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Building Advocacy in Healthcare: The Impact of Intergroup Dialogue on the Cultural Sensibility Outcomes of Health Profession Students Using an Individual Diversity Development Framework

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By

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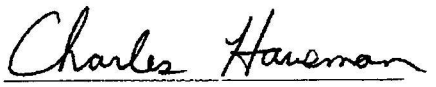

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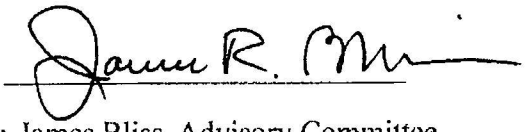

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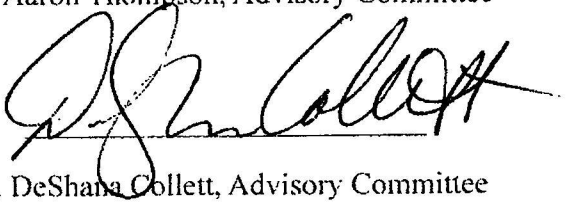

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BUILDING ADVOCACY IN HEALTHCARE: THE IMPACT OF INTERGROUP DIALOGUE ON THE CULTURAL SENSIBILITY OUTCOMES OF HEALTH PROFESSION STUDENTS USING AN INDIVIDUAL DIVERSITY DEVELOPMENT FRAMEWORK

By

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DEDICATION

My heart is so full of thanksgiving for this moment. There have been so many people that God has placed in my path to provide encouragement, inspiration, motivation, support, and love. Before I can dedicate my work to anyone on earth, I must begin with my Father in heaven. To look back over all that God has brought me through is amazing at each glance. I promised him that I would always acknowledge what HE has allowed me to accomplish. I will always keep my promise. There is no way that I would have been able to complete this work without the hand of God directing my path, removing obstacles, and allowing the impossible to be made possible. Thank you Lord for being faithful and true to your word. I will tell the world just how awesome you have been to me.

To my absolutely, charming, handsome, husband, Mr. Torrence Kantrel Douglas: I am so glad you chose me. You are the greatest support system a wife could ever ask for. Your optimism is contagious even at times when I didn't feel too optimistic. You help me see the good in everything and constantly remind me that there is light at the end of the tunnel. You did your very best to take care of me through this process, and I want you to know that I…appreciate…YOU! Now that this is behind us, we have the rest of our lives—together- before us! God couldn't have blessed me with a better partner that was more perfect for ME! Love you, sweetcake! This work is dedicated to you.

To my sweet angel, my Grandmother, Ida Mae Hutcherson: I smile as I type your name just as I do when you cross my mind. I share in this moment with you. You will always be my favorite person in the whole wide world. There is nothing that will ever change that. I look forward to the day that I can look upon your face and share a laugh or

two as if we never missed a beat. I strive to make you proud daily. I carry with me your teachings and advice always. I am forever indebted to you. Love you, Granny Ida Mae! This accomplishment is dedicated to you.

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To my two beautiful nephews, sister-in-law, and a host of aunts, uncles, and cousins: The world would be so boring without each of you in it. I thank God that he blessed me with the family that I have. You all are so supportive. When I come home, I know that I am coming to a place filled with love. I thank each of you for being who you are. This work is also dedicated to you, my loved ones.

To my best friends, Angel and Dedra: I prayed. My mother prayed. Soon, you both appeared and what a blessing you have been! I am thankful for two of the greatest friendships that I have ever had. Each of my friendships with the two of you are very

different but fulfilling all at the same time. I pray that God holds our friendships together, because I truly value each of you and what you add to my life. Thank you for your encouragement and believing in me. Now it's our time to hit the road and see "the rest" of the world! This work is dedicated to you, my dear friends.

To every young, African American student of South Fulton, TN, Fulton, KY, and the surrounding areas: I did this work for you as well. I know the feeling of growing up in small town USA and having so many goals and dreams that you could literally burst the world wide open! I urge you to push toward that dream you envisioned and that goal you set long ago. Know that you can do anything that the next person has accomplished. You are just as valuable as any other student in your classroom. Use the successful performance of your peers as your motivation…it worked for me. If you never hear an encouraging word from a teacher or even your parent, please know that I am here to uplift you. I will provide you with all of the encouraging words that you need to keep pushing toward the mark. I believe in you and your ability. Burst the world wide open with your dreams! With faith in God, you too can do the impossible just by believing in HIM.

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ABSTRACT

Racial and ethnic minorities suffer disproportionately from persistent health disparities such as heart disease, hypertension, cancer, asthma, obesity, and diabetes among others (Sullivan & Mittman, 2010). Several social inequalities influence the characteristics of minority health disparities including higher levels of poverty, insufficient education, unemployment, poor housing conditions, and lack of health insurance. However, healthcare disparities are also influential contributors to health disparities. Healthcare disparities are brought about through differences in access to or availability of quality facilities, care, and services. Given the unequal circumstances that are formed from health and healthcare disparities for minority populations, the increase in the diversity among the U.S. population poses a unique challenge for all health professions (Shaya & Gbarayor, 2006).

Research suggests that a health provider's acknowledgement of the patient's beliefs, preferences, and perspectives will positively influence the delivery of quality care, thus resulting in reducing health and healthcare inequalities. More so, every aspect of the delivery of healthcare such as patient-provider communication, delivery of health literacy, and clinical decision-making can impact the prevalence of health disparities. Data were collected from one health profession program at a coeducational, public university located in the central part of Kentucky. There were 51 first year students that participated in the study and the total population of identified first year health profession students in the selected health program was 58. Using the Framework for Individual Diversity Development, this study sought to examine the potential impact that intergroup dialogue has on the development of cultural sensibility in future healthcare providers with

the ultimate goal of continuously striving for culturally competence. The analyses revealed a statistical significance in the improvement of students' understanding of how culture influences the healthcare decision-making process and the role that cultural experiences play in their own perceptions of the healthcare system.

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CHAPTER 1: INTRODUCTION

"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane."—Martin Luther King, Jr.

