Enriching Cross-Cultural Health Care Curriculum
with Elements of Social Psychology

Sharae Kalian

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Stan Malisweski Ph.D.
Graduate Advisor

Loren Thomas Ed.D.
Second Reader

Lloyd Sharp M.A.
Third Reader

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Abstract

The need for equality has become one of the most deeply talked about subjects in the health care field. One challenge in this area is to reduce health care disparities and improve access to high-quality health care for diverse patients. There is a vast amount of literature on the implementation of cross-cultural competence in health care to reduce health care disparities. Cultural competence strategies include a racial and linguistic staff, culturally competent education and training, and integrated culturally translated signage. The cultural competence approach that is being investigated in this thesis considers the concepts of sociological factors that contribute to a complete understanding of one's culture. This thesis will examine two separate literatures: first, research on the historical culture context, sociocultural behavior and ethnic identity; and second, research on the cultural competence approach in the health care industry.

Keywords: disparities, race, social psychology factors, cross-cultural curriculum, health care

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Requests for such permission should be addressed to:

Sharae Kalian
1727 E. Elgin Street
Gilbert, Arizona 85295

sharae@sharae.com

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Prologue

The pounding in her head, and the dizziness from the double vision was of such enormity that she couldn't get up from bed. Just the day before, we trained at the beach, and now she could barely walk. In a span of five days, my healthy athletic daughter suddenly became sick with bouts of vomiting and intense blackouts. There were no obvious signs of a cold or flu, fever, cough, sore throat or any other indication that might suggest she had a viral infection. Yet, when I rushed her to the nearby medical urgent care facility, the nurse practitioner ruled it a viral infection based on a temperature test and visual examination.

Did the nurse practitioner not understand the complexity of my daughter's symptoms? Her head was heavy and throbbing, and her vision was doubled. Is there even a viral infection that causes double vision? But our problem had already been dismissed as exactly that, our problem. I was advised to increase the dosage of an over-the-counter pain reliever.

On my daughter's second day of agonizing pain, the most intense blackout occurred. I heard a loud bang from my bedroom as my daughter slammed onto the kitchen floor. This time I rushed her into the emergency room. Again, to my dismay, the attending physician said she looked perfectly fine. His seemingly cold demeanor discounted the fact that a perfectly healthy child does not suddenly have blackouts. Once again our problem became our problem.

Three days later my daughter's right eye turned outward while the left eye remained straight. She had developed palsies of the cranial nerves due to elevated spinal fluid pressure in the brain. A medical physician who had never laid eyes on her made the

diagnosis over the phone based on the symptoms that were conveyed. On his advice, I rushed my daughter into a medical facility an hour away. When we arrived, the attending physician determined she had an incoming fluid pressure of 56mm. She was subjected to two spinal taps to help relieve the pressure and would soon experience yearlong visits with medical doctors and specialists.

Between 210,000 and 440,000 hospital patients each year suffer some type of preventable harm that contributes to their death or psychological well-being (Journal of Patient Safety, 2014). While the majority of medical error has appropriately been focused on the suffering of patients and families, medical error can also be emotionally traumatic (Journal of Patient Safety, 2014).

My daughter's diagnosis of Pseudotumor Cerebri gave me a first hand feel of what it is like to have a voice go unheard. Both my daughter's cry for help as well as my own were inaudible to those in whom we often put the most trust. According to health care studies conducted by Huntington and Kuhn (2003), "breakdown in the patient-physician relationship, is most often manifested as unsatisfactory patient-physician communication" (p.157). Additionally, participants reported, "Physicians would not listen" or "failed to understand the patient's perspective" (p.157).

Pseudotumor Cerebri rarely takes place in a young athletic child. When it occurred in my daughter, she was misdiagnosed and her pain continued for several days and progressively got worse before we were finally able to get someone to listen. Throughout my research on Pseudotumor Cerebri and similar disturbances, I became more aware of other voices that went unheard. For instance, there were the fatal incidents of eighteen-month-old Josie King and Boston Globe health reporter Betsy King where

doctors neglected to "heed warnings that something was drastically wrong" (Altman, 1995, para.4; Josie King Foundation, n.d.). The more I investigated the more clearly I saw that these situations possibly could have been prevented by a change in culture: specifically, communication behavior, something so simple yet so complex to achieve. But I also saw the need to integrate interdisciplinary teams, ones that include, for example, social psychology –the study of interpersonal and psychological perspectives of behavior. Integrating multidisciplinary groups with so-called conventional medicine would create transdisciplinary education strategies to address the current needs and changing demographics of our nations population (APA, n.d.; Kreitzer, Kligler & Meeker, 2009).

What I experienced the year of my daughter's diagnosis lit a fire within me that I could not put out. I knew there was no silver bullet to cure our healthcare ills, but I also considered what it meant to earnestly live my faith. Christ spoke for those who could not speak for themselves – the ill, the poor and the destitute (Matthew 25:35-40). I saw this as a responsibility to do the same. Five years later my resolve continues to find a new basis for common sensibilities and common values, to assist in developing a healthcare system that is patient-centered and empathetically interconnected. When the focus is on the individuals, their families and their needs, a common bond is developed and a new basis is born for shared values that bring people together rather than tear them apart.

Medicine has the ability to cure;
Humanity has the ability to heal.
(Dignity Health, 2013)

CHAPTER I

OVERVIEW

The United States population on July 04, 2013 was 316,148,990, and this figure is expected to grow to 410 million by year 2050 (United States Census Bureau, 2014). Additionally, 30% of the population will be Hispanic, 15% Black, and 9.2% Asian. The number of people who identify themselves as being of two or more races is projected to more than triple from 5.2 million to 16.2 million (United States Census Bureau, 2014). Everyone excluding non-Hispanic, single-race Whites is projected to be 235.7 million out of a total U.S. population of 439 million (United States Census Bureau, 2014). By 2023, people belonging to cultural subgroups will account for half of the U.S. total population, and minorities will comprise more than half of all children (United States Census Bureau, 2014).

In a response to the diverse population, many health service industries are integrating cross-cultural education, more commonly termed "cultural competence," in their health care curricula (Gregg & Saha, 2006). The need for cultural competence in the United States was first introduced to academia around the 1960's. The Civil Rights movement toward desegregation placed African American and White children in the same classrooms (Leadership Conference Education Fund, 2014). Most teachers derived from White middle class backgrounds often had difficulty communicating with people of different value systems and normative behaviors (Leadership Conference Education Fund, 2014).

Emerging out of the Civil Rights movement was the Civil Rights Act of 1964. The act dismantled the application of Jim Crow laws, once held by the Supreme Court in

which racial segregation purported to be "separate but equal" was constitutional (LaVeist, 2005). The Civil Rights Act outlawed racial discriminatory social norms such as racially segregated hospitals and health care facilities.

Presently, the healthcare industry is one of the largest industries that deliver service amongst great segments of the U.S. population (Center for Disease Control and Prevention, 2013). The Center for Disease Control and Prevention (2013), reported that in 2011, there were “1.2 billion visits to the physician offices, hospitals, outpatients and emergency departments” (Center for Disease Control CDC, n.d. para. 5). Of that 1.2 billion, it is unknown how many came from minority groups. However, some reports indicated that racial matters are a primary concern of the American experience in the healthcare system. According to African-American adult focus group interviews conducted by Moody-Ayers, Thomas and Williams (1999), “mistrust of doctors, scientists, and the government was reported consistently by the participants” (para.1). Moreover, patients and clinicians reported trouble communicating because of language barriers or due to different ways of describing discomfort and illness (Office of Minority Health, n.d. para. 4). “The determinants of trust and distrust between physician and patient” can affect health outcomes such as patient noncompliance (Jacobs, Rolle, & Warnecke, 2006, para. 5).

In many ways, today’s culture and communication disparities exist because of minority exploitation by the medical profession that dates as far back as the antebellum period (Gamble, 1997). “Slaves and free Blacks were used as subjects for dissection and medical experiments because physicians needed bodies and because the state considered them property” (Gamble, 1997, p. 1774).

During the 20th century, after the Civil Rights movement, African Americans were ultimately accepted into the White medical system, yet, "their [Whites] impudent natured behavior produced inequalities in medical treatment" (LeVeist, 2005, p.121). These factors, along with additional historical events such as the infamous Tuskegee Syphilis Study (1932- 1972), an experiment conducted on 399 Black men that claimed to treat syphilis, continues to cast its long shadow on the contemporary relationship between African Americans and the biomedical community (LeVeist, 2005). On May 16th, 1997 former President Clinton stated:

> Medical people are supposed to help when we need care, but even once a cure was discovered, they were denied help, and they were lied to by their government… The United States government did something that was wrong -- deeply, profoundly, morally wrong. It was an outrage to our commitment to our integrity and equality for all our citizens… To our African American citizens, I am sorry that your federal government orchestrated a study so clearly racist. That can never be allowed to happen again. It is against everything our country stands for and what we must stand against is what it was.
> (President Clinton Apology, Center for Disease Control and Prevention, 1997)

As a relic of oppression, many people of color still experience a wide range of health issues, including most cancers, diabetes, unintentional injuries, and hypertension (Fiscella & Williams, 2004). According to a report by Fiscella and Williams (2004), "health disparities have been rationalized as a basic of genetic difference, despite evidence that genetics does not contribute significantly to these disparities" (p. 1140). Several studies have been released that support this claim. The Institute of Medicine

(2002) reported that racial and ethnic minorities were given lower quality healthcare than Whites even when they make as much money and carry the same insurance. Ho, Bryson and Rumsfeld (2005) noted that Blacks received older heart drugs, were less likely to have surgery, and received less effective treatment for heart problems that Whites overall.

The Northwest Federation of Community Organizations (2005) report found that unconscious racism may be the cause for some health care disparities, and it is so entrenched in the U.S. medical system that policies must be implemented to address individual behavior. This is troubling because the African American population in the U.S. is estimated to increase from 41.1 million to 65.7 million over the next 40 years (U.S. Census Bureau, 2008). Although bias on race and ethnicity may operate at an unintentional level, a patient's experience of stereotypical threats in clinical settings is conceivably an encounter of health disparities (APA, 2013 & Journal of General Internal Medicine, 2010). Racism does not have to be overt to be damaging. According to American Psychological Association (2013), microagression "everyday, seemingly minor verbal, nonverbal or environmental slights delivered with or without intent," can damage the psychological welfare of minority groups and contribute to inequalities in health care (para. 3).

Published research suggests that culturally competent education programs are needed to reduce health disparities correlated with ethnicity and race (Liaison Committee for Medical Education n.d.). The Liaison Committee for Medical Education and the Accreditation Council for Graduate Medical Education (n.d.) emphasize the need for cultural competence training in medical schools and other post-graduate programs. These

modules, in general, encompass the need for cultural sensitivity between healthcare provider and patient.

Culturally competent models have been developed that encourage all health care professionals to be sensitive to differences. The application of cultural sensitivity has been found in modules such as (1) Transcultural C.A.R.E. Associates in which Dr. Campinha-Bacote (1999) emphasizes "examination of one's own prejudices and bias towards other culture and in-depth exploration of ones own culture" (p.204); and (2) the Learn Model in which health care practitioners are instructed to listen, explain, acknowledge, recommend and negotiate (Berlin & Fowkes, 1983).

Although these models are needed for effective communication, a report by Betancourt and Carrillo (2002) revealed that few studies make the link directly between cultural competence and the elimination of racial and ethnic health care disparities. As reported by Kumagai and Lypson (2009) in a study conducted by Beach (2005), "only 2 of 34 cultural competency curricula involved the study of racism" (Kumagai & Lypson, 2009, p.782). The correlation between understanding racism and cultural competence is relevant because the concept of race has been found to be psychological and sociopathic rather than biological (Kumagai & Lypson, 2009). This perception is that racism is a form of prejudicial thinking, due to social norms taught at a very young age, that runs the risk of objectifying and stereotyping individuals (Kumagai & Lypson, 2009).

Literature on cultural competency approaches is generic, in which cross-cultural curricula focus on traits of a particular culture as a gateway to effective communication for all individuals. A report conducted by Lee and Farrell (2006) found that the word "cultural" reported in cultural competency modules is limited to a set list of

characteristics, “effectively denying the changing, multifarious, interaction nature of identity” (para.6). A list of cultural attributes potentially dehumanizes and delegitimizes the patient’s own identity in preference for what is constructed by public health (Lee & Farrell, 2006). Thus, poor communication between providers and patients, a long history of discrimination, and the inability of a provider to understand historical racial differences may lead to patient noncompliance, and health disparities will continue to emerge.

Statement of the Problem

Within the last 10 years medical education has witnessed an increase in cultural competence training, in part because the United States is becoming increasingly diverse. In addition, the increasing body of health care disparities in ethnic minority groups calls for greater appreciation of cultural difference (Kumagai & Lypson, 2009).

The current health care cultural competence modules require that a health care practitioner interact with patients from different backgrounds much like using a static checklist to perform an “abdominal exam” (Kumagai & Lypson, 2009, p.783). Checklists are too broad, combining people of diverse cultures to rigid categories (Kumagai & Lypson, 2009). Culture does not conform to categories (LeVeist, 2005); culture is fluid and refers to social elements constantly subjected to new influences. The items that form a culture tend to constitute a consistent and integrated whole. Thus, it is imperative that health care practitioners examine all aspects of a patient’s cultural environment in ways that delve beneath the surface (LeVeist, 2005). A trans-disciplinary, holistic understanding of the individual problems is the starting point for developing a new global consciousness to drive changes in behavior and lifestyles (UNESCO, 2002).

Most culturally competent modules fail to capture the nature of culture and self-identity (Lee & Farrell, 2006). Self-identity is a cultural product that occurs when individuals are accustomed to their biological potentials of the culture in which they develop (Lee & Farrell, 2006). It is not a matter of brain chemistry, nor is it invariant across cultures; instead, it is a matter of environmental and social factors. An individual's concept of self is developed by living and adapting to a culture, perhaps multiple cultures, that are not necessarily coherent and will not always join together seamlessly (Gregg & Saha, 2006).

