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Evasions in Interactions: Examples from the Transcultural Nursing Research Field

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Abstract

Transcultural qualitative research is known for its utility in eliciting in-depth narratives, resulting in increased understanding about cultural phenomena. However, sometimes specific phenomena in the researcher's inquiry are ignored, evaded, or denied; or a seemingly crucial experience demonstrating society's unfairness, which the researcher had been expecting, does not emerge. In this paper, the issue of evasions in narratives is addressed, with two examples in which participants evaded the issue about which they were asked: perceptions of discrimination for aging adults of Mexican descent, and perceptions of living with life-limiting illnesses for aging African American adults. The Ethno-Cultural Gerontological Nursing Model framework's Macro-level factors (climate of stereotypes, attitudes and ascriptions of the majority group) and Group-based influences ("Cultural/historical traditions" and "Cohort influences") organize our thinking about addressing evasions by minority research participants. Four tools synthesized from the literature and our research experiences are recommended: (1) self-assessment of one's own cultural values and lenses, (2) co-collaborating during the data collection and analysis phases, (3) acknowledging the power position of the researcher, and (4) over-reading.

Keywords

Qualitative Research, Evasions, Vulnerable Populations, Aging Adults, Mexican Descent, African American

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An aging adult from a minority group states during an ethnographic interview that he has never experienced discrimination. Minority patients with life-limiting illnesses in a narrative analysis study never mention suffering or healing. What is this data telling the researchers? What are the methodological and ethical implications?

Transcultural qualitative research is known for its utility in eliciting in-depth narratives, resulting in increased understanding about cultural phenomena (Andrews & Boyle, 2012; Barker, 2012; Cameron et al., 2014). However, sometimes specific phenomena in the researcher's inquiry are ignored, evaded, or denied; or a seemingly crucial experience demonstrating societal injustice, which the researcher had been expecting, does not emerge. In this paper, the issue of evasions in narratives is addressed, with two examples from the field; and tools for conducting ethical, culturally sensitive, and rigorous research are recommended.

The Ethno-Cultural Gerontological Nursing Model (ECGNM) (Phillips et al., 2015) situates our efforts in examining how qualitative researchers manage different levels of evasions, or what is not said or addressed during interviews or focus groups. Ethnogeriatrics inspires us to examine evasions vis-à-vis the intersection of aging, ethnicity, and health (Phillips et al.). Transcultural research often depends on interactions of the majority group with minority group research participants. Even if of the same minority group, researcher and participant may be at different subject positions (Foucault, 1973). Extant literature tends not to address cultural concepts common to more than one group. Based on this model and the underlying focus of this article, the following table details some of the important conceptual definitions related to ethno-geriatrics.

Table 1. Definitions: Ethno-Cultural Gerontological Nursing Model (Phillips et al., 2015)

CONCEPTS	DEFINITIONS
Ethnicity	“Self-identification with common social and cultural heritage” (Phillips et al., p. 120)
Culture	“A patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations” (Giger, 2012, p. 2)
Aging	“A vivacious developmental process that influences current behaviors, attitudes and responses” (Phillips et al., p. 120)
Ethno-cultural	“A view that acknowledges mutually exclusive, individual differences, within a larger cultural sphere which is composed of ideas, beliefs and values and patterns that a group has in common” (p. 120)

In this article we examine the similarities of evasions across two ethnic groups and discuss our process of over-reading in two qualitative research studies with aging minority populations.

The ECGNM explanatory framework organizes community-based participatory research (CBPR) aging research with minority populations. Transcultural qualitative researchers hone their skills in strategies from their toolkits to improve their chances of establishing rapport, choosing an environment conducive to optimal comfort of the participant or focus group members, and facilitating an open and honest dialogue about phenomena. Researchers conducting CBPR will have already gained understanding from the group or community within which the phenomenon occurs, possibly even using a “culture broker” (Tripp-Reimer & Brink, 1985) to focus on phenomena that matter (Crist, Parsons et al., 2009), within the humanistic nursing science paradigm (Paterson & Zderad, 2008). This approach is very different from empirical science conducted within laboratory settings. CBPR researchers attempt to have co-collaborators “self-disclose,” in many cases to a researcher from the majority non-Hispanic white (NHW) group. We challenge ourselves and colleagues to be aware of personal sharing that we are asking of another human being, especially across different social groups and levels of privilege. One way to “level the playing field” is to disclose of ourselves to the participant to develop trust among our co-collaborators. However, we need to judge in some way the delicate balance of self-disclosure within the interaction between the research and research participant.