The prevalence of inequalities in healthcare and health outcomes has created a great divide within our communities, and it is detrimental to the progress of our nation. As the United States increases in its variety of cultures, ethnicities, beliefs, and traditions, a means for achieving health equity across all social groups continues to present barriers, especially among socially disadvantaged groups. A social disadvantage refers to the unfavorable social, economic, or political conditions that some groups of people systematically experience based on their relative position in social hierarchies (Braveman, et al., 2011). Social disadvantage is represented by a low possession of income, wealth, educational or occupational attainment, and political or financial power. Groups that experience social disadvantage are adversely affected by healthcare and health disparities. "A health disparity refers to systematic variations in the mental or physical well-being of members of different social groups that specifically result from inequitable economic, political, social, and psychological processes" (Penner, et al., 2013). Racial and ethnic minorities suffer disproportionately from persistent health disparities such as heart disease, hypertension, cancer, asthma, obesity, and diabetes among others (Sullivan & Mittman, 2010). Several social inequalities influence the characteristics of minority health disparities including higher levels of poverty, insufficient education, unemployment, poor housing conditions, and lack of health insurance. However, healthcare disparities are also influential contributors to health

disparities. Healthcare disparities are brought about through differences in access to or availability of quality facilities, care, and services. In other words, socially disadvantaged groups experience poorer health outcomes, than socially advantaged groups due to the poorer healthcare that they receive (Penner, et al., 2013). Given the unequal circumstances that are formed from health and healthcare disparities for minority populations, the increase in the diversity among the U.S. population poses a unique challenge for all health professions (Shaya & Gbarayor, 2006).

Improving the overall health of the United States is attainable through the decrease and/or elimination of disparities among minority groups. To begin the elimination of health disparities, quality healthcare must be available and delivered to all patients despite their background and that of the health provider. When health providers are unable or unwilling to provide culturally appropriate healthcare services to patients from ethnic backgrounds due to cultural or linguistic barriers, health disparities persist. Research suggests that a health provider's acknowledgement of the patient's beliefs, preferences, and perspectives will positively influence the delivery of quality care, thus resulting in reducing health and healthcare inequalities. More so, every aspect of the delivery of healthcare such as patient-provider communication, delivery of health literacy, and clinical decision-making can impact the prevalence of health disparities. While considering the urgency of reducing health disparities and improving the health outcomes of socially disadvantaged groups, an intentional emphasis must be placed on the health provider's awareness of how culture impacts the clinical decision-making process. The extent of a provider's awareness of and sensitivity to various cultures plays

a significant role in the prevalence and prevention of health disparities. Using the Framework for Individual Diversity Development, this study seeks to examine the potential impact that intergroup dialogue has on the development of cultural sensibility in future healthcare providers with the ultimate goal of continuously striving for culturally competence.

Background

With the swift changing demographics of the United States, a focus on cultural competence is imperative to the health of minority populations and the reduction of health disparities. Cultural competence describes the ability of a healthcare system to provide quality care to patients with diverse values, beliefs, and behaviors. Betancourt et al (2003) developed a three-level framework for culturally competent care described as Organizational, Systematic, and Clinical. Each level refers to different areas of a healthcare system that must be impacted to promote true cultural competence. Organizational cultural competence refers to the importance of racial and ethnic diversity in healthcare leadership and the workforce. Minority groups currently represent more than 25 percent of the nation's population, but sadly only 10 percent of the nation's healthcare providers (Noonan, Lindong, & Jaitley, 2013). Historically, people of color have been underrepresented in all areas of health professions (Noonan, Lindong, & Jaitley, 2013).

Despite the small numbers in the health professions, African Americans, Hispanics, and Native Americans, referred to as the underrepresented minorities (URMs), are crucial providers for the nation's growing minority communities as well as

underserved populations (National Advisory Council on Nurse Education and Practice, 2001; Nnedu, 2009; Cohen, Gabriel, & Terrell, 2002). The Sullivan Commission's *Missing Persons: Minorities in the Health Professions* report, revealed that African American patients are significantly more likely to receive care from African American dentists (who treat almost 62% of African American patients) than from White dentists (who treat 10.5% of these patients) (The Sullivan Commission, 2004). Previous data also tell us that minority healthcare providers treat higher proportions of urban, less formally educated, and lower-income patients when compared with their majority peers (Mitchell & Lassiter, 2006). Cohen et al (2002) state that African American and Hispanic physicians are more likely to provide care to the poor and underserved including those patients who are on Medicaid (Cohen, Gabriel, & Terrell, 2002).

The second level of Betancourt's framework is Systematic/Structural cultural competence which ensures that the structural processes of care within a healthcare delivery system guarantee full access to quality for all patients (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). This level includes interpreter services as well as culturally and linguistically appropriate health education materials that can help to eliminate barriers to care. Recent statistics from the United States Census Bureau (2012) indicate that 12.9 percent of the population are foreign born, and 33.1 percent speak a language other than English at home (Dudas, 2012). These statistics suggest that it is increasingly important that the U.S. meet the challenge of providing services that meet the cultural and linguistic needs of our nation. The National Center for Cultural Competence (NCCC) identified several compelling reasons why healthcare systems

should focus on cultural and linguistic competence (Georgetown University Center for Cultural Competence, 2014). These reasons include:

- To understand and respond effectively to diverse belief systems related to health and well-being,
- To respond to current and projected demographic changes in the United States,
- To eliminate long-standing disparities in the health and mental health status of diverse racial, ethnic, and cultural groups, and
- To improve the quality and accessibility of healthcare services.

Linguistic competence describes the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those with low literacy skills or are not literate, and individuals with disabilities. Clearly, cultural and linguistic competence are inextricably linked (Georgetown University Center for Cultural Competence, 2014). To guide healthcare institutions and health profession schools in delivering the needed services for diverse groups, federal and state mandates were created to help govern language access for individuals with limited English proficiency and those with other diverse needs such as patients with disabilities. The federal and state mandates will be discussed in detail in Chapter 2.

The final level of Betancourt's framework is Clinical cultural competence. This level confirms the importance of sociocultural factors that can affect the clinical encounter between the patient and provider. Clinical cultural competence interventions

involve the enhancement of the provider's knowledge of the relationship between sociocultural factors, health beliefs, and behaviors and to equip providers with the tools and skills to manage these factors appropriately with quality healthcare delivery as the gold standard (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Cultural awareness is a term that is often associated with cultural competence. It can be described as knowledge of cultural similarities and differences (Dudas, 2012). Dudas states, when considering awareness, the individual must consider their own thoughts, ideas, and biases. When one believes that their own worldview is superior to another person's worldview the result is Ethnocentrism. Having ethnocentric views can infer bias that will interfere with development of cultural competence (Dudas, 2012). Dudas further explains that to understand the needs of another, one must understand oneself. Clinical cultural competence is critical due to the effects that attitudes, beliefs, and behaviors have on patients and providers. Attitudes, beliefs, and behaviors also influence the expectations that patients and providers have of each other (National Center for Cultural Competence, Georgetown University Center for Child and Human Development, 2003). As noted by Vincent and Furnham, (1997) the transaction between lay and professional parties is a matter separated by difference in power and knowledge. In order for the consultation to be a success, there must be an agreement or an understanding between the two parties about the cause, diagnosis, physiological process, prognosis and optimal treatment for the condition (Vincent & Furnham, 1997). Patient-provider relationships are affected and miscommunication happens when an understanding of each other's expectations is missing.