Healthcare facilities face the threat of government sanction if they are found to be engaging in racially discriminatory practices. Yet, subtle discrimination still exists today (LeVeist, 2005). In a report conducted by the Journal of General Internal Medicine (2010) it was noted that perceived racial discrimination has been associated with worse mental and physical health among African Americans (Sorkin, Ngo-Metzger, & Alba, 2010). Williams and Mohammed (2009) illustrated that there are forms of cultural racism that undergird a creed of inferiority that positions some racial groups as inherently or culturally superior to others. Furthermore, negative racial stereotypes are so deeply rooted in mainstream culture that discriminatory behaviors are found among persons who may not be prejudiced (Williams & Mohammed, 2009). Learning simply about culture in cultural medical education will not eliminate health care disparities (Gregg & Saha, 2006). Culture is tied up with race and ethnicity (Gregg & Saha, 2006). Culturally competent curricula must include the awareness of race and ethnicity and must link the professional training of physicians with humanistic values that foster a critical conscious of self-awareness and self-reflection (Gregg & Saha, 2006). Kumagai and Lypson (2009)

noted that critical self-awareness includes understanding interpersonal and societal social issues. Critical self-reflection includes understanding one's own assumptions, biases, and values. The development of this type of consciousness leads to rehumanization of human relationships (Kumagai & Lypson, 2009).

In the 2009 study by Johns Hopkins Center for Health Disparities Solution, it was noted that more than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities. It is estimated that the cost for the period 2003 through 2006 is $229.4 million. (LaVeist, Gaskin & Richard, 2009). The federal government and philanthropy have steadily increased resources to investigate the causes of health disparities and developed interventions for addressing inequalities. Many health care groups have responded by increasing linguistic and cultural competence in medical schools, post-graduate programs and continued medical education programs. Analysis shows that in general, many cultural competence modules call for cultural sensitivity (Lee & Farrell, 2006). Although culture matters, it does not simply explain health behaviors, nor does cultural sensitivity solve health problems.

Culture is a system of invisible fabrics of interrelated actions that bind them together (Greg & Saha, 2006). Many so-called culturally competent courses tend to focus solely on snapshots of isolated parts of a system (Greg & Saha, 2006). Thus, the problem still exists. The proposed cross-cultural health care curriculum developed from this research incorporates historical context, and individual and social factors. This form of cultural systems thinking allows for full patterns to become clearer, and assist in bringing change effectively.

Purpose of the Study

This thesis will (a) present a critical analysis of the current approaches taken to explore the historical contexts of racial and ethnic health disparities; (b) discuss the limitations of cross-cultural health care curricula; and (c) develop a cross-culturally competent curriculum that explores social psychology contexts, individual behavior, and self and ethnic identities. There is an expanding interest of minority health disparities (LaViest, 2005). One aspect of this study, therefore, is to provide health care professionals, as well as undergraduate and graduate students enrolled in health care courses, with practical knowledge in working with diverse patients.

Significance of the Study

The U.S. is becoming increasingly multicultural. Yet, it still seethes with division and social fragmentation. Medical education is answering the call to address health care disparities by integrating cross-cultural education training into the training of all current and future health professions (Gregg & Saha, 2006). This study seeks to address factors, concerns, and perspectives related to culturally competent training courses. The study reveals information that assists in finding a new basis for common sensibilities and common and shared values.

The findings from the examination of the association between health disparities and social factors, such as self-identity and behavior, can be further used to inform educational strategists. Additionally, the material can be incorporated into existing culturally competent curricula.

Definition of Terms

For the purpose of this study the following terms are defined.

Cultural competence. A set of congruent behaviors, taking into account social, cultural, and historical context, coupled with an active recognition of societal problems in search for appropriate individual solutions (Cross, Bazrom, Dennis & Issacc, 1989; Kumagai & Lypson, 2009).

Curriculum. A course or plan for learning (Van den Akker et.al, 2010).

Cross-cultural. Interaction of people from different backgrounds (IOM, 2003).

Disparities. Racial or ethnic difference in the quality of health that is not due to access related factors or clinical needs, preference, and appropriateness of intervention (IOM, 2003).

Evidence based health care education. "The process of systematically identifying, appraising, and using scientific evidence as the basis for decision-making related to health education and health promotion" (The Joint Committee on Health Education and Promotion, 2011, p.16).

Grounded theory. A "comprehensive research method that seeks to develop conceptually rich theories grounded in observations from empirical studies"(Strauss & Corbin, 1967).

Health education. "Any combination of planned learning experiences using evidence based practices and/ or sound theories that provide the opportunity to acquire knowledge, attitudes, and skills needed to adopt and maintain healthy behaviors" (The Joint Committee on Health Education and Promotion Terminology, 2011, p.17).

Medical education. "To supply society with a knowledgeable, skilled and up-to-date cadre of professionals who put patient care above self-interest" (Swanwick, 2010, p.19).

Racism. A conscious or unconscious belief that race is the primary determinant of human traits and capacities and that racial difference produce an inherent superiority of a particular race (Roberts, 2011).

Self-identity. A cultural product that occurs when individuals are accustomed to their biological potentials of the culture in which they develop (Stets & Burke, n.d.).

Social Psychology. A discipline that uses scientific methods "to understand and explain how the thought, feeling and behavior of individuals are influenced by the actual, imagined or implied presence of other human beings" (Huitt, 2006).

Limitations and Assumptions of Study

There are limitations to this study that have potential effects on the final outcome. These limitations are as follows:

1. Lack of current literature on cross-cultural health care curricula;
2. Literature on cross-cultural health care curricula 10 years or older;
3. Researcher bias may be present in this research. The researcher made the decision for the presence of curriculum style and content.

This study was conducted under the following assumptions:

1. Facilitators who utilize this curriculum will have appropriate training.
2. The health care profession will embrace the curriculum.
3. Curriculum modules can be detached from the sequence and still maintain their effectiveness.

CHAPTER II

LITERATURE REVIEW

The review of literature, research, and theory development provides the rationale for the need to implement new ideas in culturally competent education models as discussed in the first chapter.

Culturally competent health care education programs, in general, are based on traditional models that incorporate culture specific beliefs and cultural sensitivity (Betancourt, Green & Carrillo, 2002). This thesis argues that the current state of culturally competent health care education programs is narrow in focus and suggests that curricula should be expanded to include: (a) historical racism concepts, (b) sociocultural contexts based on the relationship between self-identity and environment; and (c) social cognition to address unconscious and conscious behavior.

Collaboration is critical to the success of healthcare operations. Thus, this thesis identifies the unique perspective of social psychology discipline and how the study of thoughts and behavior can contribute to cross-cultural education. The goal of the thesis is to demonstrate gaps and improvements in cross-cultural education. The first section of the literature review provides necessary definitions and a historical overview of cross-cultural health care education programs. The second section provides an overview of the discipline of social psychology's most important determinants essential to cross-cultural education. Lastly, the third section describes a cross-cultural curriculum design utilizing social psychology determinants.

Historical Context: Emergence of Culturally Competent Education

The meaning of "culture" is extremely elusive, commonly debated and vaguely defined. Culture can be understood as a system of shared beliefs, values, customs, and behaviors, collective among groups that include thoughts, styles of communication, and ways of interacting (Institute of Medicine, 2003; Urban Schools, n.d.). Culture is not simply defined by race and ethnicity. Culture is derived from individual influences (IOM, 2003, p.201) and is neither static nor latent. Culture is transmitted by systems of knowledge and behavior of human interaction, which allows for social mobility and can dynamically change over time.

Cultural competence is the movement to eliminate barriers such as sociocultural factors, in order to effectively work in cross-culture situations. The strong call for cross-cultural education began in the 1960s at the "advent of community health and the civil rights movement" (IOM, 2003 p. 201). With the larger population of minorities and the racial integration of schools, it was necessary for the U.S. to be receptive to cultural differences in beliefs, attitudes, behavior and language (IOM, 2003).

Arthur Klienman solidified the connection between "culture, illness and healthcare" in 1970 (IOM, 2003, p. 200). Klienman's (1978) influential work proposed a "method for describing individual systems and for making cross-cultural comparisons" (p. 85). In the 1980s there was an effort to incorporate a skill-focused paradigm, and attention shifted from cultural sensitivity to cultural competence (IOM, 2003, p. 202).

In a report conducted by IOM (1978-1999), trends illustrated a decrease in cross-cultural courses. Experts noted that cross-cultural education courses in health care studies (i.e. undergraduate medical education, graduate medical schools, and continued medical

education) are likely optional electives (IOM, 1978). However, cross-cultural education is believed to be critical in preparing providers to meet health care needs (p. 203). The IOM (2003) cited various opportunities to incorporate a full integration of cross-cultural courses into undergraduate, graduate and continuing medical education as a gold standard (p. 213).

Research illustrates a renewed interest in culture competency due to a call to eliminate racial and ethnic disparities in health care (IOM, 2003). Disparities, as IOM uses the term, result from biases, prejudices, and stereotyping (IOM, 2003). “These disparities can be traced to many factors, including historic patterns of legalized segregation and discrimination (IOM, 2003, p.6).

More recently, cross-cultural curricula have implemented three conceptual approaches: 1) attitudes, 2) knowledge, and 3) skills, all of which are critical components of cultural competency (IOM, 2003; Gregg & Saha, 2006). Despite progression in cross-cultural education, however, “programs may inadvertently reinforce racial and ethnic biases and stereotypes while doing little to clarify complex sociocultural contexts in which patients live” (Gregg & Saha, 2006, p. 543).

Sociocultural Factors in Culturally Competent Education

Despite the contemporaneous birth of cultural competence, there is only a limited degree of sociocultural factors incorporated into undergraduate, graduate and continued health professions education (IOM, 2003). According to IOM (2003) purely disease-oriented paradigms, medical models, and quantitative terms frame public health care (p.496). “Examining racial and ethnic bias and discrimination requires a different mode

of thinking- sociocultural, historical, constructionist, and structural, instead of reductionist" (p. 496).

The concept of sociocultural thinking is not a new phenomenon. Lev Vygotsky (1931-1997) argued:

> The social dimension of consciousness is primary in time and in fact. The individual dimension of consciousness is derivative and secondary (Vygotsky, 1979, p. 30, cited in Wertsch & Bivens, 1987, p. 68).

Sociocultural theory suggests that social interaction leads to incessant changes and can vary greatly from person to person. When a person participates in a broad range of activities and internalizes the effects of working together, he or she acquires a new knowledge of work and culture. It is socialization within a specific culture and society that molds behavior. From this perspective, it is assumed that sociocultural theory emphasizes the roles of environment on a person's development and places little importance on biological factors and ethnic background.

"Individuals often conflate the terms ethnicity and culture, suggesting that each is equivalent to the other" (Gregg & Saha, 2006 p. 544). A persons ethnic background may hold similar beliefs of another person, but "it does not necessarily or invariable mean that they share the same cultural traits" (p. 544). Moreover, "cultural belief alone doesn't cause people to behave in a certain way" (p. 544). Social and behavioral research is consistent in showing that environmental influences and social practices tend to transform and impact human behavior. "When sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated…the result may

be patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care" (IOM, 2003, p. 212).

Self-Identity, Culture, and Environmental Influences

Cultural competence requires that health care providers understand individuals' self-identity, which is more often identified by "others" on the basis of "appearance, culture, nationality, and so on" (Gregg & Saha, 2006 p. 545; LaViest, 2005, p. 8). Variations in humans exist, and human variation does not conform to categories. LaViest (2005) stated:

> A person could be a Cuban American of African descent who has lived most of his or her life in a predominately Chamorro community in the Marianas Island and speaks mainly Chamoru on a daily basis. Which group does this person belong to? (p. 8)

Often times, combining people to categories of "race" reinforces stereotypes. According to the IOM (2003) research, "Race depends fundamentally on the existence of social hegemony. The idea of race and its persistence as a social category is only given meaning in a social order structured by forms of inequality" (p. 91).

Modern scholars agree the term "race" is a relatively recent invention, and essentially a folk concept. Anthropologists define "folk concept" as "a notion that has a general, popularly understood meaning particular to a socio-cultural grouping but which has not been formally defined or standardized" (Bernstein & Edwards, 2008. para. 1).

Johann Fredrick Blumenbach is credited to have termed "race" in 1797 by classifying humans into five categories: "Caucasian or White, Mongolian or Yellow, Malayan or Brown, Negro or Black, and American of Red" (LaViest, 2005, p. 16).

Today, a growing number of scholars dispute and reject Blumenbach's race concept. In Montagu's (1942) Man's Most Dangerous Myth: The Fallacy of Race publication, he opposed the scientific validity of race. Montagu argued that race does not exist as a biologic concept and is a largely a social construction. There is a growing consensus amongst notable anthropologists, geneticists, and evolutionary biologists that argues that race does not exist at all. The characteristics used to define race (e.g. skin color and hair texture) are simply a human variations (e.g. hair color and eye color) (LaViest, 2005).

Cross-cultural education attempts to capture ethnicity, skin color, and nationality all in one inclusive term. LaViest (2005) demonstrates that the American idea of grouping Mexican, Cuban, and El Salvadoran immigrants in the category of Hispanic obscures their cultural differences. Black Cubans and Black Americans tend to share the same skin colors, "however, they are from distinct ethnic traditions, resulting in different dietary habits; thus they would have different dietary health risk profiles" (LaViest, 2005, p. 20). According to LaViest (2005), the way "race" is currently analyzed assumes that something about a persons skin color brands the person to risky behavior (p. 27). A one-dimensional concept of culture reinforces stereotypes by reifying ideas of racial culture and beliefs (Gregg & Saha, 2006, p. 45).

Environmental Influences

Environment, culture, and society exert tremendous influence on self-identity rather than race or skin color. Society tends to shape values, engineers a view of the world, and patterns responses to experiences (Adler, 2002). Social psychologists describe the term "self" in a number of ways. However, "there is a reciprocal relationship between self and society" (Stets & Burke, n.d., p. 1). In essence, self is a cultural product that occurs when

individuals are accustomed to their biological potentials of the culture in which they develop. This culture may change numerous times throughout the life span of a person.

