fenton, 1985). However, as DSM-III criteria were used by the hospital psychiatrists for diagnosis of depression, I also had to adhere to the same criteria, to avoid any conflict with the protocol of a formal organization. Thus conflict between the "researcher's" agenda and the research centre was averted through cooperation with the agency.

### Pilot Study

A pilot study was initially conducted to determine the relevance of questions in the interview guide and to determine if additional questions would help in eliciting emic responses. The importance of adhering to specific diagnostic criteria, such as DSM-III in that setting became evident in the pilot study. The outpatient department utilized the International Classification of Diseases-9 (ICD-9) criteria for diagnosis of depression rather than the DSM-III criteria that was used by CARB. In the ICD-9, explicit criteria are not provided and the clinician is largely on his/her own in defining the content and boundaries of diagnostic categories. In contrast, the DSM-III provides specific diagnostic criteria as guides for making each diagnosis (DSM-III, 1980). Thus, I had to obtain sample subjects based on DSM-III criteria to maintain uniformity and consistency with the psychiatric unit. For this purpose, subjects had to be initially diagnosed in the outpatient department using ICD-9, and were once again evaluated by the research centre psychiatrists using DSM-III criteria according to hospital protocols. Once this was accomplished, subjects were contacted for their willingness to participate in the study.

The pilot study also revealed the problem of role conflict in qualitative research. May (1980) stated that the nurse-researcher's role is sufficiently unfamiliar to patients as subjects, that they will "cast the research in a life role more comprehensible" to them and identify the nurse research with only the more familiar Nursing role and its attendant expectations. Two of the three subjects were observed to cry uncontrollably, frequently asking for reassurance about their "mental illness" as well as to help "show them a way out" of this illness. Although the need for immediate therapeutic intervention was recognized, I found myself responding frequently with interventions which would have influenced the data. Consequently, this issue was addressed in the study by explaining the sensitive nature of the topic to the subjects prior to the interview. Acknowledging their need for catharsis, they were told that support and assistance would be provided after the interview was completed. This served to minimize the nurse-researcher conflict.

### Data Collection

Data were collected in summer. Morse (1987) discussed the unpredictability and uniqueness of each research situation. I had not anticipated the hospital employees including physicians, nurses, and social workers to be on "strike" for a brief period of two weeks because of salary and benefit-related issues. This temporarily suspended my ability to recruit subjects, interview selected subjects, etc. which resulted in further delay in collecting data.

Qualitative interviewing calls for a flexible sample design. The researcher starts out with a general idea of what people to interview and how to find them, but is willing to change course after the initial interview (Taylor & Bogdan, 1984). Due to the exploratory nature of the study, a purposive and convenience sample of 30 respondents was drawn from Tamil speaking, married and widowed women of Hindu religion, ranging in age from 20 to 65, and diagnosed with major depression using the

DSM-III criteria.

Of the 30 subjects, 12 subjects who met the study criteria were chosen from a list of females who were currently under treatment and receiving follow-up services. These 12 subjects were mailed letters in the Tamil language for follow-up services through the research department according to protocol set up by the CPO. It was thought that accessibility and availability of subjects would be feasible and expedited only through letters mailed from the research staff who were familiar with the subjects. In addition, the interpersonal and trusting relationship that had already been established with the research staff was of importance, given the sensitive nature of the phenomenon under study. These subjects were then contacted by me after an initial introduction. A brief explanation of the study was given and subjects were asked about their willingness to participate. All were willing to participate, and appointments were made for the interview.

The remaining 18 of the 30 subjects for the study were obtained through the hospital outpatient department when they presented themselves with symptoms of depression. These subjects were interviewed by the psychiatrists from the research staff using the DSM-III criteria and diagnosed with depression. They were then approached by me and asked about their willingness to participate in the study. All who were approached were wiling to participate in the study, and dates were set for the interview.

The primary method of data collection was through semi-structured interviews supplemented with observation. Interviews were scheduled at times convenient to the subjects, that is, from 9 a.m. to 1 p.m. This was also the period when the psychiatrists were available to help with interviewing and diagnosing subjects from the outpatient department. Interviews were conducted in the Tamil language because of the importance of establishing a trusting relationship. It was also recognized that the subjects might lack knowledge of the English language due to their educational status.