Toward achieving this balance, the following reflexive interpretations about conducting research are organized within two major ECGNM constructs. The first is “Macro-level factors;” that is, “climate of stereotypes, attitudes and ascriptions of the majority group” (Phillips et al., 2015, p. 122). The second is “Group-based influences” (p. 122); that is, cultural/historical traditions” and “cohort influences” within which are grouped referential-indexical and high or low context culture.

Macro-Level Factors: Subject Position, Clinical Gaze, and Social Desirability

Subject Position. One of the basic tasks as researchers is to be aware of not only our participants', but our personal "subject position" (Foucault, 1973). This is especially important when embarking on research with minority cultures when we are of the majority culture or of a more advantaged social status in Western culture. Subject position is that perspective or set of regulated and regulatory discursive meanings from which text or discourse makes sense (Barker, 2012). The experiences of both researcher and research participant must be identified in order for the discourse to be meaningful for both parties. This identification and awareness of "subject position" tends to situate us as a certain kind of subject or person and is unavoidable in human interaction. It is during the process of self-disclosure between both parties that community-based relationships can flourish and co-collaboration can be established to co-create new culturally sensitive knowledge. Evaluation of the "situational and interactional contexts" (Phillips et al., 1994, p. 206) are necessary as part of the interpretive process. For example, NHW researchers often use member checking (Lincoln & Guba, 1985) to confirm and assure credibility of the reported findings. However, Packer and Addison warn that participants may report revised memories when their original narratives are reviewed with them (1989). In general, member checking technique is thought to minimize interpretive biases.

Clinical Gaze. Foucault introduced the "clinical gaze," as the historical phenomenon that occurred when health care was moved from the community to hospitals and clinics as centers for medical training (1973). The clinical gaze has been related to treatment of people of Mexican descent; for example, Mexican migrants (Holmes 2012). Emphasis was given to clinical observation, characterized as one-way focus on the patient, rather than an interactive exchange between humans, highlighting the clinical assessment, bedside teaching (the ward round) and the incitement for the patient to make known his/her concerns (Foucault). Similarly, we find a paradox in our role as qualitative researcher. The researcher traditionally is staged in the dominant role; yet we are asking for frank, genuine openness in this basically one-way "gaze" at the participant. We sit in comfortable chairs at a kitchen or library table in a seemingly social context; and [we hope that] participants will forget the artificiality of the seemingly social situation. Indeed, participants will be sensitive to us, the researchers, hesitating to ask us about unpleasant or shameful issues which would not usually be discussed in social situations. Equally, we as researchers are also trying to be sensitive to participants' potential discomfort with complex personal issues during research situations and social interactions.

Social Desirability. Social desirability is a tendency to respond to inquiries with preconceived expectations. "With regard to people's reports about themselves, social desirability is the tendency to respond to questions in a socially acceptable direction. This response bias occurs mainly for items or questions that deal with personally or socially sensitive content" (Spector, 2004). This "yea-saying" is a natural response set for minorities responding in ways meant to satisfy the dominant group (Aday, Chin, & Andersen, 1980). However, the researcher can expand the concept of social desirability to include reciprocity, not just presented as the participant giving a socially desirable response. Rather, the researcher and participant are co-collaborators of what is shared between the two. The reciprocity dynamic shows the "respectful nature" (Maiter, Simich, Jacobson, & Wise, 2008) occurring within the interaction between co-collaborators, thus promoting a trusting relationship.

Group-Based Influences: Referential vs. Indexical Self and High and Low Context Cultures

Referential vs. Indexical Self. Another relevant theory is Landrine's "referential" versus the "indexical" self (1992). In this theory, individuals in allocentric cultures such as the

Mexican culture view themselves “referentially,” as parts of the whole, that is, of the group, or the society, rather than seeing the world in relation to their autonomous selves. Thus referential individuals may not perceive or report their own personal experience as separate from others, as might NHW researchers expect. Researchers need skills in perceiving reports about the group experience that otherwise might go unnoticed if they are only seeking individual, separate experiences. Researchers should also have an awareness of level of acculturation which also may affect levels of referential vs. indexical perspectives, as it also can affect, for example, “health needs, health-seeking behaviors, and self-disclosure” (Phillips et al., 2015, p. 125).