Purpose

The present study was designed to provide a framework for developing culturally competent healthcare systems. The researcher proposed that transformation of healthcare systems and organizations must begin with the healthcare providers that interact at multiple levels with patients from different backgrounds, thus justifying the case that healthcare providers can implement change that will impact the overall healthcare system. This study measured health professional students' ability and openness to recognize how cultural perspectives shape patient-provider interactions, affect transactions, and influence the development of culturally competence. Healthcare providers that develop the ability to provide culturally competent care by understanding how cultural beliefs and perspectives shape patient-provider interactions can become change agents and advocates for cultural competency transformations.

In order to acquire the ability to recognize the effects that cultural perspectives have in the healthcare process, healthcare providers must first have an understanding of individual diversity. Chavez et al. (2003) describes individual diversity development as: "Cognitive, affective and behavioral growth processes toward consciously valuing complex and integrated differences in others and self." (Chavez, Guido-DiBrito, & Mallory, 2003). The Individual Diversity Development Framework was selected for this study due to its focus on the growth processes of individuals learning to consciously value the differences and commonalities in others as well as self. As the individual encounters identities that are different from their own, they have the opportunity to acknowledge that each person is unique and comprised of multiple identities. The various

encounters help to impact the way in which the individual views and interprets the world, thus transitioning them through different dimensions of growth with advocacy and validation of others as the end goal.

A proven method of increasing individual diversity development has been achieved by bringing together individuals from multiple social groups and providing opportunities for dialogue across differences. Intergroup dialogue is a social justice approach that brings together a group of people from various backgrounds with the goal of creating understanding, valuing commonalities and differences, and finally facilitating action for change. Dialogue encourages listening for understanding to allow the possibilities for individuals' biases and assumptions to be challenged. This study uses the intergroup dialogue method to engage students in conversation about differences with the intent of causing cognitive dissonance in previously held inaccurate beliefs of others. An in depth overview of this educational intervention will be discussed in Chapter 3.

Significance

Health profession students that have limited contact with individuals who are different from themselves will possess inadequate experience in treating patients from diverse backgrounds. Enhancing the education of health professional students by incorporating curricula that challenges biases and inaccurate assumptions held about - others is vital for the development of cultural competence. Although cross-cultural education initiatives in health professional schools date back to the 1970's, the act of requiring cultural competency education in health professional programs is still in its beginnings. In recent years, federal and state mandates have charged educational and

healthcare institutions with implementing cultural competency healthcare initiatives; unfortunately, a lack of consensus about the type of education, training and evaluation of healthcare professionals in the provision of culturally competent healthcare exists (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006).

One issue that adds to the challenge of implementing cultural competency healthcare initiatives is the ongoing debate regarding the appropriate terminology needed in describing the essence of cultural competency. Several scholars have proposed different terms to describe cultural competence, such as intercultural competence, multicultural competence, cultural proficiency, cultural sensitivity and awareness, as well as others. More recently, Curcio et al (2014) proposed a progression from using the term cultural competency to instead using cultural sensibility. The researchers state that the previous cultural competency models focus on developing clinicians into becoming experts in particular cultures. They further suggest that students were expected to learn broad generalizations related to various cultural beliefs and practices, yet because of the complexity of culture and the many facets to one's cultural background, Curcio et al. believe that it is impossible for anyone to become *competent* in another's culture (Curcio, Ward, & Dogra, 2014). The goal for cultural sensibility was to define culture more broadly and takes into consideration a wide range of factors that make up an individual's cultural background. This term also signifies that everyone has a cultural background that guides their individual decision-making, perceptions, beliefs, and actions.

Clearly, there is no consensus on the terminology around cultural competence (Deardorff, 2011). Depending upon the discipline, the concept of cultural competence

varies, but no matter the term used for the description, the definition and outcome are extremely valuable. Cultural competency denotes the knowledge, skills, attitudes, and behaviors required of a practitioner to provide optimal services to persons from a wide range of cultural and ethnic backgrounds (Cohen, Gabriel, & Terrell, 2002). The Office of Minority Services defined cultural competence as the ability to deliver "effective, understandable, and respectful care that is provided in a manner compatible with patients' cultural health beliefs and practices and preferred language" (Anand & Lahiri, 2010). Due to the increase in minorities and immigrants across the United States, it is particularly important for healthcare professionals to be able to effectively interact with and treat patients from any background with a special emphasis on those who speak English as a second language. Doctor-patient communication is imperative to the provision of quality care. To remedy language barriers and the lack of a diverse workforce alone are just the tip of the iceberg when it comes to the elimination of racial/ethnic disparities in health. Culturally competent care is brought forth through a realization that people share unique belief systems, cultural biases, family structures, and other factors that influence how patients adhere to medical advice, trust the medical provider, and respond to treatment (Cohen, Gabriel, & Terrell, 2002; Mitchell & Lassiter, 2006).

The National Center for Cultural Competence maintains that, in order to achieve cultural competency, organizations must:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve; and
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery, and systematically involve consumers, key stakeholders, and communities. (Evans E. , 2006, p. 1)

Evans (2006) contends that as an individual or organization attempts to meet all of the above criteria, they will pass through five different levels toward achieving cultural competence indicated on the following chart.

Table 1-1

Evan's Levels of Cultural Competence

Level 1	No insight about the influence of culture on care.
Level 2	Minimal emphasis on culture in medical setting.
Level 3	Acceptance of the role of cultural beliefs, values, and behaviors on health, disease, and treatment.
Level 4	Incorporation of cultural awareness into daily practice.
Level 5	Integration of attention to culture into all areas of professional life.

Source: Evans, E. (2006). An Elective Course in Cultural Competence for Healthcare Professionals. *American Journal of Pharmaceutical Education*, 1-7.

This study will examine the impact of intergroup dialogue on the individual diversity development of health profession students. Using the Framework for Individual Diversity Development created by Chavez et al, this study will propose a look at how intergroup dialogue can increase individual diversity development, thereby increasing one's cultural competency. This researcher suggests that progressive development toward cultural competence cannot be reached by solely reading from a textbook, hearing classroom lectures or one particular experience with a culture different from one's own. Students' continual involvement in activities and interactions that challenge their personal attitudes, beliefs, and understanding of different cultures will help to better shape their diversity learning outcomes. This approach to cultural competence development will aid in producing health professionals that can move past only accepting their personal viewpoints to instead welcoming and learning from the views of others. The impact from providers' growth in cultural competency will be reflected on an individual, organizational, and structural level with the belief that each patient and provider is influenced by their own race, gender, origin, socioeconomic status, and any other dimension that make up their identity. Progression in cultural competency development will intentionally provide better quality of healthcare for patients from minority-underserved backgrounds, thus resulting in a reduction of disparities.