The "self induces society through the actions of individuals, thus creating groups, organizations, networks, and institutions that is variant, fluid and susceptible to change. Reciprocally, society influences the self through its collective language and meanings" (Stets & Burke, n.d. p.1). This enables a person to take the role of the "other," engage in social interactions, and reflect upon oneself as an object (Stets & Burke, 1999). Thus an individual's concept of self is created by living and adapting to an invariably changing culture.

In this sense, culture cannot simply package people by the languages they speak, or the color of their skin (Adler, 2002). Social theorist Mary Ellen Richmond (1917) wrote: "Treat unequal things unequal" and "Do different for and with different people, and study their difference" (p. 370). Cross-cultural education calls for a new way of thinking, one based on a new view of human nature and a revised conceptualization of self-identity. By eliminating the term "race" and understanding the development of self-identity, health care providers may accept and appreciate the difference that exists amongst all human kind.

Social Cognition: Unleashing the Unconscious Mind

Numerous scholars have argued that the study of culture alone cannot eliminate health care disparities (Gregg & Saha, 2006; Kumagai & Lypson, 2009). Culture study may strive to understand the "sociohistorical organization of conscious phenomena such as attitudes or customs, however it cannot explain subtle arcane unconscious process" (Ratner, 1994). According to IOM (2003) there are three mechanisms that might be

operative in health care disparities from the providers' side: "1) bias, 2) stereotyping and 3) uncertainty" (p. 9). These processes may exist unconsciously, amongst people who endorse "egalitarian principals" and who find "prejudice morally abhorrent" (IOM, 2003, p. 10). IOM (2003) suggests that an exploration of social cognitive processes that influence patients' and providers conscious and unconscious perceptions of others are needed in research.

The topic of social cognition has received a great deal of attention by social psychologists. It seeks to explain "how the thoughts, feelings, and behavior of individuals are influenced by the actual, imagined, or implied presence of others" (Huitt, 2006, p. 9). The term "unconscious," as defined in social psychology, is based on unintentional actions that influence or trigger stimuli (Bargh & Morsella, 2008, p. 74). The discipline of psychology utilizes scientifically-based principles and research methods to study the extent to which people are aware of influences on their judgments and decisions. This research has led to the view that "the unconscious mind is a pervasive, powerful influence" (Barge & Morsella, 2008, p. 74).

According to Aronson (2011), the human brain is powerful and efficient, yet it is far from perfect. Most people end up believing many things that are simply not true (Aronson, 2011). The IOM (2003) cites the 1990 General Social (GSS) showing that 54% of Whites believe Blacks are less intelligent, 62% considered Blacks as lazier, 56% rated Blacks more prone to violence and 78% deem Blacks preferring to live off welfare (p.93). "Health care providers, like all individuals, develop their racial and ethnic attitude by social trends" (IOM, 2003, p. 102).

Within the social cognition context, individuals perceive and interpret information

they generate themselves (intrapersonal) and information generated from others (interpersonal) (Huitt, 2006). The Social Learning Theory (1941) illustrates the development of behavioral patterns, such as unconscious racism overtime. These behavioral patterns can be traced to many factors, including historical racism, segregation, and discrimination (IOM, 2003).

Evolution also influences preferences. Bargh and Morsella (2008) noted, “We are predisposed to prefer certain objects and aspects of our environment over others” (p. 76). According to Bargh and Morsella (2008) behavior is controlled by several conscious and unconscious neurotic symptoms. Evaluating behavioral change depends on three social factors that continuously influence each other: environment, people and behavior (Bargh & Morsella, 2008). Additionally, social environment elements may include family members, friends and colleagues.

Attitude Awareness

The culturally competent education model provided by Campinha-Bacote (1993), requires that health care providers become sensitive to beliefs and values of others cultures. Culture awareness, as Campinha-Bacote describes, refers to “know thyself” by becoming aware of one’s own biases and prejudices (p. 204). Johns Hopkins Cross-Cultural Care and Health Disparities/Communication Curriculum trains residents to “focus on one’s own culture, beliefs, and biases” with the objective of helping to eliminate disparities (Hopkins Medicine, n.d). Harvard Medical School (HMS) established the Culturally Competent Care Education Committee (CCCEC) to ensure that students are culturally competent in providing medical care. One of HMS key goals is to “increase awareness of racial and ethnic disparities in healthcare” by becoming familiar

with the cultural practices of different populations (Harvard Medical School, 2005).

Awareness is the first step; however, a change in attitude is needed to sustain culturally competent behaviors beyond the culturally competent workshops. Such a process of change consists of "a learned predisposition to think, feel and behave towards a person (or object) in a particular way" (Allport, 1954, p. 3). Attitudes are the most "distinctive and indispensable" (Allport, 1954, p. 3) concept of social psychology. Alford presumed that attitudes are relatively stable, unless affected by some other process or event (Allport, 1954). Thus, unless the psychological aspects of attitudes are explored in culturally competent education, health care providers will continue to behave in particular ways towards particular people.

Cross-Cultural Curriculum Development

According to Herbert Kliebard (1989), defining curriculum development is more "elusive than appears on the surface" (p. 1). Curriculum development is not simply what something does, but whom it works for (Kliebard, 1989).

Curriculum development includes three vital intentions: "content, purpose and organization of learning" (Van den Akker et.al, 1999, p. 15). However, there is a more complex thought process behind these three vital attentions. Curriculum development must validate why educators should teach "this" rather than "that" it must not only be effective but also valuable and it should address "who" will receive the knowledge (Kliebard, 1989).

The attempt to "rethink learning in social, cultural, and historical terms" (Lave, 1991, p. 64; Hofer & Paul, 1997) has led a number of discussions on the nature of knowledge and knowing. According to Hofer and Paul (1997), "how individuals come to

know, the theories and beliefs they hold about knowing, and the manner in which such epistemological premises are a part of" influences the cognitive processes of thinking and reasoning (p. 88). A person's epistemic belief will determine an individual's inclination to learn. Thus, cross-cultural curricula should include educational and psychological research, which focus on the development and stability of epistemic beliefs, activities, and learning processes (Bauer, Festner, Gruber, Harteis, & Heid, 2004). Furthermore, a cross-cultural curriculum should move the learner from "I" to "we" by wisely applying principles of altruism, excellence, caring, ethics, respect, communication, and accountability (Stalburg, 2014).

Components of a Curriculum

A set of curriculum development principles grew out of Kliebard's (1989) curriculum development research (p. 5). They include:

- A justification for why certain things should be examined rather than others. The curriculum developer must constantly assume a critical vision on what is taught and must examine the assumptions, implicit and explicit.
- Detailed examination of not simply "why" we impart knowledge but to "whom".
- A set of rules that governs teaching the things to be studied.
- Components of curriculum that go beyond the principal of effectiveness and connect interrelated items such as historical racism and modern African American health disparities. (Kleibard, 1989, p.5)

Moreover, curricula are represented in three forms: intended (ideal, formal, or written), implemented (perceived or operation) and attained (experiential or learned) (Van den Akker et.al., 1999).

According to Van den Akker et.al (1999), curricula may be approached utilizing one of three methods: 1) substantive (addressing classical curriculum question about what knowledge is of most worth for inclusion in teaching and learning), 2) technical-professional, (concentrating on how to address tasks of curriculum development) and 3) socio-political, (referring to curriculum decision-making processes, where values and interests of different individual and agencies are at stake).

Krathwohl's (2002) modification to Bloom's Taxonomy states that educational objectives should contain verbs in sentence format that illustrate what students are expected to learn. Additionally, factual knowledge (i.e. terminology, dates, and elements), conceptual knowledge (theories, models, and structures), procedural knowledge (i.e. subject specific skills and methods criteria), and metacognitive knowledge (i.e. strategic, contextual, and conditional knowledge) will assist in a learner-based curriculum. For the purpose of this curriculum project, the focus will center on an intended ideal curriculum. A curriculum also includes a map of theories, beliefs, and intentions.

Characteristics of an Effective Evidence-Based Health Care Curriculum

Medical education spans three sectors: undergraduate, postgraduate and continuing professional education of established clinicians (Swanwick, 2014). Kern, Thomas and Hughes (2009) suggest that curriculum development for medical education include the following:

- Problem identification and general needs assessment
- Needs assessment for targeted learners
- Goals and objectives

- Educational Strategies
- Implementation
- Evaluation and Feedback (Kern, Thomas and Hughes 2009)

According to the Centers for Disease Control (2013), an effective health education curriculum should reflect the following characteristics:

- Focuses on clear health goals and related behavioral outcomes.
- Is research-based and theory-driven.
- Addresses individual values, attitudes, and beliefs.
- Addresses individual and group norms that support health-enhancing behaviors.
- Focuses on reinforcing protective factors and increasing perceptions of personal risk and harmfulness of engaging in specific unhealthy practices and behaviors.
- Addresses social pressures and influences.
- Builds personal competence, social competence, and self-efficacy by addressing skills.
- Provides functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions and behaviors.
- Uses strategies designed to personalize information and engage students.
- Provides age-appropriate and developmentally appropriate information, learning strategies, teaching methods, and materials.
- Incorporates learning strategies, teaching methods, and materials that are culturally inclusive.

- Provides adequate time for instruction and learning.
- Provides opportunities to reinforce skills and positive health behaviors.
- Provides opportunities to make positive connections with influential others.
- Includes teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning. (Centers for Disease Control, 2013)

Swanwick (2014) explained that "educating health professionals in the twenty first century is a challenging endeavor" (p. 13). Internal challenges including the focus on disease, behavior, inpatient and outpatient education as well as external factors such as learning styles, growth in knowledge, and societal influences that require diverse leadership (Densen, 2011). Additionally, skillful teaching requires explicit knowledge and skills beyond an expertise (Ball & Forzani, 2011). Lynn (2011) stated, "Medical educators are often charged to plan educational experiences without specific training in education" (p. 1).

The role of social environments (e.g. sociocultural context, self-identity, and environmental influences) is suggested as a significant element in cross-cultural education. However, "traditional models of health professionals' education emphasize mastery of skills within their individual professions" (John A. Hartford Foundation, n.d., para. 3). Healthcare professional must break down the traditional silo approach and collaborate with educators, diverse professionals, and practice organizations in order to develop the competencies needed to deliver effective care (John A. Hartford Foundation, n.d.).

For the purpose of this curriculum project, all health education curriculum characteristics suggested by Kerns, Thomas and Hughes (2009) and the Centers for Disease Control (2013) could be applied. Moreover, this curriculum is intended to provide accurate, reliable, and credible information that constructs social psychology determinants into cross-culture health care education.

Summary

Health care professionals will see patients from a broad range of cultures as the U.S. becomes more diverse. Research shows that communication is linked to patient satisfaction and health outcomes. Cross-cultural education has emerged as a strategy to reduce health care disparities. However, the current health care culturally competence modules require that a health care practitioner interact with patients from different backgrounds much like using a static checklist to perform an “abdominal exam” (Kumagai & Lypson, 2009, p. 783).

The role of social environments (e.g. sociocultural context, self-identity, and social cognition) is suggested as a significant element in cross-cultural health care education. The curriculum development and design discussed in Chapter IV is an important step toward developing a cross-cultural education curriculum that includes social psychology determinants.

CHAPTER III

RESEARCH METHODOLOGY

OVERVIEW

This study attempts to examine the content of culturally competent health care curricula. The new curriculum developed from this study incorporates concepts of sociological factors that contribute to a complete understanding of one's culture. The research question was developed during the examination of cross-cultural health care curricula. This research approach is based on grounded theory.

Prevalent cultural competence curricula explored in this study were Campinha-Bacota (2009, 2011), A Model and Instrument for Addressing Cultural Competence in Health Care, The Crash Course in Cultural Competence, based on the Learn and Belief Models, and The Culture Advantage Awareness Model. While the cultural competence curricula provided strategies on becoming aware to differences in cultures, little focus was given towards historical exclusion, conscious and unconcious biases, and social constructivism.

Research Goal and Thesis Research Question

The goal of this thesis is to enrich cross-cultural health care curriculum with elements of social psychology. This thesis will describe (a) sociocultural context and its relation to culture identity, (b) sociological construct of self-identity, and (c) social cognition and racial relations.

The thesis seeks to determine the following research question: In what ways can elements of social psychology enrich cross-cultural health care education to reduce health care disparities? This research question directed the study and provided structure for

Chapter 2 (literature review), Chapter 3 (research design), Chapters 4 and 5 (results and recommendation) and Appendix A.

Design and Methods

The theoretical framework of this study was generated by grounded theory. Cross-cultural curricula were collected by performing an environmental scan for information on the topic of cross-cultural curricula, cross cultural health care education, and culturally competent education. The environmental scan consisted of gathering information through literature and Internet searches.

Internet sources are as follows:

1. Published Literature – articles, books, and reports on health care disparities, cross cultural education, cross-cultural theories, and frameworks.
2. Public and Private Health Organizations – continued cultural competent education guidelines training material.
3. Social Psychology Literature- specific to human development, attitudes, self-identity, conformity, culture.
4. Health Disparities in Minority Groups- specific to African, Black, historical and current health disparities.

The primary literature search method included using web-based databases such as U.S. National Library of Medicine, Medline, Academic Medicine, American Psychological Associations and Social Psychology Network. Internet searches utilized search terms related to “cross-cultural education curricula” and “social psychology determinants.”

Emphasis was on gathering the most recent and widely referenced information. Material on cross-cultural curricula pertained to health care – undergraduate, graduate,

and continued medical education students. The majority of information found on physician cross-cultural education focused on physician-patient relationships. There is virtually no published information on material specific to culturally competent education in undergraduate or graduate courses (IOM, 2003). Cross-cultural practical guides and tool-kits were utilized as resources for continued medical education. Material on social psychology related to sociocultural factors, cultural identity, race, discrimination, and ethnic values was examined.