High and Low Context Cultures. Cultures vary in expectations of how explicitly issues are discussed. In “high context” cultures, topics may be left unsaid directly but still communicated indirectly. High context cultures expect communication to be subtle, non-confrontational, and delivered via implicit cultural expectations (Rosado, 2005). If conflict arises, communication is indirect and vague. Members of communities with high context culture use many more non-verbal cues through years of practice immersed in and inseparable from the culture. There is an assumption that what is implicit is clearly understood. However, members of communities with “low context” culture use much more direct statements that may be characterized as less polite and more confrontational and clearly overt (Hall, 1976; Würtz, 2006). There is an assumption that what is stated directly is received directly.

Close observation of both is imperative in the interpretation of communication. However, in this case, an individual of a high context culture who does not question or confront directly might not necessarily approve or agree. Disagreement may be communicated with pauses and/or silence. For example, if a nurse is explaining post-hospital care options to family caregivers, an individual from a high context culture might nod and even say “yes” along with pauses of silence in between. If the nurse were from a low-context culture, communication would be assumed to be direct; and subtle cues of doubt, confusion, or disagreement might be easily missed.

As nurse researchers exploring minority aging adults’ service use disparities and sensitive issues related to life limiting illnesses, we noticed similar experiences across the two transcultural research studies. We are both NHW women who have spent time in the field and in both communities, respectively, to establish rapport and trust. As indications of being accepted by the groups, one of us had been told that she had been thought of as a one of the daughters of a primary Mexican descent community leader’s family in southern Arizona, founding members of the ENCASA Community Advisory Council; and one of us was affectionately always introduced by the African American informants in Mississippi, “Our crazy white girl.” We believed we were non-biased in our data collection and analysis yet unexpected gaps remained which we termed “evasions.” Following is a report of the findings for both examples from the field, presented as two case studies.

Examples from the Field: Two Case Studies

In this section we present two examples in which participants either evaded the issue about which they were asked; or themes that were expected did not emerge. The examples are on the topics of perceptions of discrimination for aging adults of Mexican descent, and perceptions of living with life-limiting illnesses for aging African American adults.

Perceptions of Discrimination for Aging Adults of Mexican Descent

After a discrimination questionnaire did not show significance when tested with southern Arizona Mexican descent aging adults compared to NHW aging adults, a focused

ethnography was conducted with Mexican descent participants (n=6), ages ranging from mid-60s to mid-80s. Participants were interviewed about their perception of nursing care and whether they felt they had experienced any discrimination in the health care system. One participant was a native of Mexico; the rest had been born and raised in Arizona or other nearby areas of the Southwest; all were bilingual. The participants were asked to tell stories about experiences they had had with nurses, either in the hospital or in another setting. Once they related a story, they were then asked whether they had sensed discrimination in any of those encounters. Descriptors and components were extracted. Statements were studied for significance, recurrence, patterns, and meanings, using Ethnomethods (Crist, 2002; Leininger, 1990). Major themes were identified. Although the investigator conducting the focused ethnographic portion of the study was fluent in Spanish and English, and was known and trusted in the community, she was NHW.

All of the participants denied that they had experienced discrimination. A typical description of care received was, "they treated me like a queen in the hospital, the doctors and everyone. It was a wonderful operation." However, as participants denied ever having experienced overt discrimination in a health care setting, they reported discriminatory instances in other settings, ranging from refusal of service in restaurants, to unfair treatment in the military, and even to an accusation in a schoolroom incident. All these experiences were reported as having taken place in the distant past, or as incidents involving others, while denying that it ever happened to them. One participant stated, "I've never had any problems, but I know some friends that had some problems because they were Mexican. Going to restaurants, they would be the last to get served." One participant spoke of discrimination as a generality. When asked whether he had experienced it, he responded, "I've heard that, yes I have heard it, but I've never experienced it, or if I have experienced it, I can't remember. But I'm sure that there is discrimination, just like there is in different areas. I feel that we're all discriminatory in one way or another. We're all prejudiced in one way or another, but we have to try to be fair, because we're all in this together."