The transcultural Nurse researcher needs to understand the usual modes of communication for interpretation of substantive data. Further, important data can be lost due to the interviewer's lack of sophistication in the study subject's verbal language (O'Brien, 1981). Therefore, the use of a native interpreter will help minimize this lack of sophistication in the language. I had requested a psychiatric social worker from the research centre to be present throughout the interviews to help with clarification and interpretation of colloquial terms and regional dialects that were unfamiliar to me, as language is still an issue even when the investigator and the sample share a language, since regional variations and dialects can affect understanding (de Chesnay, 1983). Although I was fluent in the Tamil language, I found it difficult to understand the regional dialect. The presence of a native interpreter thus eliminated the language barrier. Despite differences in my educational attainment and other demographic differences such as residing in the U.S.A., these variables did not appear to affect the extent to which the subjects expressed their thoughts and emotions. The fact that I was a Hindu female reduced barriers that might have been present with a male or non-Hindu, non-Indian interviewer.

### Data Analysis

As the interviews were conducted in the Tamil language, data were initially transcribed verbatim in Tamil and then translated into English. I enlisted the help of bilingual transcriptionists from the local university who were fluent in both English and Tamil languages as well as the regional dialect. This was done to maintain accuracy in the process of transcribing and to preserve the essence of the interviews. Once in U.S.A., I used secretarial help to type (as they were handwritten) all the translated transcripts for ease of reading and further analysis. Data analysis also included attention to reliability and validity issues. In addition, the issue of bias was examined. These issues are further discussed below.

### Reliability and Validity

"Reliability focuses on identifying and documenting recurrent, accurate, and consistent or inconsistent features, as patterns, themes, values, world views...confirmed in similar and different contexts" (Lenninger,

1985, p. 69). Validity refers to gaining knowledge and understanding of the nature, essence, meanings, attributes, and characteristics of a particular phenomena. Qualitative validity is concerned with confirming understanding associated with the phenomena (Spradley, 1979). Spradley stated that while researching familiar cultural scene, the language differences seem to be slight and are easily overlooked. Since my native language was Tamil, problems of communication due to differences in the language were minimal. These were further resolved with the help of the psychiatric social worker serving as interpreter, and through constant mutual clarifications.

If one can demonstrate commonality of behaviour across data gathered in different ways the validity of the information is increased (Field & Morse, 1985). Based on availability of subjects and accessibility of homes, I also visited six of the subjects' homes to validate interview data as well as to capture the environment in which they lived. The environment was consistent with subjects' explanations of lack of finances and poverty in their lives which resulted in depression.

Interrater reliability was determined between the preliminary and final phases of content analyses. After returning to the United States I contacted four nurses from the United States who were masters prepared and who were in doctoral education. They were asked to code data, identify concepts and recurring patterns, and themes. Following the suggestions of Miles and Huberman (1984), transcripts and decision rules used for sorting of data were given to these nurses. Two transcripts each, of the same subjects, were given to two nurses, and one transcript each, of the same subject, was given to two other nurses. The research questions guided the decision rule for coding data. One of the nurses had questions related to semantic clarity of terms such as "giddiness" (dizziness) and "motion" (loose bowel movement). These were then clarified by me.

Reliability and validity of the data were therefore considered as satisfactory on the basis of the consistency between perceptions of subjects' significant others, subjects' records, field notes, and visits to subjects' home settings, and the nurse and my themes derived from the data.

### Bias

Bias is a universal phenomenon, and the observer who can become aware of his/her biases can minimize distortion of observations by knowing and specifying them (Schwartz & Schwartz, 1955). I was dealing with a sensitive topic such as depression in which the majority of the subjects had prior suicidal attempts and some continued to have persistent suicidal ideations. Cowles (1988) stated that it is difficult to not have "preconceived attitudes" and "emotional responses" especially when the researcher is dealing with sensitive topics. If the researcher's perspective is to use data to generate knowledge and understanding, it is necessary to maintain objectivity and detachment. I had a "debriefing system" (Cowles, 1988) of two friends in the area who were willing to listen to me following the interviews, maintaining subject confidentiality simultaneously.