Type of Study

Grounded theoretical analysis, a form of qualitative research, was used in this study: selection and discussion of theoretical and descriptive material, in context, and detailed comparison of theories in terms of their applicability.

Grounded theory research allows the researcher to gather data in order to formulate ongoing plans and to discover the nature of its research. Theory is generated through logical deduction from past studies and existing knowledge and not from the data itself (Glaser, Barney & Strauss, 1967). The researcher spends a considerable amount of time reviewing the literature and planning details of all of stages of the research process. The aim of grounded theory is to discover a theory (Glaser, Barney & Strauss, 1967).

Grounded theory can appear in various forms; “a well codified set of propositions; a running theoretical discussion; or using conceptual categories and their properties” (Glaser, Barney & Strauss, 1967, p. 36). The theoretical discussion form is generally preferred due to its comprehensibility and propensity to not "freeze" the theory in a set of propositions (Glaser, Barney & Strauss, 1976).

Glaser, Barney & Strauss (1976) suggest utilizing a comparative analysis to generate two types of theory – substantive and formal. Substantive theory identifies differences and similarities of contextualized instances, such as patient care and professional education and focuses on similar themes within the literature. Formal theory is a conceptual area of inquiry such as socialization and deviant behavior. "More studies generating substantive theory will ultimately generate and improve formal theory" (Glaser, Barney & Strauss, 1976, p. 36).

The elements of theory generated from comparative analysis are first conceptual categories. Constant comparison of these groups draws the researchers' attention to their many similarities and differences. Abstract categories and properties will begin to form patterns and interrelations, which will ultimately form the core of the emerging theory (Glaser, Barney & Strauss, 1976). "It's essential to allow the categories to emerge than to come into the study with pre-set categories based on existing theories" (Glaser, Barney & Strauss, 1976, p. 40).

The collection begins by collecting empirical data (i.e. existing cross-cultural health care curricula and literature). After cross-cultural health care curricula are reviewed the researcher begins to categorize the data to reflect commonalities. As categories are formed the researcher looks for patterns to emerge. Labels are developed which include naming, categorizing and describing phenomena.

Grounded theory "provides a detailed, rigorous, and systematic method of analysis which has the advantage of reserving the need for the researcher to conceive preliminary hypotheses" (Jones & Alony, 2011, p. 96). This allows the researcher freedom to explore the research area and permits questions to emerge (p. 96). Thus,

grounded theory is valuable in delivering insight into areas that are relatively unknown by the researcher.

Grounded theory is a significant method in exploring topics of a social nature. According to Fernández and Lehmann (2005), “We propose a new methodological alternative: grounded theory building research, where the emerging theory helps explain, in conceptual terms, what is going on in the substantive field of research” (p. 2). The value of grounded theory is to delve deeper into the issue and to adjust and refine the research ideas as the exploration progresses. By allowing the research question to emerge through exploration, the researcher will discover the main concern of the research by exploring data rather than developing a hypothesis first.

Grounded theory does not exist without disadvantages. Grounded theory is a systematic inductive method for conducting qualitative research. It may be difficult to detect or to prevent researcher-induced bias, though, present in most research.

Grounded Theory and Health Care Education

Grounded theory “provides a systematic way to generate theoretical constructs and/or concepts that illuminate human behavior and the social world” (Tavakol, Torabi & Zeinaloo, 2006, p. 2). Complex human intentions, for instance, teaching and learning in hospital settings, evaluation of programs, and processes of curriculum implementation and development, are best examined using qualitative research, namely, ground theory (Tavakol, Torabi & Zeinaloo). According to Tavakol, Torabi and Zeinaloo (2006), research questions that emerge from grounded theory are useful in refining aspects of medical education, providing analysis of existing curriculum design, and developing new hypothesis for future inquiry.

Data Collection

The data collection and analysis for this study employed theoretical sampling. Research utilizing theoretical sampling "refines elaborates, and exhausts conceptual categories," allowing the researcher to determine what is selected (Gibbs, 2010). The researcher began by selecting literature based on the following criteria: (a) published articles, books and reports from reputable sources; (b) culturally competent health care literature, modules, and cross-cultural curricula; and (c) credible literature related to social determinants. The collection of culturally competent health care literature and curricula was followed by the collection of data on health disparities in African American groups; however, the qualitative method in this study is concerned with social variables that influence a patient's frame of reference. Thus, the burden of disease in minority populations, how often minorities get sick, and disease that causes death will not be used for the purpose of this curriculum development.

The researcher then analyzed existing cross-cultural health care curricula in order to find a potential indicator of a phenomenon. The phenomenon discovered that although existing cross-cultural curricula addressed attitudes and sensitivities towards diverse groups, cross cultural curricula reinforced stereotypes by placing individuals into components or categories based on skin color. Furthermore, multifactorial causes of disparities such as historical exclusion, discrimination and social constructivism were not addressed in existing cross-cultural curricula. The researcher then discovered the main concern of the research. As a possible research methodology, case studies were also explored. However, the decision to utilize grounded theory was further supported by the

lack of cross-cultural health care curricula. According to Yin (1989), grounded theory research should serve specific purposes one of which is to extend emerging theory.

Theoretical Sampling and Coding to Refine Categories

Through the process of data collection and coding a theoretical framework is developed (Glaser, Barney & Strauss, 1976). The researcher begins with as few predetermined ideas as possible. According to Glaser, Barney and Strauss (1976), "existing theoretical framework will merely blind them to the richness of the incoming data" (para. 18). A researcher must become theoretically sensitive by allowing the data collection and analysis to be the guide (Glaser, Barney & Strauss, 1976).

The researcher reviewed existing cross-cultural health care curricula and literature. Existing literature can also be used to inform the development of categories, though the categories should not be forced to fit the literature (Glaser, Barney & Strauss, 1976). Research publications on cross-cultural education and cross-cultural health care curricula included concerning events that were used as data in the coding.

Theoretical Memos

Theoretical memos are a set of post it notes written by the researcher in order to record the researchers thoughts and ideas (Glaser, Barney & Strauss, 1976). This process often takes place throughout the entire research process. Theoretical memos enable the researcher to reflect on codes and think theoretically prior to writing the research. According to the Grounded Research Institute (n.d.) "Data is always available, and can be analyzed at any time. Ideas are fragile. They should be written down at the earliest possible time." (para. 2).

Summary

This qualitative research was exploratory in nature and sought to generate innovative insights for the cross-cultural curricula development. The project utilized a grounded theory approach to implement social determinates into a new cross-cultural curriculum.

Cross-cultural course specifics and material are “virtually” unknown in undergraduate medical education (IOM, 2003, p. 203). Current undergraduate, graduate, and continued medical education (CME) courses teach “unifying facts of cultural norms”, which reinforces racism and stereotypes (IOM, 2003, p. 203). The new curriculum guide included in this thesis places cross culture in a historical social context designed to meet the needs of the undergraduate, graduate, and CME population.

CHAPTER IV

RESULTS AND DISCUSSION

The development of a cross-cultural curriculum (Appendix A. Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist, and Structural Concepts) is the result of this research study. The curriculum design was guided by the main research question in Table 1.

RESEARCH QUESTION

In what ways can elements of social psychology enrich cross-cultural health care education to reduce health care disparities?

Findings

Identification of formal assessment methods used in existing cross-cultural heath care education curriculum is a challenge beyond the scope of this research. How does one evaluate the efficacy of a critical consciousness?

Curriculum Design and Layout

Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist, and Structural Concepts is established to fill a gap in current cross-cultural health care education modules. The curriculum design was based on common characteristics obtained from collective resources: Centers for Disease Control (2013), McGraw-Hill Higher Education (2013), the National Academy for Academic Leadership (n.d.), Understanding by Design (2011), and Zenger (1982). The framework for Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical,

Constructivist, and Structural Concepts is established in a traditional manner, outlined by an introduction, philosophy and learning objectives.

According to the Understanding by Design (UbD) framework, a curriculum is "guided by the confluence of evidence from two streams – theoretical research in cognitive psychology, and results of student achievement studies" (ACSD, 2011, para. 4). UbD suggests planning the curriculum backward from the long-term desired results through a three-stage design process as follows:

- Desired Results – what the students should know, in the end, to be able to use what was learned in other settings (Understanding by Design 2011).
- Evidence – an assessment that documents and validates that targeted learning is achieved (i.e. quizzes, tests, observations and work samples) (Understanding by Design 2011).
- Learning Plan – facilitates meaning of material; teachers as coaches establish clear performance goals, supervise ongoing learning, often providing feedback and advice about how to use content effectively (Understanding by Design 2011).

As a part of the curriculum design process a "curriculum guide" or course of study is needed. McGraw-Hill Higher Education (2013), suggests that a curriculum guide should include:

- *Statement of philosophy*: describes the purpose and rationale of the program.
- *Specific goals:* describes the skills, knowledge, and dispositions the students will learn.

- *Sequence of performance indicators/objectives/outcomes:* outlines objectives sequentially from the beginning of the program through the end of the program.
- *Content framework:* organizes program objectives by content area into units or themes.
- *Yearly block plan:* describes what content area will be taught and when.
- *Assessment plan:* determines if the program goals have been achieved.

The curriculum was guided by the UbD Framework- designed (Understanding by Design 2011), with the end result in mind. There were no single cross-cultural curricula that best supported the intention of this curriculum project. Through analyzing research data on current cross-cultural curricula it was necessary to integrate social determinants into cultural competent education.

Data Analysis

For this study open coding was employed. Open coding allowed core themes and categories to emerge within the existing cross-culture literature and cross-cultural health care curricula. The researcher's decision to use open coding was based on the need to find distinctive concepts and categories within the data. Data collected from literature on social variables provided rich information demonstrating the value of understanding social processes in cross-cultural education.

It was important to investigate a collective number of resources in order to develop a research question. Cross-cultural literature, cross-cultural health care curricula, and social psychology determinants were analyzed and codes developed from them. After the literature was transcribed, the codes, categories, theoretical memos were read over

repeatedly until common categories emerged. After careful analysis one prominent theme emerged: cross-cultural health care education includes misconceptions of race, culture, and self-identity.

Description of Commonalities

One commonality identified in this study includes the outline of the curricula. The framework for this curriculum is implemented in a traditional manner outlined by an introduction, philosophy and learning objective, and resources, commonly found in other curricula. The curriculum is designed in a process-based format. "Process evaluation may occur with or without outcome evaluation and may include a combination of qualitative and quantitative data collection strategies" (Community Interventions for Health, 2014, para. 2). The curriculum incorporates activities for implementation: however, the results of these activities such as the changes in behavior of individuals or groups of people may occur after the implementation.

Improving knowledge of social context is extremely different from understanding how an individual learns and actively utilizes the information presented. Individual learning is beyond the scope of this project. Chapter V will provide a summary of research and future recommendations for assessment methods.

Summary

The design of this curriculum differs from selected curricula. Much of the selected cross-cultural curricula deals with culture awareness. There were no cross-cultural curricula that placed culture in a social or historical context. Despite the growing diverse population and increasing disparities amongst ethnic minorities, very few curricula identify unique methods to deliver culturally competent health care (IOM, 2005,

Liaison Committee for Medical Education n.d.). This study advocates, based on the research presented herein that historical racism, sociocultural factors, and social cognition are paramount to cross-cultural education to illustrate how those contexts both maintain and alter culture. Gregg and Saha (2006) reported that "racism is not solved by simply teaching about culture, a robust curriculum is needed to clarify the contextual nature of others' cultures" (para. 546).

CHAPTER V

RESEARCH SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

This chapter includes a summary of the study, discussion of research findings limitations, and future research recommendations.

Summary of Research

This study examined the content of culturally competent health care education curricula. The analysis expounded on the culturally competency literature by weaving the concepts of sociological factors that contribute to a complete understanding of culture. The goal of this thesis is to (a) present a critical analysis of the current approaches taken to explore the historical contexts of racial and ethnic health disparities through continued medical education curricula; (b) discuss the limitations of cross-cultural health care curricula; and (c) develop a cross-cultural curriculum that incorporates social psychology determinates.

The research was conducted using a grounded theoretical analysis. This qualitative study consists of a selection and discussion of literature, an environmental scan for information related to cross-cultural education, detailed comparison of objectives and theories, and developing a hypothesis and final curriculum.

Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist, and Structural Concepts is developed based on the findings of this study. The curriculum includes social psychology's determinants essential to cultural competencies.

Implications of Study

This study is significant because it incorporates social psychology determinates into cross-cultural curricula. It is beneficial to undergraduate, graduate and continuing medical education students. By understanding environmental influences and social practices on cultural identity, the one-dimensional concept of culture can be removed.

Limitations of Study

The major limitation of the study is the lack of implementation and evaluation of the proposed curriculum. This study is solely grounded in research and development. Therefore, it is an untested curriculum.

The foundation of this curriculum is based on social psychology determinates central to culture: sociocultural factors, values and norms, and self-identity. It is hypothesized that this type of curriculum could improve current curricula of patient provider relationships and aid in reducing health care disparities.

Suggestions for Further Research

This study introduced social psychology factors into cross-cultural curricula. The following recommendations for further research are based upon findings from this study.

1. Develop an evaluation tool to determine the impact of curriculum on health care.
2. Develop key performance indicators tied to result-based outcomes.
3. Develop additional modules that include historical racial factors for different minority populations to enhance this curriculum.
4. Additional work is needed to determine how people learn awareness and to examine a critical consciousness.

5. Additional work is needed to consider how multidisciplinary and transdisciplinary education teams can contribute to patient safety and care.

Conclusion

This thesis set out to investigate cultural competence training and cross-cultural health care curricula. Based on its findings a new curriculum was developed to enrich current cross-cultural curricula with elements of social psychology. The final section will review the research contribution of this thesis.

Contributions

The following are the main research contributions of this thesis.