Several participants related discrimination to skin color variations. One participant said, "I've never had a problem [with discrimination], but I don't look Mexican." Another participant expressed a similar sentiment, explaining, "If I were darker, maybe they would treat me differently." One Mexican descent aging adult told a story of her fair-skinned brother who had obtained a mining job during the Depression, but had been fired soon afterward when the company became aware of his ethnicity. These stories would indicate the existence of a sense of discrimination based on ethnicity.

In some cases, the participants acknowledged discrimination happening to someone else, but blamed it on the person's perception, indicating that Mexican descent people were responsible for their experiences. Most participants denied having experienced discrimination in situations regarding health care, congruent with the non-significant results in the quantitative survey; and indicated that they would not hesitate to use health care services. These statements may have been driven by culturally embedded intents of social desirability or *personalismo* to protect the harmony of the interaction, or a way to protect the image of the participants' group.

Some participants acknowledged that some discrimination existed; but they placed a certain distance between the participant and the complaint. For example, the incident had taken place decades in the past, or it was a second-hand story. Several participants spoke of unfairness to Mexican descent people who were darker skinned, or of actions of one group of Mexicans against another. Participants generally told of an awareness of discrimination against their ethnic group, but denied having experienced it individually. This may support allocentrism, the cultural perspective that maintaining the integrity of the group is more important than meeting individual needs (Crist, McEwen et al., 2007), or a form of the referential perspective (Landrine, 1992).

The Evasions of Suffering and Healing for African American Aging Adults

In a narrative analysis study with seriously ill African American aging adults (N=13), ages ranging from 60 to mid-80s, “evasions” were noticed with the absence of the terms “healing” and “suffering.” Through the “narrative tool” of overreading (Poirier & Ayres, 1997), that of looking within and across the narratives and reading “between the lines” (Ayres, 2000, p. 362), the PI recognized the absence of “suffering” and/or “healing” within the stories told (Ayres, Kavanaugh, & Knafl, 2003). In this study, the aim was investigating suffering and healing in life limiting illnesses; yet, despite the researcher’s using these terms throughout the interview, these terms were not used by the participants—a silence of what was not said by these participants.

For these African American aging adults, serious illness was not portrayed as suffering; rather, as one more of life’s difficulties. Their serious illness was reported as being less difficult than some of their prior difficult life experiences or others’ experiences of suffering. Only one of the 13 participants used the word “suffer” in relation to self in reference to physical suffering: “suffering with my lungs.” Five other participants used the word suffering in reference to how others had suffered. These participants never discussed “suffering” in relation to their own illness. Instead, if negative aspects of their personal illness were discussed (i.e., “went down little hills”), their stories quickly changed to optimistic language to show how they “had learned,” or “how God” helped them deal with their illness. In this story and others, suffering was not acknowledged as being experienced by participants.

Six African American aging adult participants used a form of the word “healing.” When they did speak of healing, it was discussed only in relation to physical healing that occurred through their strong spiritual beliefs. One participant used the word in relation to a spiritual healing when referring to praying for others: “our reward is praying for others, because as we pray...others are to be strengthened and to be healed.” Five participants told stories of physical healing, based on how God provided this healing. For example, Elanda (pseudonym) said after her stroke, “God come back and he didn’t want to leave me like that, so he come back and I started to heal, my limbs, first my legs I started using my legs, and my arm, they just return.”

These prior studies had findings that were similar because they were not congruent with the literature, our clinical experiences, and anecdotal findings. We were perplexed by the absence of qualitative and quantitative reports of discrimination for Mexican descent aging adults or the omission of any claims of healing or suffering from life limiting illnesses by African American aging adults. Therefore, we looked to the literature to explore other instances of these gaps and for insight into whether we were biased or culturally insensitive, or what other issues also might be part of the reasons for not yielding expected results. We found four tools that could be helpful to researchers and in moving the discussion forward of these issues.

Researchers’ Tools

Researchers’ awareness of evasions in interactions can develop through practical applications from the tools discussed in this article. Culture is a part of both the researcher and the participants. It “has deep roots... and influences how we see objects, making the generation of meanings always social” (Beuthin, 2014, p. 127). Awareness of this social collective can be applied at every phase of the research process. Prior to beginning and throughout the research process, four tools are critical: (1) self-assessment of one’s own cultural values and lenses; (2) co-collaborating during the data collection and analysis phases, (3) acknowledging the power position of the researcher; and (4) over-reading.