Theoretical Framework for Individual Diversity Development

The theoretical framework used for this study is based on a social development theory called the Individual Diversity Development Framework created by Chavez, Guido-DiBrito, and Mallory (Chavez, Guido-DiBrito, & Mallory, 2003). This model

begins with a stage of unawareness describing an individual's lack of exposure or awareness of "others", identities different from their own. The model's final stage ends with the validation of "others". The differences in the Individual Diversity Development Framework and other cultural competence development models related to is the focus on individual self-identity from the very beginning stage as well as the intended end results of advocacy for others. Further discussion of this model will take place in the following chapter.

This study will explore 1) what impact intergroup dialogue has on health profession students' awareness of individual cultural perspectives, 2) if the study participants believe that their personal perspectives guide patient/provider interactions, processes of care, and the development of quality for diverse populations, and 3) if there are particular student characteristics that influence participant outcomes.

Research Questions

This study was guided by the following research questions regarding the impact of an intergroup dialogue session on the development of cultural competence in future providers.

1. To what extent do cultural sensibility outcomes of health profession students improve by participation in "I am…" Diversity Movement workshops?
2. Are there differences in cultural sensibility outcomes of health profession students by gender for those that participate in "I am…" Diversity Movement workshops?

3. Are there differences in cultural sensibility outcome gains of males that participate in "I am…" Diversity Movement workshops compared to females?

Limitations of the Study

There are important limitations to note in this study. Often times when sensitive issues are measured such as cultural beliefs, attitudes, or behaviors, participants may provide a socially desirable response instead of an answer that reflects their true behaviors, thoughts, or actions. This study is limited to one institution in the southern part of the United States; consequently, the results may not be generalized to health professions students at other institutions. Due to the timing of this study, the diversity workshops took place during the summer academic term when the student population on a college campus is much lower resulting in a smaller sample size. The variety of health profession programs offered at the university include nursing, dentistry, public health, health sciences, pharmacy, and medical degree programs. While the study will be open to students from one particular health profession program at the university, the results will only be reflective of the participants that chose to take part in the study. The framework for this study begins with a dimension of Unawareness, however, it is important to note a worse dimension than being unaware of others and that is, being aware, yet hate individuals who are different from you. Along the same lines, the goal from participation in intergroup dialogue is for individuals to change their behavior and model a behavior of advocacy for others. Unfortunately, participants may never realize the value of those individuals that are different from themselves, therefore, these individuals may never

change their worldview nor will they willingly become advocates for others as long as they remain close-minded.

Summary

Much of the previous Organizations such as the Sullivan Commission have been very influential in making recommendations to increase minority presence in health professional schools and improve their retention efforts. While this is extremely significant, it is equally important to ensure that all healthcare professionals are able to adapt and work within diverse patient populations in order to provide quality care and continually work to transform healthcare institutions. The key to providing quality care to patients of all cultural backgrounds begins with developing skills to learn about cultural and personal beliefs in a respectful fashion (Anand & Lahiri, 2010). Although all patient populations can certainly benefit from a more diverse healthcare workforce, healthcare providers' development of an awareness and appreciation of diversity actually allows for majority professionals to reap benefits as well (Noonan, Lindong, & Jaitley, 2013; Cohen, Gabriel, & Terrell, 2002). A well- trained, qualified, culturally competent healthcare workforce would produce the highest quality of care for all patients (The Sullivan Commission, 2004).

This study will add to the large body of literature on producing culturally competent healthcare providers. Previous research and reports suggest the benefits of cultural competence in healthcare and the solution that it provides to the reduction of health and healthcare disparities. Federal mandates are in place to encourage the implementation of such programs, yet guidelines or best practices are scarce in providing

the appropriate action to take. This recommended approach moves beyond existing methods of diversity training utilized within current health professions literature where cultural competence is referenced as an outcome that occurs from one occurrence in a class, a lecture, or an activity (Bloom S. , 2005). Instead, intergroup dialogue encourages the identification of personal beliefs and attitudes, challenging participants to have continuous conversations about diversity in order to move to a level of true integration, allowing participants' behaviors to reflect their newly discovered thoughts and feelings.

By targeting health profession students from a predominately white institution within the state of Kentucky, this study tested the participants' level of cultural sensibility before intervention and after. Students participated in an intergroup dialogue session that promoted healthy dialogue and discovery of dimensions in identity, various aspects of diversity, and the results from making assumptions, as well as aspects of socialization, discrimination, and privilege. The findings from this study could impact how universities and health profession programs approach cross-cultural education to enhance the development of cultural competence in health profession students. The next chapter of this study will synthesize selected literature representing existing knowledge on the role of culture, cultural variables that impact the patient-provider relationship, an overview of intergroup dialogue and the individual diversity development framework, and finally federal and state mandates that drive healthcare systems toward becoming culturally competent.

Definition of Terms

1. *Cultural Competence*: A process of learning that leads to an ability to effectively respond to the challenges and opportunities posed by the presence of social cultural diversity in a defined social system (Achugbue, 2003).
2. *Cultural Competence in Healthcare*: The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence is described both as a vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share (Bean & Metzner, 1985).

   Cultural Competence is defined by Campinha-Bacote (2012) as a process in which the nurse strives continuously to achieve the availability and ability to effectively work within the cultural context of an individual, family, or community. Developing cultural competence is an ongoing journey that is part of the lifelong learning that is a core value of registered nurses (Hines, 2012). This definition is applicable not only to nurses but across healthcare professions.
3. *Ethnocentrism*: The practice of using a particular ethnic group as a frame of reference, basis of judgment, or standard criteria from which to view the world. Ethnocentrism favors one ethnic group's cultural norms and excludes the realities and experiences of other ethnic groups (Achugbue, 2003).

4. *Cultural Group*: The integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group (Cross, Bazron, Dennis, & Isaacs, 1989).
5. *Minority Groups*: Globally, non-Caucasians constitute a majority, thus, the term is used to refer to a variety of groups who have been disadvantaged in one way or another (Cross, Bazron, Dennis, & Isaacs, 1989).
6. *Underrepresented Minorities*: In the healthcare workforce, the underrepresented minorities are identified as African Americans, Hispanics, and Native Americans (National Advisory Council on Nurse Education and Practice, 2001; Nnedu, 2009; Cohen, Gabriel, & Terrell, 2002).
7. *Individual Diversity Development*: Cognitive, effective and behavioral growth processes toward consciously valuing complex and integrated differences in others and ourselves. This definition is provided primarily for the development of faculty, staff, and students to understand, in an ethical way, the developmental frameworks of persons with whom they interact in higher education environments (Chavez, Guido-DiBrito, & Mallory, 2003).
8. *Intergroup Dialogue*: A face-to-face facilitated conversation between members of two or more social identity groups that strive to create new levels of understanding, relating, and action (Zuniga, 2003).