- **A historical racism perspective** that examines the origins and evolution of racial and biased thinking (Chapter 1). This framework demonstrates the evolution of healthcare disparities as a form of prejudicial thinking taught at a very young age. “Discussions of racism should be prevalent in curriculum content” (Kumagai & Lypson, 2009)
- **Cultural systems thinking** that allows for full patterns of culture to become clearer (Chapter I). In the context of system thinking, culture is understood through interrelated components (i.e. historical context, individual and social factors).
- **Self-identity** and its etiology approach to culture. (Chapter II). In this context the analysis illustrated that an individual’s culture is fluid, constantly changing and subjected to social and environmental influences.
- **Sociocultural factors** emphasize the role of environment and society on an individual’s culture and places little importance on biological factors and ethnic

backgrounds (Chapter II). The research defined improving cross-cultural curricula to include human nature and conceptualizations of self-identity. "A person's medical needs are shaped by the individual's culture, environment, religion– in short, his or her individuality" (Bustillos, 2005).

- **Social cognition and interpersonal and societal influences** that influence patient and provider conscious and unconscious perceptions of others (Chapter II). The examination provides an illustration of how individuals perceive and interpret information they generate themselves and from others. It also provides a natural guide towards future research in unconscious racism.
- **Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist, and Structural Concepts** (Appendix A) is intended to promote a common understanding of what culture is and what strengthens health systems through cross-cultural curriculum. This curriculum incorporates humanistic beliefs, the potential value and goodness of human beings that emphasize common human needs, and seeks sensible ways of solving human problems.

Health care disparities will continue to exist if the current cross-cultural curricula do not undergo a significant transformation. As reported by Gold (2014), the National Health Care Quality reinforced this notion by stating, "health care quality and access are suboptimal, especially for minority and low-income groups" (para. 4). According to the U.S. Department of Health & Human Services – Agency for Research and Quality (2011), higher quality and more equitable health care is needed to reduce "disparities related to race, ethnicity, and socioeconomic status" (para. 12).

The review of literature in this thesis and the development of Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist, and Structural Concepts in Appendix A., support the movement for a cross-cultural curriculum to include a foundation for understanding and eliminating racial and ethnic health disparities. Cross-cultural curricula must be mindful of a patient's perspective, environment, unique identity, and socioeconomic status and how these factors contribute to an individual's culture. Assuming that there is a one-size fits all checklist to combine diverse groups reinforces racism (Kumagai & Lypson, 2009). Thus, enhancing cross-cultural curriculum with elements of social psychology (e.g. historical racism, sociocultural context, and self-identity) will introduce new kinds of patient care, educate health care professionals and medical students on issues of growing importance to society, and ensure culturally-competent care for vulnerable populations.

Epilogue

Early Monday morning, April 8, 2013, my thirteen-year-old daughter woke me with a massive swelling and throbbing pain in her left eye. She was unable to open it. Naturally, as a concerned mother, I rushed her to the nearest emergency room. I will never forget the doctor who greeted us. He pulled up a chair and sat casually beside my daughter, as if he had known her for years. "Hi, I am John" he said. He extended his hand to acknowledge us both, in what I recognized as a sincere gesture. "What did you do to your eye?" he exclaimed in a jovial manner.

Although now I am certain Dr. John knew the moment he saw my daughter that she was having an allergic reaction to something, he still proceeded with his diagnosis and never once broke his friendly and concerned manner. Nor did he ever make us feel ridiculous for being there. I could not help but replay his introduction over and over again in my mind. In fact, after he left and returned to the room to check on my daughter, I inquired about why he introduced himself by first name only.

He gave a warm and genuine smile. "I am John first. Too many of us forget why we came into our profession. I never want to pull myself away from the people I serve." I realized, unfortunately, that we tend to live behind a title like it is a wall, never completely exposing ourselves as humans to the people that we serve. He stated that he was no different than anyone else. In fact, during our casual conversation I learned that his daughter attended the same school as my daughter, and she was on the same student team as my daughter in seventh grade.

What Dr. John did not know about me was that I studying social psychology, in which one of my focuses was how clinical performance is based on behavior and how

being aware of culture and behavior can create better relationships with coworkers and the population and community in which we serve.

I will forever remember Dr. John. He left such a profound impact on me. In fact, I hope that I would one day I have the opportunity to thank him. I am driven by the belief that based on our behavior the world can be a better place, one person at a time. Meeting Dr. John helped solidify that belief. I would also like to thank him for the other people whose hearts he may have touched. His simple approach, jovial personality and just-like-me attitude might mean the difference between life and death, and maintain some respectability and dignity in an otherwise difficult position.

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Appendix A: Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist, and Structural Concepts

Rehumanize Cross-Cultural Curriculum

with

Historical, Constructivist and Structural Concepts

ShaRae Kalian

DISMANTLE RACISM:

Rehumanize Cross-Cultural Curriculum
with
Historical, Constructivist and Structural Concepts

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Disclaimer:

The content within this curriculum is designed for the education of health care professionals, education administrators, teachers and school counselors. The intent of the curriculum is to inspire professionals to strive for excellence in the implementation of effective cross-cultural education. While the author has made every effort to ensure accurate information in *Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist and Structural Concepts* the author specifically disclaims all legal liability with respect to the completeness or usefulness of any information contained in *Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivist and Structural Concepts.*

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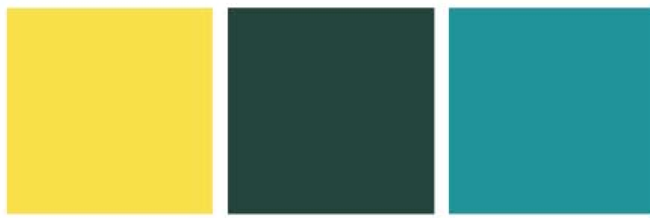
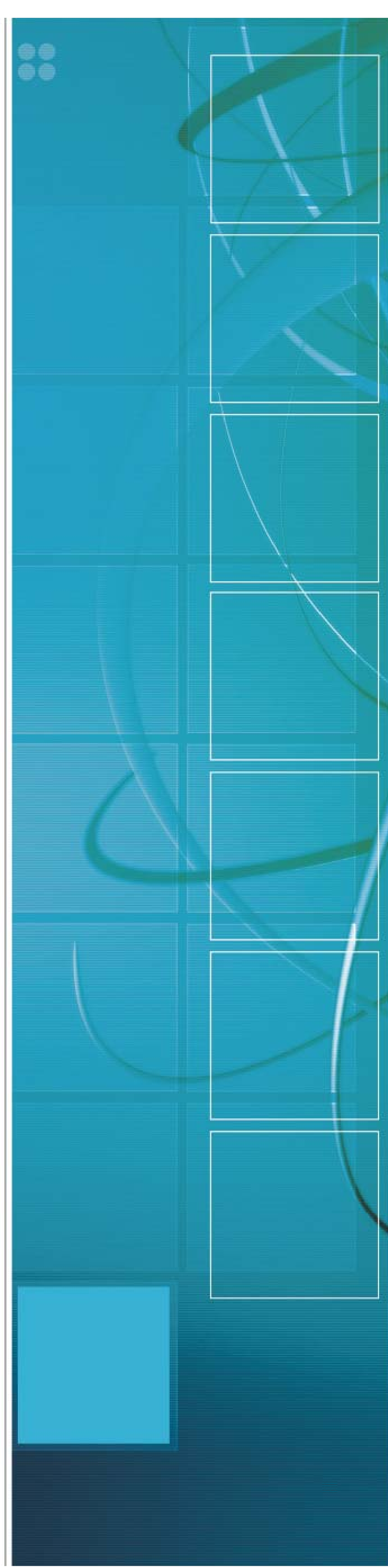




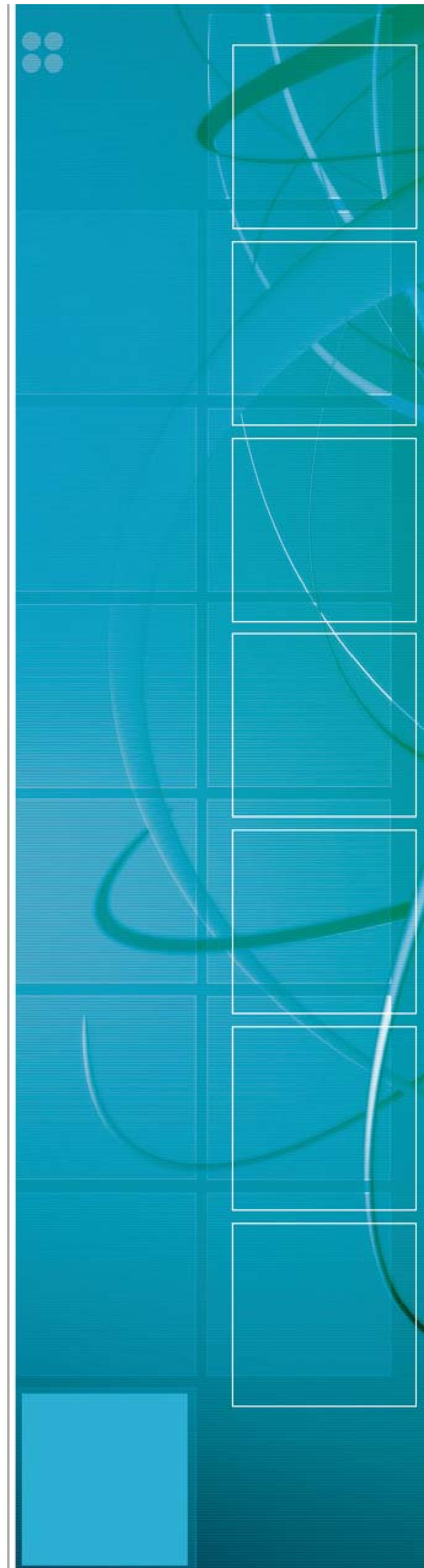
INTRODUCTION

Racial inequality is one of the greatest challenges facing the United States. It has become one of the most deeply talked about subjects in the social health field. One challenge is to reduce health care disparities and improve access to high-quality health care for minority patients. Another concern is the disproportionate representation of minorities in areas of education amongst other industries. Moreover, the U.S. demographic trends are changing. Census figures document that by 2023, minority groups are projected to account for more than half of the U.S. population.

The facts are clear. There has never been a more important time than now to develop a culturally competent workplace. Dismantle Racism: Rehumanize Cross Cultural Curriculum with Historical, Constructivist, and Structural Concepts was written for the health sector; however, it can be adapted by a variety of industries. For instance, education administrators, teachers, school counselors engage with students on a daily basis. It is critical that they are educated on cultural competence to serve a diverse nation.

There is a broad amount of literature on the implementation of cultural competence to reduce disparities. Cultural competence techniques include a racially diverse staff, culturally competent education and training, and integrated culturally translated signage. These tactics are vital. However, there is a grave disconnect between cross-cultural education and social justice.[13] Many cross-cultural education modules categorize individuals, which may reinforce stereotypes and racism. If social justice is an educational goal of cultural competency, real discussions of racism, race and ethnicity should be prevalent in curriculum content.

To understand individuals through cross-cultural education without understanding the entire context, one cannot fully understand the social factors that form human identity. Cross-cultural education must weave social psychology factors that contribute to a complete understanding of one's unique culture. To this end, this curriculum was written with intent to provide social health professionals with an overview of historical race concepts, sociocultural behavior, self-identity formation, social cognition, and unconscious racism.



This curriculum was developed from preliminary research for a Masters thesis project. The author saw a need to incorporate factors of social psychology such as race, self-identity and unconscious behavior in culturally competent education. The curriculum reflects the expertise of social psychology research. It is designed to improve existing culturally competent curricula. This curriculum begins with a module on race, including historical racism concepts and biological statistics. The next module describes social constructionism including social cognitive processes that influence conscious and unconscious perceptions of others. The final module explores structural thinking and the social factors that contribute to self-identity.

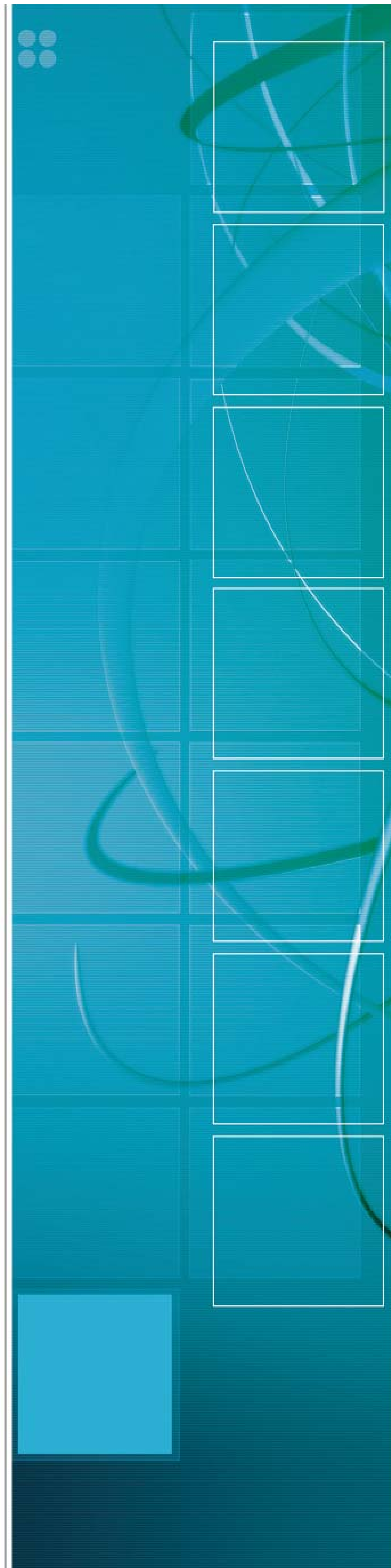
This curriculum was designed in a modular format so it can be adopted for use in a variety of ways. One educator might choose a single module to supplement existing information on cultural competence. Another might choose two or more modules to provide a complete review of the social factors that contribute to culturally competent staff.

The following are the main research contributions of this curriculum:

- **Racism historical perspective** that examines the origins and evolution of racially biased thinking. This framework demonstrates the evolution of disparities as a form of prejudicial thinking taught at a very young age.