First, before we begin our transcultural research, self-assessment of one's own cultural beliefs and values is essential. Cultural self-assessment (Andrews & Boyle, 2012) is a method for examining our own families' cultural lens, through which we often view the world without reflexivity. This lens, often unexamined, may affect research design decisions (e.g., data collection methods and how results are analyzed). Reissman (2008) discusses reflecting on the role of the interviewer taking a stance as being the "insider tempered by outsider." The researcher may not be an insider in the culture or may not have the illness, therefore "can never know fully another's direct experiences" (p. 23). Reissman explains that researchers' "influence" is moderated by "neutrality." One's own beliefs about, for example, personal space, body image, education, life experiences, and other beliefs, influence the interaction. The researcher needs to examine and be aware of how "one looks, acts and speaks" (p. 23).

Second, in establishing the team for the research study, co-collaboration is important. Prolonged engagement, facilitated by culture brokers as typical with CBPR (Tripp-Reimer & Brink, 1985), establishes the co-collaboration approach; however, establishing enough trust for authentic co-collaboration can require a lengthy time frame. For example, after the first author had met with the ENCASA Community Advisory Council quarterly for 8 years, during a typical discussion about a colleague's new instrument on ethnic identity, members politely gave feedback on the Spanish translation. Finally, a fairly new member, a (South American) linguist with a PhD, shared that the items seemed stereotypical and condescending. Other (Mexican descent) members agreed, one stating the researcher dressed more the Mexican part with her long skirts and dangling earrings than they; and one founding member quipping, "Should I get out my 'zoot suit'?" The researcher was taken by surprise that it had taken so long for members to confide their discomfort with the items. Possibly, typical high context (Hall, 1976) "*respeto*" (respect for authority and credentials) and "*simpatico*" (politeness), prevailed, rather than her more (low context) egalitarian pattern of communication she was used to and expected.

Beuthin (2014) suggests that face-to-face interviews may help develop trust within the relationship. In the African American aging adults research example, the face-to-face interview was enhanced as all interviews were collected in the participants' home. During interviews, the researcher remains an "active participant, engaged, genuinely present and authentic, open and subjective" (p. 126). To help facilitate an open narrative, the researcher should not focus on only getting the story, but on "entering into and exploring the story with the participant that they co-construct together" (p. 126). To do this, the researcher, through attentiveness, is linking the ideas and/or events the participant is describing; thus, both parties remain as interactive participants building the co-constructed description of the interactive interview experience.

Riesman suggests creating presence through emotional attentiveness, engagement, and listening (2008). Reissman recommends several interviewing best practices to use. The interviewer should follow the thread of the story as it unfolds, be genuinely curious, ask, engage, and be spontaneous, and give up control in the interview. For example, one dilemma is the use of audio-recording. The researcher must not forget that the audio-recorder may be an intruder into a trusting, attentive situation. Sometimes the best data may be gathered after the audio-recorder is removed, or when not using the recorder at all. Regardless of how one chooses to record the interview, the researcher should stay engaged, through "leading by following" the narrative (Beuthin, 2014, p. 125).

Third, in positions of power, the researcher needs to think about equality moderated by power positions while conducting the interview (Reissman, 2008). The interview becomes a sharing between both the researcher's and the participant's personal and professional boundaries. Through time, these boundaries can be learned and implicitly drawn. Then reciprocity is formed, thus helping to equalize power imbalances of subject position (Barker, 2012; Foucault, 1973). If reciprocity is present within the relationships, probing further or

allowing silence becomes more natural in the interview process. How much to ethically push for more information during the interview process becomes easier to discern. Qualitative researchers' purpose to collect rich meaningful data needs to be balanced with not exposing the participant and breaking down the reciprocal and trusting relationship. This trust then needs to be safeguarded by responsibilities between the two parties. At times, researchers may feel that something has been taken from the participant who has become the "vulnerable person" by sharing his/her story. Researchers need to remain aware that all interview participants volunteered and opened up due to the trusting relationship as they shared their stories. The researcher then must "do justice with the new story" and attempt to "pay full honor to the voice of the storyteller" (Beuthin, 2014, p. 130) to the fullest extent when presenting it to the healthcare community.