CHAPTER 2: LITERATURE REVIEW

"Ultimately, people of color may face barriers that our standard quality improvement tools may not fully address. Hypothetically, and with some preliminary evidence, it seems that quality improvement efforts will need to embed components of cultural competence to truly achieve equity. This process will require creativity and innovation."—J. R. Betancourt, M. D., MPH

This chapter will begin by creating a foundation upon which culturally competent healthcare systems are developed. The review of literature begins by addressing the meaning of culture to form a deeper understanding of how an individual's cultural beliefs and values are developed, shaped, and evolved over time. Research suggests that the quality care of patients from minority populations is rendered when a healthcare provider acknowledges and strives to understand the cultural beliefs and perspectives of their patients. This study will identify the variables that impact healthcare delivery and provide a review of how the healthcare provider's own cultural background impacts the healthcare delivery process. The Individual Diversity Development Framework will be discussed in detail providing an overview of an individual's growth processes toward advocacy of others. An explanation of the intergroup dialogue intervention will present a form of cultural diversity development training that has a proven track record toward increasing cultural competence. Finally, the researcher will establish an overall framework for meeting federal, state, and organizational recommendations by beginning at the clinical level of the healthcare process.

The Development of Culture

Before beginning to detail the concept of cultural competence, one must first begin by defining culture and connecting the ways in which culture relates to healthcare. Throughout the literature, culture is frequently defined by numerous authors with varying differentiation. Campinha-Bacote (2007) uses Tylor's definition that defines culture as "that complex and whole, which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of a society." This definition possesses a broad view of culture extending beyond only focusing on race and ethnicity. Tylor defines culture by including multiple groups formed in terms of ethnicity, race, sexual orientation, language, religious affiliation, age, disability, gender, socio-economic status, and many other characteristics. Tylor's definition also allows one to believe that culture extends beyond one single identifying characteristic to actually allow an individual to belong to several different cultural and subcultural groups. Revealing another holistic definition of culture, Onyoni and Ives (2007) viewed culture as the set of distinctive, spiritual, material, intellectual, and emotional features of society or a social group. The researchers state that culture encompasses language, communication patterns, lifestyles, and practices, which are learned behaviors, value systems, traditions, and shared beliefs (Onyoni & Ives, 2007).

Brach and Fraserirector (2000) state that culture is the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (Brach & Fraserirector, 2000). Similarly, Purnell and Paulanka (2003) specified that culture is "the totality of socially

transmitted behavioral patterns, arts, beliefs, values, customs, life-ways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making" (Colleges of Nurses of Ontario, 2009; Purnell & Paulanka, 2003). Purnell and Paulanka further explain that culture can be categorized into three levels: (1) a tertiary level which is observed and is visible to outsiders, (2) a secondary level in which only members know the rules of the group and can articulate these rules to others, and finally (3) a primary level in which rules are known and observed by all on the deepest level (Purnell & Paulanka, 2003). Across all definitions, there was a core set of assumptions created: (1) culture shapes how we explain and value our world, (2) culture is the lens through which we give our world meaning, (3) culture shapes our beliefs and influences our behaviors about what is appropriate, (4) culture is learned implicitly or explicitly; and (5) culture is all the shared, learned knowledge that people in society hold (Bloom S. F., 2005).

In reviewing the various ways that culture is defined, it is clearly communicated that each individual is a member of distinct cultures and may identify with several sub-cultural groups. One's cultural beliefs, values, and practices are learned from birth and then enhanced within the home, church, educational institution, or any other environments where individuals connect and spend a great deal of time. As varying cultures interact in a certain place or environment, the opportunity for establishing a mutually satisfying relationship develops if both parties attempt to learn about one another (Purnell & Paulanka, 2003). While understanding that everyone has a dynamic culture, which changes and evolves over time as that individual evolves, there should also

be an understanding that there is no single approach to all cultures or individuals within a particular cultural group. Believing that all individuals within a particular cultural group are the same, have the same needs, and/or require the same services can easily be mistaken for stereotyping. An effective means of relating and understanding people on an individual basis has become more imperative given the growing diversity of the American society.

Culture as it Relates to Healthcare

Responding to Considering the Role of Culture in Healthcare

Minorities continue to outpace whites in growth of the U.S. population. In 2005, one-third of the nation was comprised of racially, ethnically, and culturally diverse groups. Hispanic and Latino groups were registered as the fastest growing minority group and are projected to surpass African Americans as the largest minority group by 2050 (Onyoni & Ives, 2007). Asians, Native Hawaiians, and Pacific Islanders are also projected to increase from 3.7% in 2000 to 8% by 2050. The Native American population is growing faster than the general population registering 2.6% in 1990 to 3.3% in 2005. Finally, immigration also adds to the increase of diversity in the United States. Between 1990 and 2005, the number of immigrants increased 50% (Onyoni & Ives, 2007). The anticipated demographic shifts heighten the need for healthcare providers to consider the role of culture in addressing racial/ethnic disparities in health and healthcare outcomes.

As our nation's population has become more diverse, healthcare systems and providers need to reflect on and respond to patients' varied perspectives, values, beliefs, and behaviors about health and well-being (Betancourt, Green, & Carrillo, 2002). The

concept of culture as it relates to health is critical in the delivery of quality care to all patients. Healthcare choices and outcomes must be understandable to patients in terms of their own individual culture and experiences. Healthcare providers are confronted with the need to develop cultural competencies that allow them to recognize their own cultural norms, understand the patient's viewpoint, and effectively adjust their behaviors to maximize care (Anand & Lahiri, 2004). The key to providing quality care to patients from all cultural backgrounds begins with developing skills to learn about cultural and personal belief systems. The clinical encounter can be negatively impacted by various preconceived notions, biases, and prejudices that will result in ineffective care for the patient.

> Socials issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large. Therefore, the goal of cultural competence training in healthcare should be to guide physicians in bringing these power imbalances into check. This process, consisting of ongoing self-reflection and self-critique, requires humility. In fact, the concept of "cultural competence" may be better described as "cultural humility." (Anand & Lahiri, 2004)

Recognizing and Managing Cultural Differences

An ethnocentric view describes one's idea that their own group or culture is better or more important than others (Merriam-Webster Dictionary. Purnell defines ethnocentrism as the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways (Purnell L. ,

2005). If a provider is ethnocentric, his or her interactions, diagnosis, and treatment will be skewed by their biases (Anand & Lahiri, 2004). Ethnocentrism perpetuates a dualistic attitude in which beliefs that differ greatly from one's own are viewed as strange, bizarre, or unenlightened and therefore wrong (Purnell L. , 2005). Possessing this type of belief system interferes with the quality of care provided to minority populations. Anand and Lahiri (2004) describe medical ethnocentrism as a barrier to accessing healthcare as it inhibits a health practitioner's understanding of the patient's beliefs and behaviors. Results of medical ethnocentrism could lead to the patient's refusal to communicate their beliefs or behaviors and potentially the patient's death (Anand & Lahiri, 2004).