- **Cultural systems thinking** that allows for full patterns of culture to become clearer. In the context of systems thinking, culture is understood by interrelated components (i.e. historical context, individual and social factors).

- **Self-identity** and its etiological approach to culture. In this context the analysis illustrates that an individual's culture is fluid, constantly changing and subjected to social and environmental influences.



- **Sociocultural Factors** emphasize the role of environment and society on an individual's culture and places little importance on biological factors and ethnic backgrounds. The curriculum includes human nature and conceptualizations of self-identity.

- **Social Cognition and Interpersonal and Societal Influences** that influence individuals' conscious and unconscious perceptions of others The examination provides an illustration of how individuals perceive and interpret information they generate themselves and from others.

Disparities will continue to exist if current cross-cultural curricula do not undergo a significant transformation. Dismantle Racism: Rehumanize Cross-Cultural Curriculum with Historical, Constructivism and Social Concepts enhances cross-cultural curriculum with elements of social psychology (e.g. historical racism, sociocultural context, self-identity). The curriculum promotes an understanding of what culture is, an individual's perspective of his or her unique identity, and incorporates humanistic beliefs - the potential value and goodness of human beings that emphasize common human needs, and seek sensible ways of solving human problems.

.

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HISTORICAL I THINKING

"Medical people are supposed to help when we need care, but even once a cure was discovered, they were denied help, and they were lied to by their government… The United States government did something that was wrong -- deeply, profoundly, morally wrong. It was an outrage to our commitment to our integrity and equality for all our citizens… To our African American citizens, I am sorry that your federal government orchestrated a study so clearly racist. It is against everything our country stands for and what we must stand against is what it was."

HISTORICAL THINKING

(President Clinton Apology , Center for Disease Control and Prevention, 1997)[8]

THE RACE CONCEPT

Objectives

The purpose of this module is to:

1. Discuss historical concepts of race.
2. Recognize individual assumptions of race and ethnicity.
3. Summarize anthropologist and biologist theories about race.
4. Outline the U.S. race and ethnicity classification system.
5. Identify the difference between race and ethnicity.

Educational Strategies

1. Interactive Internet modules
2. Oral presentation - Small Group meetings and seminars
3. Engage frontline clinicians and create a structure for peer learning

Educational Lectures

1. Race, Ethnicity, and Culture
2. Health care disparities
3. Cultural beliefs, Health behaviors and Patient mistrust
4. Cultural self-awareness
5. Cross-cultural communication

Evaluation

1. Observation of small group discussions
2. Patient satisfaction survey with specific questions addressing cross-cultural communication
3. Self -reflection/awareness journaling & monitoring

Key Points

1. Race does not exist.
2. Race is a folk concept -A notion that is general, popularly understood but which has not been formally defined or standardized.
3. Categories reinforce stereotypes.
4. Race and ethnicity are not one inclusive term.
5. Race and ethnicity are psychological and socially constructed.

Outcome and Achieved Results

Be able to analyze historical influences of racism that shaped perception of modern race and ethnicity.

Overview

Published research found that few cross culture education curricula connects cultural competence and the elimination of racial ethnic disparities.[5] Yet, reports displayed that racial matters are a primary concern of the American experience.

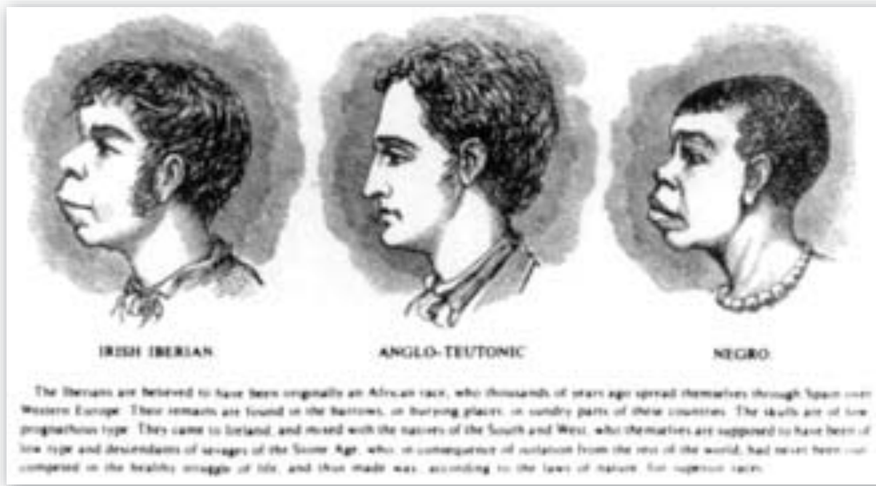
The 1999 survey conducted by Moody-Ayers, Thomas and Williams reported communication problems amongst physicians and patients due to trust and mistrust that dates as far back as the antebellum period.

In the 19th century, slaves and free Blacks were used as subjects for dissection and medical experience.[11] During the 20th century African Americans, although accepted into the White medical system, received inequalities in medical treatment, for instance, the infamous Tuskegee Syphilis Study (1932-1972), an experiment conducted on 399 black men that claimed to treat syphilis.[15] More recently, in the 21st century, a Michigan lawsuit (2013) was filed by a black nurse claiming a note posted on a clipboard that read "No-African American Nurse to take care of baby".[13] Brandt (1978), suggested that historical racism events, namely the Tuskegee study, must be explored to understand modern American racism.

The correlation between understanding racism and culture is relevant because the concept of race has been found to be psychological and socially constructed rather than biological.[7] This chapter considers the modern term "race" as objectifying and reinforcing stereotypes by placing people into rigid categories.

HISTORICAL THINKING

Historical Race Foundation



Classifications of human beings into distinct entities commonly known as "races" began in 1600's by French Physician François Bernier. Bernier divided people into groups based on physical characteristics, such as skin color and the profusion of facial hair in males. The philosopher's beard was thought as a divining characteristic commonly found in European males.

Carl Linnaeus (1707 -1778), a physician and zoologist, continued the establishment of racial classification. Linnaeus established the origin of the color scheme, habitat and character of races. According to his system, each race possessed physiognomic characteristics: The European race was white-skinned with gentle character; the Africans were black-skinned, with negligent character.

Anthropologist and professor of medicine Johann Friedrich Blumenbach is credited to have termed "race" in 1797 by classifying humans into five categories: Caucasian or White, Mongolian or Yellow, Malayan or Brown, Ethiopian or Negro/Black, and American or Red.

Early discussions of race began with one of the most obvious feature: skin color. During the eighteenth century the concept of facial features and the conformation of the skull became more prominent. Dutch anatomist and painter Pieter Camper (1722–1789) developed the concept of facial angle, found in Europeans, as the most beautiful, subsequent craniometrics and believed this to be the measurement of human worth.

A growing amount of research and evidence disputes and rejects the historical race concept. Montagu's (1942) *Man's Most Dangerous Myth: The Fallacy of Race* publication argues that race does not exist as a biologic concept and is largely a social construction.[17] Similar reports and publications illustrate that the idea of race is an existence of social hegemony that is only given meaning in a social order structured by forms of inequality. Notable anthropologists, geneticists, and evolutionary biologists illustrate that race does not exist at all. Race is a relatively recent invention, and essentially a folk concept. The characteristics used to define race (e.g. skin color and hair texture) is simply a human variation (e.g. hair color and eye color).[2]

An illustration from American magazine *Harper's Weekly (1899)* shows the alleged similarity between "Irish Iberian" and "Negro" features in contrast to the 'superior' "Anglo-Teutonic." The accompanying caption reads:

The Iberians are believed to have been originally an African race, who thousands of years ago spread themselves through Spain over Western Europe. Their remains are found in the barrows, or burying places, in sundry parts of these countries. The skulls are of low prognathous type. They came to Ireland and mixed with the natives of the South and West, who themselves are supposed to have been of low type and descendants of savages of the Stone Age, who, in consequence of isolation from the rest of the world, had never been out-competed in the healthy struggle of life, and thus made way, according to the laws of nature, for superior races.[25]

HISTORICAL THINKING

There is Only One Race

* Romans categorized people not on biological race or skin color, but on differing legal structures upon which they organized their lives. [1]

* In the medieval era, Muslims and Christians divided humans based on the categories of "believer" and "nonbeliever," not on biological race. Additionally, the Jews based the differences between "goyim" (non-Jew) and "Jew" on faith rather than on biological differences [1]

*Humans differ genetically in some ways, such as blood type and skin pigmentation, but have not evolved into separate subspecies or races. [1]

*Human beings do not fit into the zoological definition of race. [1]

*Most anthropologists and biologists believe race is a political grouping with roots in slavery and colonialism. [1]

*Genetic variety is not between races, but rather within races. For example, two random Italians are as likely to be as genetically different as an Italian and a Chinese. [1]

*U.S. Census Bureau defines race as a social category recog[1]nized by the United States and does not attempt to define race biologically, anthropologically, or genetically. [1]

* Most people who identify themselves as African American in the United States have some European ancestors. Additionally, a large number of people who identify themselves as European American have some Native American or African ancestors. [1]

*The Human Genome Project proved that race could not be identified in genes. While scientists may use the idea of race to make practical distinctions among fluid sets of genetic traits, all people belong to the same hominid species, *Homo sapiens sapiens* (Latin for "wise man" or "knowing man"). In other words, biologically, there is one human race. [1]

HISTORICAL THINKING

The current population in the U.S. is about 308 million people and this figure is expected to grow to 410 million by year 2050.[28] Additionally, 30% of the population will be Hispanic, 15% Black, and 9.2% Asian. The number of people who identify themselves as being of two or more races is projected to more than triple, from 5.2 million to 16.2 million. Everyone, excluding non-Hispanic, single-race whites, is projected to be 235.7 million out of a total U.S. population of 439 million.[28] By 2023, people belonging to cultural subgroups will account for half of the U.S. total population and minorities will comprise more than half of all children.[28]

Although race and ethnicity is an enduring aspect of the United States, it's remarkable how elusive and perplex the definitions of race and ethnicity can be. The issues surrounding the definitions of race and ethnicity are themselves a product of racism's long and conflicted history in our society. "An examination of American social history points to the legacy of America's fascination with skin color, caste, and social status" (Carter, 2007). [23]

The Race to Categorize

HISTORICAL THINKING

Capturing ethnicity, skin color and nationality all in one inclusive term demonstrates that the American idea of grouping Mexican, Cuban, and El Salvadoran immigrants in the category of Hispanic obscures their cultural differences.[15] Black Cubans and Black Americans tend to share the same skin colors, yet, they are from distinct ethnic traditions.[15] Ethnicity differs from the ideology term "race" in a number of ways.

Many researchers agree that ethnicity relates to cultural factors such as language and beliefs and is best understood as a dynamic, frequently evolving creation of both individual identity and group association. In other words, an individual's ethnic identity is influenced by his or her own perceptions of ethnicity and the perception of others in the world in which they live.

Nagel (1996) describes the situational changes of ethnicity as individuals who carry a multitude of ethnicity, which are "salient" in various situations.[19] As the person's environment changes, an array of ethnic choices emerges, which produces a "layering" of ethnic identities.[19]

A modern racial-classification system strongly influences health and education disparities. Research has found that these categories are socially constructed to form inequalities. Common examples of categorical notions of race include the Holocaust, slavery, and the destruction of American Indian populations. Race categories have also been used to discriminate and to distribute resources unequally. Anthropological Association (1997) noted, "The danger in attempting to tie race and biology is not only that individuals are never identical within any group, but that the physical traits used for such purposes may not even be biological in origin".[2]

The notion that race as a biological basis is an ancient belief that continues to be debated. However, race and racism are modern inventions that arose and became part of the dominant ideology of society. American Political Philosopher, Arendt (1951), argues that racist ideology (modern racism) helped to legitimize imperialist conquest such as Herero and Namaqua Genocide (1904 -1907), the Armenian Genocide (1915 – 1917), the Nazi Holocaust (1938 -1945). Racist ideology continues in the 21st century influencing prejudice, intolerance, and health disparities.

Understanding race through historical context delivers an awareness of how interpretations of race are reflections of ideologies developed throughout history. However, awareness is not enough. It simply treats race and racism as a form of bad ideas without addressing the cognitive processes that underlie racial acceptance.

Racism ideology is embedded within the U.S. culture. Every member of society shares viewpoints of the ideology race. Unconscious racism, for instance microagression is demonstrated within day-to-day interactions with each other. As a result of these ideologies, every day, seemingly, minor, verbal, nonverbal or environmental slights delivered with or without intent create certain hostilities and conflicts on one or more races of people.

"**Racism** is not about how you look, its about how people assign meaning to how you look."[25]

- Robert D. G. Kelley, Historian

HISTORICAL THINKING

RACE DEFINED

1. The racial classifications used by the Census Bureau govern categories used to collect and present federal data on race and ethnicity. The Census Bureau requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race.[28]

2. Categories developed in 1997 by the Office of Management and Budget (OMB) that are used to describe groups to which individuals belong, identify with, or belong in the eyes of the community. The categories do not denote scientific definitions of anthropological origins. The designations are used to categorize U.S. citizens, resident aliens, and other eligible non-citizens. Individuals are asked to first designate ethnicity as:

-Hispanic or Latino or
-Not Hispanic or Latino

Designate race as:

-American Indian or Alaska
-Asian
-Black or African American
-Native Hawaiian or Other Pacific
-Islander
-White

ETHNICITY DEFINED

1. Cultural differences, and an ethnic group is a people who share a historical and cultural heritage (and frequently have a sense of group identity). It may or may not overlap with race. However, there is nothing within the concept of a cultural group that excludes that group from being multiracial. For example, members of the U. S. society share a cultural identity. That cultural identity is their ethnicity.