Through the awareness of power positions related to the researcher's and participant's ethnicity, a hybrid dialogic performance methodology grounds the qualitative data collection experiences. "Talk among speakers is interactively (dialogically) produced and performed as narrative" (Beuthin, 2014, p. 105). The realization that when gathering interviews in qualitative research through this "dynamic interactional communicative opportunity" (p. 125), "knowledge is constructed in the everyday world through an ordinary communicative act-storytelling" (Riesman, 2008, p. 14). Research using this dialogical performance requires "interactional sensitivity and artful collaboration between interviewer and participant" (Beuthin, p. 131).

For example, when involved in qualitative data collection processes, the ever present acknowledgement of the power positions (subject position) between the researcher and the participants is necessary (Barker, 2012; Foucault, 1973). In the discrimination study, the adults valued a human, *personalismo* manner of health care delivery. Concerning the interaction of NHW nurses and Mexican descent clients, the participants pointed out that the nurse had to take the time to establish trust, and to remember that "with the Hispanic people, you have to have that personal attention. Slow, easy, don't rush me."

Research implications include gaining insight into what factors may be at play in working with minority participants. Knowing that a participant may be hesitant to be thought of as complaining, researchers need to take extra time to make a human connection. Expert transcultural nurse researchers are adept at "knowing the patient" and being able to make quick, accurate, intuitive assessments (Benner, Tanner, & Chesla, 1996). The expert transcultural nurse researcher should add to his/her interviewing toolkit the cultural component insight that the minority participant may be making every effort to "be a good citizen" and "not complain," even when more information is being solicited during the interview. Transcultural nurse researchers are cognizant that their work depends upon the generosity of participants to inform and share from the heart through the interactive process of co-constructing new knowledge.

During this interactive process, social desirability can lead to "silences and secrets of what is not said" (Poirer & Ayres, 2007, p. 551). Quantitative studies measuring possibly socially uncomfortable issues should include the Marlowe-Crowne Social Desirability Scale (1960) when possible, to help develop a competing hypothesis if group differences are shown to be non-significant; and qualitative studies should use data collectors of the same ethnicity when possible, also in an attempt to increase familiarity and decrease "socially desirable" responses.

Researchers must realize consistently the potential tensions that occur during these interactions and situations among researchers and participants of different power positions. The knowledge that narratives are "constructed by socially situated individuals from a perspective and for an audience" (Riesmann, 2008, p. 23) comes from the foundations of social constructionism (Crotty, 1998). It is within these acts the "potential for new or richer

meanings” can be created (Beuthin, 2014, p. 127). From these creations, “complex representations containing the plural voices of many” can be heard (p. 127).

Fourth, over-reading is part of the interpretive process that occurs when analyzing narratives. Over-reading may be necessary during the iterative process of reading back and forth between the qualitative data. Over-reading requires the researcher, within the interpretive process, to be “attentive to characteristics of texts such as repetitions, evasions, omissions, implied endings and incongruities of the narrative data” (Ayres, 2000, p. 361). Within this over-reading of the narrative, to understand that which is not told (e.g., traumatic, fearful or stressful experiences), the researcher requires “different analytical strategies” (Poirer & Ayers, 2007, p. 556). In the study with aging African Americans, the evasion of “suffering” and healing” required over-reading of the data.

In the over-reading process, the researcher pays special attention to the balance of what is said and unsaid, what is emphasized and what is not mentioned, what is verbal and what is non-verbal. In an earlier study, a form of over-reading revealed dissonance between how caregivers described their work and the descriptors they actually used, indicating potentially abusive dogmatism (Phillips & Rempusheski, 1986).

In another study focused on quality elder caregiving, Phillips et al. advocated that researchers take into account the influence of the interactional process on caregiving while incorporating the cultural background of both the participants (i.e., the aging adult and/or the caregiver) and the researcher. In this way, both “situational and interactional” (1995, p. 206) insights are included. A special strength of some high-context cultures is to combine the dark and light, sadness and humor, recognizing both as part of life, without necessarily trying to hide one or the other. Identifying such patterns will elicit a more complete story whether researching within high or low-context cultures. Pattern recognition could include, for example, watching for what is vehemently denied. What is emphasized in this way may be an unspoken concern. Also, over-reading could include noting the timing of silences; for example, before or after a question. As interpretive researchers, we must be aware that for the storyteller, these silences are most likely present for a reason. The storyteller might not want the interviewer to have the information; or the information is too painful to tell. This may be further data which can inform the interpretation.