Differences amongst cultures do exist and impact the delivery of healthcare; however, without interactions between people from varying cultures, a person may assume or generalize a characteristic of a particular person(s) is the same for their entire cultural group. To avoid generalizations and stereotyping, understanding culture and how it relates to the delivery of quality healthcare is imperative. Culture is largely unconscious but has powerful influences on health and illness (Purnell & Paulanka, 2003). Failure to recognize and manage socio-cultural differences will have significant health consequences for minority groups in particular (Betancourt, Green, & Carrillo, 2002).

Rationale for Cultural Competence

The Impact of Healthcare Providers' Biases and Assumptions in the Clinical Encounter

The impact of racism has attributed to the increase of health disparities leading to poorer health outcomes for diverse patients. The Institute of Medicine's (IOM) *Unequal*

Treatment: Confronting Racial/Ethnic Disparities in Healthcare report (2002) revealed results from a committee that examined over 100 studies assessing the quality of healthcare for various racial and ethnic minority groups. While controlling for access-related factors such as insurance status and patient income, the researchers found that the vast majority of the studies indicated that minorities are less likely than whites to receive needed medical services. Some of the studies that the IOM reviewed suggest that attitudinal behavior of minority patients may have an effect on the quality of care that they receive. While this is true for some instances, only a small number of studies suggested that minorities reject recommended treatments from healthcare providers. Instead, the IOM identified three main set of factors that may be associated with disparities in healthcare. The first set are those related to assessing the patient's needs and preferred methods of care. The second deals with the operation of the healthcare system and environmental factors such as cultural and linguistic barriers as well as where minorities tend to receive care. The final set of factors identifies discriminatory actions such as beliefs held by the provider about the behavior or health status of minorities, provider biases and patient uncertainty of care that emerges from the clinical encounters (2002).

Clinical barriers take place during the interactions between the patient and the provider. These types of barriers are said to occur when sociocultural differences between the patient and provider are not fully accepted, appreciated, explored, or understood (2003). For instance, in a study completed with adolescents, DelBello et al. found that there were no differences in psychotic symptoms among African Americans and

Caucasians, yet African American adolescents still received more antipsychotic medications. DelBello believed that one explanation for this discrepancy was that clinicians perceived African Americans to be more aggressive and more psychotic, thus prescribing them with more antipsychotic medications (Campinha-Bacote, 2007).

In a study with similar findings on healthcare provider biases, Van and Burke examined the biases of 193 provider-patient interactions with 842 patients (57% white and 43% African American) in regard to the degree to which the patient's race and socio-economic status affected physicians' perceptions of patients during the encounter. After controlling for patients' income and education levels, the researchers found that providers rated African American patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely not to comply with medical advice, and more likely to lack social support than white patients (Campinha-Bacote, 2007). These issues necessitate the importance of acknowledging and empathizing with diverse beliefs, individual preferences, and cultural influences that are prevalent amongst patients from culturally diverse backgrounds.

Gender Differences in the Processes of Care

The current study examines gender differences in health profession students understanding of the impact of culture in the healthcare delivery process. Male and female differences in their performance at health profession schools have been observed for years, yet the literature on gender differences in the processes of care is small. While research continues to relay the fact that men perform better than women on measures of basic science examinations, the research is mixed regarding the performance of women

and men in clinically based performance examinations. Most of the literature primarily discusses the impact of gender and cultural competence from the perspective of the patient. In a meta-analysis of literature performed by Roter et. al. (2002), the researchers found a consistent outline of gender differences in provider communication from the patients' perspectives. Female providers were found to be more conversational, as one would assume simply by nature, than male physicians. When exploring partnership building, which Roter et al. defined as occurring when a physician actively facilitates patient participation in the medical visit or attempts to equalize status by assuming a less dominating stance within the relationship, the researchers found that female physicians scored significantly higher in this category (Roter, Hall, & Aoki, 2002). Social conversations and positive talks with patients were also areas that female physicians were ranked significantly higher in. The findings also showed that female physicians spent a greater amount of time with their patients during the clinical encounter than male patients (Roter, Hall, & Aoki, 2002). Haist et al. had similar findings in a study that found female medical students performed better on clinical skills examinations than male students (Haist, Witze, Quinlivan, Murphy-Spencer, & Wilson, 2003). Considering these findings and the enormous impact that cultural competency has on the clinical encounter, greater research is needed to determine if there are differences in gender outcomes based on the results of diversity training techniques that focus on patient-provider communication.

A Framework of Individual Diversity Development

This study proposes that cultural diversity development of healthcare providers is crucial to the advancement of cultural competence in healthcare organizations and

systems. The researcher recommends an opportunity for change beginning with the education of health profession students within their first year of their studies. The belief is that a healthcare provider that develops greater cultural competency will be more likely and better equipped to aid in transforming entire systems due to their many interactions with patients. As quoted by Katz, "The creation of truly engaging learning communities requires individual as well as community diversity development (Chavez, Guido-DiBrito, & Mallory, 2003). Chavez et. al.'s Framework of Individual Diversity Development was chosen for this study due to its emphasis on helping student affairs and other higher education professionals, faculty, and students develop cultural competence by using self-reflection as a means of growth. Since the study focuses on health profession students, a framework in student development is fitting for this study. The researcher anticipates that this framework will be instrumental in inspiring health profession students to consider their role in addressing diversity issues in a more significant manner as well as moving toward becoming advocates for "others."

Unique in its form, this model was designed with a focus on themes and patterns identified through literature and practice versus distinct observational developmental stages that are shaped based on a single theory or practical foundation. Chavez et al created their framework with the idea of "constructivism" in mind, proposing that practice is guided by theory and theory can be created by practice. The basis for their framework encompassed three primary sources:

1. A theoretical foundation;
2. Collective work as educators, consultants, and trainers; and

3. Reflection on their personal development and the development of those they worked with as educators.

Chavez et al suggests that narrative, storytelling, and autobiographies have recently achieved legitimacy as meaningful data collection tools in educational environments, developing new knowledge based on shared stories and experiences.

The term, individual diversity development, is defined as: "Cognitive, affective and behavioral growth processes toward consciously valuing complex and integrated differences in others and ourselves." (Chavez, Guido-DiBrito, & Mallory, 2003)

In contrast to most diversity theoretical frameworks, Chavez et al's model was not created as a means to develop tolerance, sensitivity, or awareness; instead, the goal is for individuals to progressively transform their cognitive, spiritual, psychological, and behavioral abilities. Borrowing from a number of theoretical viewpoints, Chavez et al provide a holistic perspective on development centering on cognitive (the mind), affective (the heart/spirit), and behavioral (the body) characteristics.