2. Cultural factors such as nationality, culture, ancestry, language and beliefs.

3. Common characteristics of a group of people that distinguish them from most other people of the same society.

4. A group that has a distinct culture of its own.

RACISM DEFINED

1. Any policy, belief, attitude, action or inaction, which subordinates individuals or groups based on their race.[29]

2. Any attitude, action or institutional structure which subordinates a person or group because of their color.[29]

3. A belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race.[22]

4. Dividing people into populations or groups on the basis of various sets of physical characteristics.

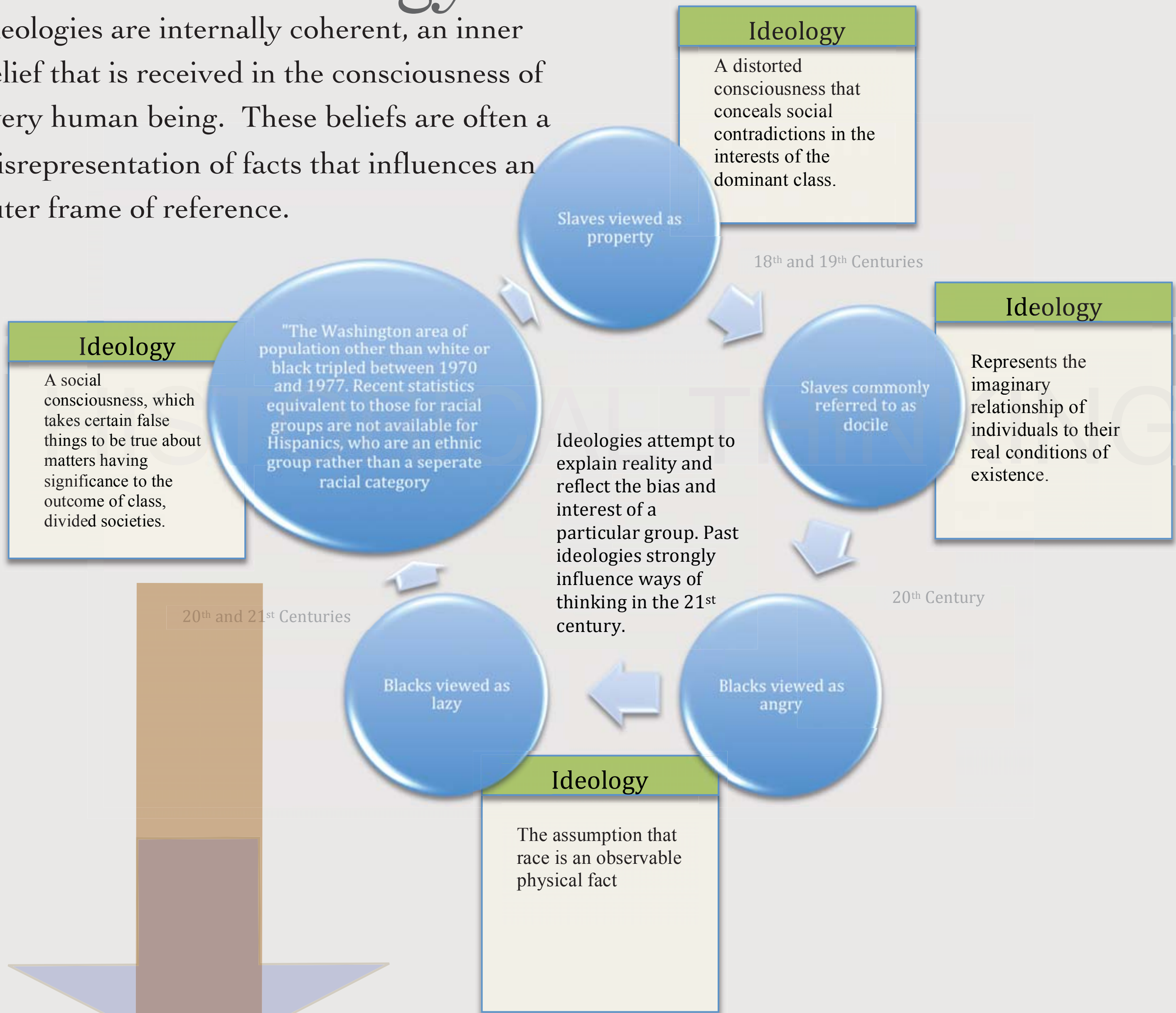
HISTORICAL THINKING

Talking about black people having a gene that predisposes them to some disorder or another "feeds a social process" that is deeply negative. Black Americans suffer more from high blood pressure than white Americans. We don't know why, but everyone says it is genetic. But if you look around the world, by far the highest hypertension rates are in Poland, Finland and Russia. Much higher than black Americans. The average difference in blood pressure between blacks and whites is about 4mm of mercury, the difference between whites in the US and Russia is about 20mm. No one has ever said that these white people are genetically predisposed to hypertension: it must be their diet. But when they talk about blacks, it has to be genetics. That, in a nutshell, is the whole problem with this whole way of thinking.[21]

-Richard Cooper, professor of medicine at Chicago Loyola

Racist Ideology

Ideologies are internally coherent, an inner belief that is received in the consciousness of every human being. These beliefs are often a misrepresentation of facts that influences an outer frame of reference.



Color is Racism

Anthony and Sherry have been married for three years. Both are well educated and devout Christians. Together they have one child. During their long plane trip to visit Anthony's family in Michigan, Anthony and Sherry talked about their 5-year relationship reminiscing on how they met. A lot had changed since then, amongst things, Sherry had completed her graduate studies in social psychology - the study of race, racism, diversity and ethics.

Anthony's family has always embraced Sherry with affection and love. One night during dinner, while Anthony was visiting with his male relatives outside, Sherry and the other women gathered around the dinner table to laugh and catch-up. Her sister-in-law, Sade, began to share a story about a client that she knew.

Sade: I have a black client that comes in all the time. She is an older woman and very funny. The last time I saw her I mentioned that I now had black people in my family. My client said well we have white people in our family.

Everyone laughed

HISTORICAL THINKING

Sherry sat silently.

Sade: I told the client that my sister-in law who was black has beautiful skin. My client said well you know what they say black don't crack.

Everyone laughed

Although Sherry continued to sit silently, she couldn't help but think about the last time she was in Michigan and her sister-in-law referenced the color of her skin. Sade once said that Sherry and Anthony would endure challenges of racism because they were an interracial couple. Anthony considered himself Armenian while Sherry considered herself American. However, her skin tone of a golden brown nutmeg told a different story. Sherry was black and no matter how much her in-laws adored her, they too could not get pass her minority status.

Historical Side Note

The Ottomon government considered Armenians minority and enacted a systematic decimation of the Armenian population from 1915 to 1923. By 1918, the Armenian genocide had claimed the lives of over one million people. Many Armenian survivors migrated to the United States. In the twentieth century the Cartozian v. United States case categorized Armenians as white for naturalization purposes.[30] Anti-miscegenation laws (1913 -1948) prohibited marriages between whites and blacks, as well as whites and Native Americans and Asians. Additionally, the law criminalized minorities that partook in interracial marriages. Although Armenians were once considered minorities, their skin color could pass as European. Thus, Armenians who married white American's were not discriminated against. One year following the Cartozian v. United State case, Michigan District Court held the United States v. Ali (Hindus and Arabs) case on Naturalization. Judge Tuttle decided that Ali was not white and wrote, "His skin is certainly not white, but unmistakably dark, like that of the other members of his race." [29]

Discussion Questions:

1. What are covert and overt racist and prejudicial behaviors?

2. What are the racial stereotypes we hold in our heads?

3. How can a simple statement based on the color of skin belittle someone?

Questions to ponder:

1. What are the causes of racism?

2. What can be done to eliminate racism?

HISTORICAL THINKING

Racism can take many forms. It can be overt or convert often excluding particular groups or individuals. Racism leads to the division of many groups and enforces racial biases and prejudices. The belief that one particular race or ethnicity is superior to others is often used to justify inequalities. It is vital that we continually challenge this notion in order to eliminate harmful behaviors. The more attention that is brought to systems of biases, prejudice and stereotypes the greater the chances at repairing America's

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II

SOCIAL CONSTRUCTIONISM

Mapping the Language of Racism

Objectives

The purpose of this module is to:
1. Outline elements of racism such as social cognition and social schema.
2. Identify the role of unconscious behavior.
3. Provide a model for behavior modification as a purpose for eliminating racial lines.
4. Recognize the association between individual and vicarious racial beliefs.

Educational Strategies

1. Interactive Internet modules
2. Oral presentation - Small Group meetings and seminars

Educational Lectures

1. Social Cognition and Race Disparities
2. Race, Ethnicity, and Culture
3. Cultural beliefs, Health behaviors and Patient mistrust

Key Points

1. Bias, stereotyping and uncertainty contribute to disparities.
2. The unconscious mind leads to unintentional actions.
3. Racial attitudes develop overtime.

Outcome and Achieved Results

Be able to evaluate their biases, prejudice and discriminating behavior at both a conscious and unconscious level.

Overview

Although overt racism has declined significantly since the 1960's, unconscious racism still persists today. Numerous scholars have argued that the study of race, ethics and culture alone cannot eliminate racial disparities. Culture may understand[3] the socio historical organization of conscious phenomena such as religion, however it cannot explain subtle arcane unconscious processes such as: 1) bias 2) stereotyping and 3) uncertainty, all of which are very pernicious.[3]

The term unconscious is based on unintentional actions that influence or trigger stimuli. Aronson (2011) *The Social Animal* reveals the human brain as a powerful and efficient, yet a far from perfect organ. Aronson argues that most people end up knowing a lot of things that are simply not true.[2]

Social cognitive processes influence conscious and unconscious perceptions of others. Within social cognition, individuals perceive and interpret information they generate themselves (intrapersonal) and from others (interpersonal).

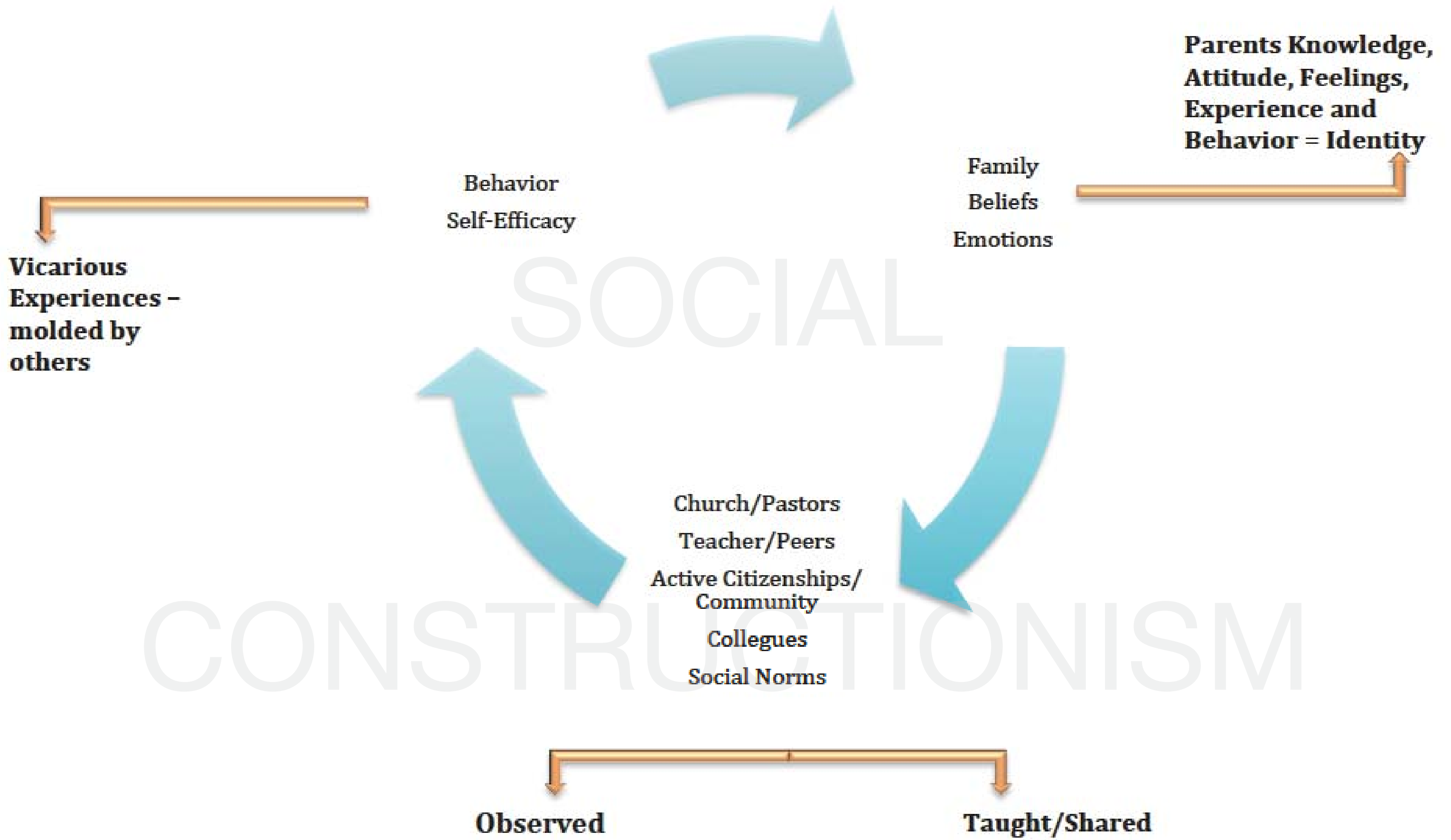
People are predisposed to prefer certain people, objects and aspects of an environment to others - a behavior that is developed overtime and controlled by conscious and unconscious neurotic symptoms.[8]

These behavioral patterns can be traced to factors including historical racism, segregation and discriminations.[8]

> The 1990 General Social Survey (GSS) reported that 54% of whites believe blacks as less intelligent, 62% considered blacks as lazier, 56% rated blacks more prone to violence and 78% deem blacks preferring to live off welfare.

Evaluating behavioral change depends on three social factors that continuously influence each other: environment, people and behavior.

Social Learning



SOCIAL CONSTRUCTIONISM

"What I noticed is that there's no lines in outer space. We invent them, they're figments of our imagination. And yet, on earth we kill people over those imaginary lines."