Discussion

Insights through researchers’ cultural self-assessment, co-collaborating acknowledging power positions, and over-reading may improve quantitative transcultural research. For example, revised instruments may be made more valid by addressing discrimination, suffering, or healing with built-in distance, based on the insights gained from our participants’ views. Discrimination has entered more into the public consciousness recently (ABC News, 2015; Lilly, 2015; Saccaro, 2014). It is evident that discrimination, while only addressed directly with one of our two examples, is part of the “Macro-level, Political/World Climate” context in the United States (US) presently. One ENCASA Community Advisory Council member stated that aging adults consider discrimination as part of the way the world is; a different member stated that aging adults are aware of discrimination, and talk about it. Both agreed that younger Mexican descent people are more likely to be vocal about it. Also, “institutional” discrimination, or “structural” or “systemic racism” (Feagin & Bennefield, 2014; Sabo et al., 2014) may be conceptualized as part of society’s context in the US, rather than being perceived as on a “personal level.” Institutional discrimination is one of the three dimensions in the instrument we tested, corresponding to “everyday” discrimination that is subtle, ambiguous, but pervasive (Sue et al., 2007).

The remarkable tendency toward detachment from the personal dimension of discrimination corresponds to results in a study whose literature review showed different variables affected perceptions of discrimination between high- and low-status groups (Shorey, Cowen, & Sullivan, 2001). As a low-status (and inferential) group, Mexican descent people would tend to avoid claiming having experienced discrimination in order “to maintain a sense of control over their experiences and bolster self-esteem” (p. 7), but would not hesitate to attribute claims to their group as a whole. Each individual would protect his or her self-image by contending to be better treated than Mexican descent adults as a group. During community discussions focused on sensitive topics; for example, instrument development, adequate time should be budgeted not only for the specific task, but also for respondents’ debriefing, both for their emotional safety and to gain insight into the potential impact of asking about the topic with future respondents. Also, researchers need to remember to employ a human, *personalismo* manner when asking minority aging adults about sensitive topics.

Limitations of the Studies

Limitations of the studies could be using NHW investigators. In the Mexican descent discrimination study, the interviewer was NHW although she was fluent in Spanish and English. She was known in the community as an approachable and respectful member of the ENCASA Community Advisory Council, previous resident of the local neighborhood, and public health nurse. In the African American life limiting illnesses study, the interviewer was NHW, known in the community as a nurse practitioner and local nursing school faculty. The investigators’ race and ethnicity may have caused three or more limitations: missed verbal nuances and non-verbal cues that could have been explored more in-depth during interviews but were missed opportunities; possibly decreased ability to establish as familiar and natural trust as one of the same race or ethnicity; and overlooking nuanced results in the qualitative narratives during data analysis. Although saturation was reached (Lincoln & Guba, 1985; Sandelowski, 1995) in the previously conducted qualitative studies noted above, seeking more informants or conducting multiple interviews with the same informant (Crist & Tanner, 2003) might have contributed more rigor to the original findings of these studies.

Conclusions

Cultural awareness is a foremost concern with transcultural nurse researchers. A balance between “over-reading” and respecting participants’ “co-collaborator” status and clear preference to leave words or topics unsaid will move research further toward understanding of harmful, pervasive experiences that may inappropriately limit use of vital services for growing minorities in the US. In accord with Phillips et al. (2015), there is scant data that incorporates the intersection of aging, ethnicity, and health; for example, ethnogeriatrics.

Finessing research with the recommended tools can contribute to not only more culturally sensitive research practices, but also knowledge that may contribute to culturally appropriate care for diverse aging adults. As transcultural nurse researchers, reframing the narrative encounters as “acts of service” allows for one to “listen generously” just as practicing nurses are trained (Remen, n.d.) Within this service oriented view, the importance of inter-subjectivity and contingency during the interactions between co-collaborators is “offering one another our experiences” (Gadow, 1995, p. 213). In the nursing research world, sharing and dependence on local knowledge between all parties is essential, perhaps where “safe passage may be found” (p. 212).

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