Learning to value and choosing to validate others, as well as differences within ourselves, is unique in a sense but commonalities are typically found amongst individuals (Chavez, Guido-DiBrito, & Mallory, 2003). From birth, individuals store learned information while trying to make sense of the world. They construct their own idea of the group with which they consider the "other" based on their own experience, or lack thereof, with the group. Normally, individuals take what they have learned about groups of people, whether the information is correct or incorrect, and apply this directly to individuals, responding cognitively, affectively, and behaviorally to these generalizations.

The individual diversity development process moves participants from becoming aware of, exploring, understanding, integrating, and valuing several dimensions of otherness (Chavez, Guido-DiBrito, & Mallory, 2003) by learning that all individuals are made up of characteristics across a wide identity spectrum, some of which are familiar and those that may seem unusual (other). Individual diversity development posits that as individuals learn each person is unique and comprised of multiple identities, using generalized concepts held about groups of people are challenged (2003). Chavez et al state that individual diversity development is a sensitive process for most because discussing otherness typically makes individuals uncomfortable. This framework advocates a meaningful change that impacts the way an individual views and interprets the world. Diversity development happens over time with considerable practice from ongoing interactions with otherness. This model encourages the validation and advocacy of persons from similar and different backgrounds, cultures, and belief systems.

Chavez et al present a framework of five dimensions transitioning individuals through each as they encounter various dimensions of "otherness." Displayed in Figure 2-1, these dimensions include: unawareness, dual awareness, questioning and self-exploration, risk-taking or other exploration, and integration. While the outcome of this model is validation of others, individuals may or may not consciously choose to validate the other, but it is possible that they will make more conscious and complex choices toward better understanding diverse others (Chavez, Guido-DiBrito, & Mallory, 2003).

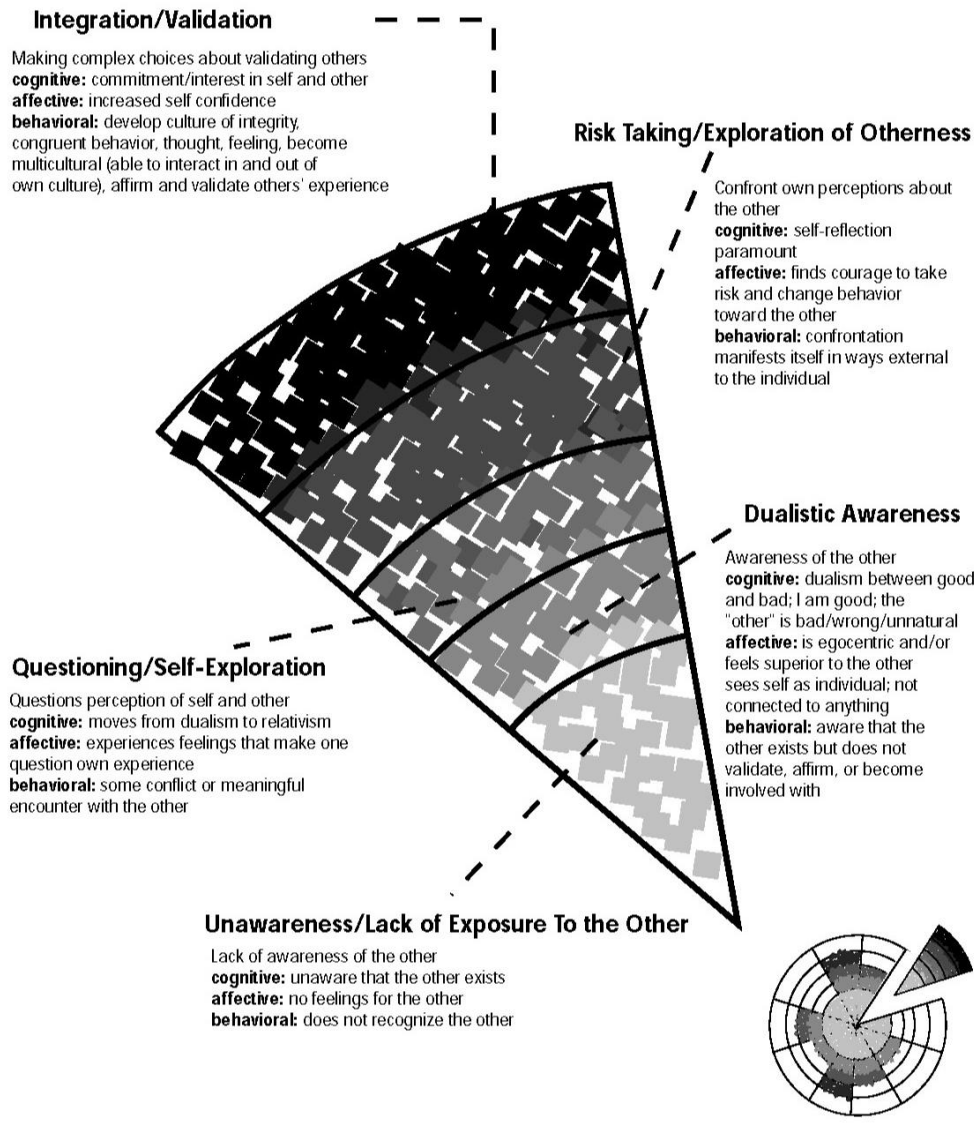

Figure 2-1. The Five Dimensions of Individual Diversity Development

Unawareness/Lack of Exposure to Other

The Unawareness/Lack of Exposure to Other dimension describes an individual that has a lack of conscious sense of a particular type of diversity (Chavez, Guido-DiBrito, & Mallory, 2003). Cognitively, individuals may be unaware of the existence of

differences or not personally had interactions with "others." Affectively, the individual has no particular type of feelings about otherness due to possessing no experience on which to base the feelings. Behaviorally, individuals may not recognize or react to differences upon experiencing them (Chavez, Guido-DiBrito, & Mallory, 2003). Chavez et al suggests that while individuals are in this dimension, they should be involved in activities that involve their emotions allowing them to reflect on common types of differences that they may be easily aware of like body type, religion, or personality.

Dualistic Awareness

An individual centered in the Dualistic Awareness dimension is aware of others, but the characteristics that are different from their own are viewed as unnatural or bad. Cognitively, differences amongst individuals are seen as "good or bad", "natural or unnatural", and "black or white." Affectively, individuals possess a sense of ethnocentrism, believing that they are superior to those that are different. They are unlikely to reflect on or examine their own beliefs in this dimension. Behaviorally, individuals in this dimension are less likely to interact with others intentionally, unless their intentions are to point out wrong, correct wrong, or hurt the others. Chavez et al recommend education that is followed by affective reinforcements for individuals in this dimension, stating that knowledge alone will not affect behavior. Feelings and thoughts on individual experiences are crucial to changing behaviors.