-Rusty – Astronaut in a Pre-Lunar Mission
Quoted by Peter (Johns Hopkins)

Attitude
What we think

- What are your current beliefs about race?
- What are your current beliefs about racism?
- What are your current beliefs about racism/ethnic groups socially constructed?

Behavior
What we say

- What is your perception of stereotypes given to ethnic groups?
- Do you perceive all people of color belonging to an ethnic group?

Control
What we do

- Have your perceptions led to conscious or unconcious racism?
- Are your current beliefs helping?
- Can you change your thinking?

Social Cognition and Social Schema

Social cognition seeks to explain how the thoughts, feelings, and behavior of individuals are influenced by the actual, imagined, or implied presence of others.[1]

Unconscious cognitive processes enable humans to react quickly to incoming information by categorizing. For instance, grouping individuals by age, gender, or race. The organization of knowledge about a particular subject is referenced to as social schema.

Social schemas are interpreted by past and new experiences in the environment (i.e. family, friends, work). From the mental notes that are unconsciously embedded in an individual's schema, inference, judgments and decisions are made about a person.

Mental notes are often influenced by pre-existing judgments, whether accurate or not. This may contribute to cognitive beliefs such as stereotypes and affective feelings towards a group such as prejudice.

We are all born without any culture. We are socialized into a culture of beliefs, thoughts, feelings and norms conveyed by parents, caregivers, teachers and others. We use this data to form boundaries, categories; to shape our ideas and experiences. This data, actual or flawed determines our behavior, what we perceive and what we choose to ignore.

SOCIAL CONSTRUCTIONISM

Beyond The Classroom: Psychological Aspect of Attitudes

The common definition for "attitude" is becoming conscious of events, and having knowledge or cognizance.

A learned disposition to think, feel and behave towards a person or particular object is relatively stable, unless affected by other processes or events.[1] Not only must individuals become aware of their attitudes, there must be constant evaluation of attitudes in order to sustain positive behaviors beyond the workshop. Such a process of change consists of investigating the relationship between attitudes and behaviors.

Social Participation and Biases

Social environments largely determine what an individual perceives. Perceptions are shaped by the culture in which he or she participates. When it comes to beliefs regarding racial and ethnic equality many people may know what their opinion is; however, unconscious attitudes such as biases, constructed through social participations, are often what forms inaccurate judgments, and illogical thinking.

Biases- human tendencies to favor a person, idea, or object against another. Biased perspectives are based on predetermined mental beliefs or notions.

Implicit Racial Bias – also known as hidden bias or unconscious bias is a subtle mental attitude or bias towards a person, idea, or object that someone holds at the unconscious level. For example, an individual may consciously reject racism, but hold negative associations about a particular racial group in his/her mind unconsciously.

Microagression –ideologies, everyday, seemingly, minor, verbal, nonverbal or environmental slights delivered with or without intent among different racial groups and culture.

Break the Prejudice Habit

Devine, Forscher, Austin and Cox (2012) developed a multi-faceted prejudice habit-breaking intervention to produce long-term reductions in implicit race bias.[6]

Stereotype replacement - This strategy involves replacing stereotypical responses for non-stereotypical responses. Using this strategy to address personal stereotyping involves recognizing that a response is based on stereotypes, labeling the response as stereotypical, and reflecting on why the response occurred. Next, one considers how the biased response could be avoided in the future and replaces it with an unbiased response (Monteith, 1993). A parallel process can be applied to societal (e.g., media) stereotyping.[6]

Counter-stereotypic imaging - This strategy involves imagining in detail counter-stereotypic others (Blair et al., 2001). These others can be abstract (e.g., smart Black people), famous (e.g., Barack Obama), or non-famous (e.g., a personal friend). The strategy makes positive exemplars salient and accessible when challenging a stereotype's validity.[6]

Individuation - This strategy relies on preventing stereotypic inferences by obtaining specific information about group members. Using this strategy helps people evaluate members of the target group based on personal, rather than group-based, attributes.[6]

Perspective taking - This strategy involves taking the perspective in the first person of a member of a stereotyped group. Perspective taking increases psychological closeness to the stigmatized group, which ameliorates automatic group-based evaluations.[6]

Increasing opportunities for contact - This strategy involves seeking opportunities to encounter and engage in positive interactions with out-group members. Increased contact can ameliorate implicit bias through a wide variety of mechanisms, including altering the cognitive representations of the group or by directly improving evaluations of the group.[6]

Although thinking patterns differ from individual to individual all behavior should be moral, kind, compassionate, and supportive. Whose truth is the truth anyway?

SOCIAL CONSTRUCTIONISM

Discussion Questions:

1. What are some early memories you have of when you noticed or were informed that your were a member of a different group (i.e. white)?

2. What are some early memories you have of when you noticed or were informed that you were a person of a specific ethnic or racial group?

3. What makes you proud of being a member of that group?

Questions to ponder:

1. Name some examples where white people receive certain advantages – either unconsciously or consciously – that people of color do not receive. Are these examples of white privilege institutional or interpersonal?

2. How can people work collectively to address issues of race?

SOCIAL CONSTRUCTIONISM

Reality is socially defined. Individuals prefer that their thinking, understanding and beliefs are in sync with societal beliefs - accurate or not. Often if beliefs are confronted with conflicting ideas individuals will become uncomfortable. However, change can only happen if we step outside of our current way of thinking. We must become comfortable with being uncomfortable and challenge our ideologies of race. An awareness of how our interpretation of race are themselves reflections of history and social ideologies will help to inform the strategies needed to combat racism.

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STRUCTURAL III THINKING

BEYOND TECHNIQUE

Objectives

The purpose of this module is to:

1. Identify social factors that contribute to self-identity
2. Summarize the relationship between self and society
3. Illustrate the role of cultural transmission and social transmission on constructing identities
4. Defend an individual's perception of himself or herself

Educational Strategies

1. Interactive Internet modules
2. Oral presentation - Small Group meetings and seminars
3. Engage frontline clinicians and create a structure for peer learning

Educational Lectures

1. Race, Ethnicity, and Culture
2. Health care disparities
3. Cultural beliefs and Self Identity
4. Cultural self-awareness
5. Cross-cultural communication

Evaluation

1. Observation small group discussions
2. Self -reflection/awareness journaling & monitoring

Key Points

1. Culture is constantly in flux.
2. Culture is not static and refers to social elements, constantly subjected to new influences.
3. Culture does not conform to categories.

Outcome and Achieved Results

Be able to illustrate that culture is continuous and an individual's concept of self and identity will continue to evolve.

Overview

In the 20th century psychologists were less concerned about the social influences on self and more concerned about the science of the mind- the study of thought and learning separate from any physical or physiological accompaniments. Today, however, self and identity begin with the assumption that there is a shared relationship between the self and society.[10] The self influences society through the actions of individuals. And, reciprocally, society influences the self through its collective language and meanings.[10]

This enables a person to take the role of the other, engage in social interaction, and reflect upon oneself as an object.[9] Thus an individual's concept of self is by living and adapting to an invariably changing culture.

Elliot Arnoson (1999) provides an example of research conducted by Philip Zimbardo,Psychology Department at Stanford University, in which his students created a simulated prison The students were a group of mature, stable, intelligent men. One half of the students would be prisoners while the other half would be guards. The outcome was as such:

"At the end of only six days we had to close down our mock prison because what we saw was frightening. It was no longer apparent to us or most of the subjects where they ended and their roles began. The majority had indeed become "prisoners" or "guards", no longer able to clearly differentiate between role-playing and self. There were dramatic changes in virtually every aspect of their behavior thinking and feeling. In less than a week, the experience of imprisonment undid (temporarily) a lifetime of learning; human values were suspended, self-concepts were challenge, and the ugliest most base, pathological side of human nature surface. We were horrified because we saw some boys ("guard") treat other boys as if they were despicable animal, taking pleasure in cruelty, while other boys ("prisoners") became servile, dehumanized robots who thought only of escape, of their own individual survival, and of their mounting hatred of the guards."[2]

STRUCTURAL THINKING

A person could be a Cuban American of African descent who lived most of his or her life in a predominately Chamorro community in the Marianas Island and speaks mainly Chamoru on a daily basis. Which group does he belong to? [7]

LaViest, 2005

STRUCTURAL THINKING

Sociological Construction of Self Identity

The ability to see and understand the role that social influences information plays on self-identity is crucial. "Individuals often conflate the terms ethnicity and culture, suggesting that each is equivalent to the other".[3] A persons' ethnic background may hold similar cultural beliefs of another, but it doesn't necessarily or invariable mean they share the same cultural traits.[7] Moreover culture beliefs alone do not cause people to behave in a certain way. The underlying structure of social influence is what determines the behavior of an individual. Environment, culture and society exert tremendous influence on self-identity rather than race or skin color. As people change, move and form new groups, cultural transmission and social transmissions begins to construct new identities. The transfer of knowledge between individuals (culture transmission) and the positive adaptation of behavioral traits from one individual to another (social transmission) can change an individual's original identity.

Individuals should be understood as having various cultural identities rather than segmented parts.

Culture cannot simply package people by the languages he or she speaks, or the color of their skin. Social theorist Mary Ellen Richmond (1917) wrote: "Do different for and with different people, and study their difference".[1]

Currently, self-identity is understood on the basis of appearance, culture, nationality and so on. However, self-identity is developed as a cultural product through an individual's interaction with society and personal experience. Self-identity greatly occurs when individuals are accustomed to their biological potentials of the culture in which they participate. This culture may change numerous times throughout the life span of a person.

Key Words and Examples

Enculturation -The process by which individuals acquires their own culture.

Cultural Transmission- the transfer of knowledge between individuals.

Social Transmission - the positive adaption of behavioral traits from one to another.

Physical features such as brown eyes and dark hair may be inherited from parents, however language is acquired in the culture with other speakers and not from parental genes.

Black Cubans and Black Americans tend to share the same skin colors, "however, they are from distinct ethnic traditions, resulting in different dietary habits, thus they would have different dietary health risk profiles.[7]

STRUCTURAL THINKING

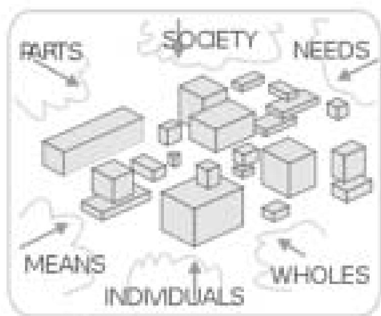
By africa, published on 04 May 2011 Stock Photo - image ID: 10040307

Systems Thinking

Conventional ways of thinking about culture are inadequate. People are not simply defined by the color of their skin then perfectly packaged into a ready-made category. People are complex systems of invisible fabrics of interrelated actions. Infinite complexities that include families, organizations, cities and nations are revealed within each individual's human identity. These invisible fabrics of interrelated actions bind individuals to a variety of cultures, allowing an individual to define his or her own identity. The problem, however, is that many organizations tend to focus solely on snapshots of isolated parts of a system and are surprised that the problem such as racism still exists. An individuals' culture is complex and not comprehensible by searching for a single cause (i.e. race) or by trying to condense individuals into separate components (i.e. categories)

STRUCTURAL THINKING

A new approach to thinking is needed one that views the relationships and interactions of people within a non-linear holistic method. Systems thinking allows for full patterns to become clearer, and assists in bringing change effectively.



Marcel Douwe Dekker (2007) based on Pierre Malotaux (1985), "Constructieleer van de mensenlijke samenwerking", in BB5 Collegedictaat TU Delft, pp. 120-147.

People as Systems

The nature of the world in which we live consists of organizations. Every participant of this world has multiple experiences of those organizations. From family to schools; churches to workplaces; charitable organizations to government agencies; sports teams to social clubs; and so on, each individual is affected by positive or negative experience involving organizations.

A social system is an organization of individuals into groups or structures that have different functions, characteristics, origin and or status. People in a society are considered organizations made up of relationships. Individuals carry their social organization systems wherever they go attaching new systems or culture along the way. Each of these organizations is made of people that have influenced an individual's self-identity.

To group an individual into one particular culture without understanding the entire context, such as social interactions, family and environment, one does not fully understand all of the factors that determine an individual's self-identity.

There are several components that make up an individual. It is not necessary to break things down to the level of cause and effect. It is necessary to look at how various components of an individual make up his or her unique culture.

Discussion Questions:

1. How do you identify yourself? Is it your sex, race or ethnicity?

2. What makes you the person that you are today?

3. Does your identity change depending on societal influences for example, projects you are involved in or whom you are with?

Questions to ponder:

1. Do we choose our identity or is it chosen for us?

2. How has minority groups identity been manipulate by outside influences such as media, technology and parody's.

Society tends to shape values, engineers a view of the world, and patterns responses to experiences. When a person participates in a broad range of activities they acquire a new knowledge of culture. Fluid environmental influences and social practices tend to transform and impact human behavior resulting in continuous development on an individual's identity. Although socialization within a specific culture and society variably shapes a person, its important to explore and challenge sets of societal meanings that individuals have attributed to themselves.

Resources:

Aronson, E., Aronson, J. (2008). *The social animal*. New York: Worth Publishers.

Hunter, M. (2011). Perpetual self conflict: Self awareness as a key to our ethical drive, personal mastery, and perception of entrepreneurial opportunities.

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A Note from the Author

The United States' increasingly diverse population will create both challenges and opportunities. Diversity will change the face of America's workplace- expanding organizations' creativity, innovation, and productivity. However, with these opportunities we must also work harder to awaken our conscience. Not only must we become aware of unconscious assumptions, behaviors and biases, we must eliminate them. Nothing is gained if our moral sensitivities, ethical precepts and humanistic values are questionable.

Cross-cultural education calls for a new way of thinking, one based on a new view of human nature and a revised conceptualization of self-identity. By eliminating the term "race" and understanding the development of self-identity, organizations and individuals will accept and appreciate the difference that exists amongst all human kind.

- ShaRae Kalian