Role clarification between the Nurse as a researcher and Nurse as a therapist was needed during the interviews. The pilot study revealed the need for role clarification, as subjects might have expected the nurse to serve their own interests rather than those of the research project, until roles became clear. This was minimized by explaining to the subjects at the onset of interviews that provision for assistance and support would be made after the interview was completed. Whenever the subject exhibited tearfulness, crying and sobbing during the course of the interview, audiotaping was interrupted. Morse (1988) stated that "it is unethical to use unstructured interview techniques without accompanying therapeutic or counselling support" (p. 215).

## Problems and Recommendations

Conducting transcultural Nursing research was a learning experience. Issues that were identified during negotiating entry, preparation of data collection, data collection and data analysis as well as recommendations are included.

### *Negotiating Entry*

The length of time for corre-

spondence and the ensuing delay to make any preparation of the study was monumental. My letters to the CPO were not responded to within an adequate period of time and his unavailability when phone calls were made to establish contacts resulted in frustration. Further delay resulted from ICMR in granting approval for the study. Despite being a citizen of India, I encountered problems from the government for research approval. It is of utmost importance to establish contacts with the person in power well in advance of considering to do a study. Reimbursement/remuneration for service provided may be necessary even at the highest level of power in order to accomplish the task.

*Preparation for Data Collection*

Once in the field (in Madurai) there were a few unanticipated problems. The CPO who had promised to meet me and help start my data collection was out of town for a week which again resulted in delay. I was planning to finish my data collection in summer and return to the USA due to my commitments for fall. The other problem was the government employees' "strike" which fortunately did not last long, and over which I lacked any control. Therefore, one needs to allow for ample time in preparation for data collection to allow for unanticipated problems.

*Data Collection*

1. The use of diagnostic criteria such as DSM-III was a limitation. According to Kleinman (1987), a standard approach such as application of DSM-III to cross-cultural research is a "category fallacy" (a reification of nosological category developed for a particular cultural group that is then applied to members of another culture, thereby lacking in coherence and unestablished validity) (p. 452). I had to comply with the protocol of a formal organization although my research agenda was to not use DSM-III criteria. Clarification with the CPO about the criteria used for diagnosing even while negotiating entry could have helped with modification in the initial proposal. Using the DSM-III criteria could have resulted in the medicalization of social problems rather than an accurate portrayal of social and cultural problems with a distorted view of pathology (Kleinman, 1987).

2. The long time lapse that evolved between the time the subjects were seen at the outpatient department by the psychiatrists, and finally by the researcher could have affected the interview process itself, although subjects did not verbalize as such. Again, I had to abide by the rules and regulations of a formal organization.

3. Lack of such resources as the feedback from a mentor, an adequate well-equipped library (1,000 miles away), and support from colleagues during data collection were disconcerting. One has to be most discrete in the supplies taken with a luggage limit of 44 kilograms. Additionally, mailing the necessary supplies should be done with caution for fear of being stolen as well as problems with customs.

Thus the researcher lacks any control over the social setting but needs to document the problems, changes and proceed with the study (Morse, 1986).

*Data Analysis*

Kleinman (1987) states that translation is the essence of ethnographic research. Perhaps adequate time with one translator could have minimized this problem. The process of translating transcripts from Tamil to English involved the help of five translators who were proficient in both languages. Consequently, the translators used *different* semantic equivalents for depression like "mana sorvu," "mana vyadhi," as well as other ethnographic terms, and semantic terms which needed clarification for Interrater reliability. Thus, although the contextual meaning was preserved in the translations, the nuances in meaning *might* have been lost in the process through the use of different translators.

## Conclusion

In this paper I have reviewed my study and some of the methodological problems I encountered while conducting the study. Although there were problems identified, transcultural Nursing research can be a productive, enriching experience (O'Brien, 1981) even for a novice and may reveal unique insights into another

culture's patterns of health-illness belief and behaviour.

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