Questioning/Self-Exploration

Questioning/Self-Exploration is described as the most critical dimension. Perhaps, it is due to the moments of reflection that take place in individuals centered in this dimension. It is described as an integrated tool as individuals move throughout the dimensions because it produces a moment of realization that the teachings shared by an individual from a young age are now being challenged. Individuals may begin to feel as if they are betraying people from their families, communities, or social groups. Cognitively, individuals begin to recognize that their way is not the only way. Without always admitting this new reality, individuals in the Questioning dimension move from dualistic to a more relativistic perspective. Affectively, individuals experience a sense of anger and imbalance as they struggle with their new viewpoint. They may also have feelings of excitement as they gain new information about themselves and others. Behaviorally, individuals begin to do minimal exploration. Internally, they question themselves and their beliefs, but externally they may seek conversations with people with whom they feel comfortable, or observation through media. Chavez et al suggest for individuals in this dimension to use journaling as a way to make sense of their challenged beliefs and acquired information. It is also suggested that participation in small group discussions or exploration using the internet, books, and television may be beneficial.

Risk Taking/Exploration of Otherness

As individuals begin to explore and challenge their own worldview of a particular identity characteristic, they begin to move into the Risk Taking/Exploration of Otherness dimension. Experiencing feelings of discomfort is normal in this dimension. Individuals

may encounter rejection from their own communities, the "others", or both groups. Described as the most fragile dimension of all, individuals face the complex dilemma of consciously trying to understand the characteristics of others, while avoiding stereotypical views. Cognitively, reflections on careful specifics from observations and experiences are compared with their former teachings. Affectively, the individual may experience low self-esteem as they continually explore their new world, both internally and externally, while trying to discover how they fit into diversity. Behaviorally, individuals undergo an experimental process. They seek intentional interactions with others and, at some periods, may decide to leave their own culture to immerse themselves momentarily into another culture. Suggested activities involve immersing the individual into the other culture through study abroad opportunities, living and learning communities, and service learning projects. Chavez et al described a student who experienced life in a wheelchair temporarily for a class project. This student experienced moments of frustration and guilt, but also gained a new understanding and appreciation for individuals with disabilities. The Risk taking dimension may produce the beginning acts of advocacy by extending a helping hand to a member of the "other" group, but Chavez et al believe that mutual activism would be more beneficial.

Integration/Validation

The final dimension of the Individual Diversity Framework is Integration/Validation. In this dimension, individuals are able to join together their idea of self and others and actually "see" themselves and others. They have internally reconciled the notion that individuals are members of various populations but also the

fact that individuals are complex beings possessing an array of identities and traits. The Integration/Validation dimension allows individuals to understand that there are some commonalities and differences amongst all people. Cognitively, individuals within this dimension are able to understand the similarities and differences amongst people and acknowledge the rights, responsibilities, and contributions of self and others. Affectively, individuals are more secure in themselves. They display higher levels of self-esteem because they feel less threatened by differences. Chavez et al found that levels of comfort increase as individuals have more experiences with a spectrum of differences and develop a greater understanding and appreciation of others. Behaviorally, individuals develop a deep sense of integrity and interact with more confidence in and out of their own cultural group. Their thoughts, feelings, and actions are consistent, which allows individuals the capacity to affirm beliefs that are different from their own. Chavez et al state, "The deeper an individual becomes a part of this dimension, the harder it is to see any individual through only a generalized lens." Figure 2-2 provides details for how an individual can be in different dimensions of growth with various identities.

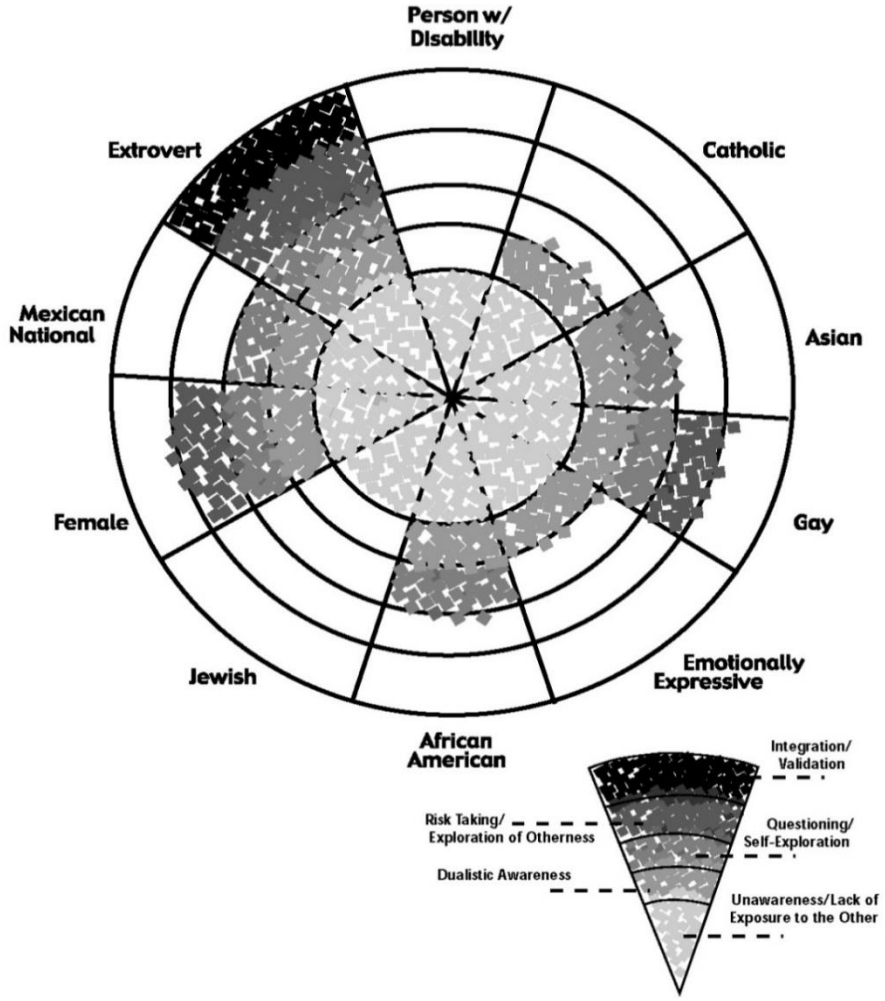

Figure 2-2. An Example of an Individual's Growth in Various Identities Using the Framework of Individual Diversity Development

Intergroup Dialogue

A proven method of fostering the individual diversity development of college students can be achieved through the use of intergroup dialogue. The University of Michigan's affirmative action case in 2003 asserted that student interactions with diverse peers encouraged each party to learn about and from one another, understand

perspectives that are brought forth through different life experiences and social backgrounds, and improve upon the cultural competence needed to transform individuals and communities (Nagda, Gurin, Sorensen, & Zuniga, 2009). Similar to the goals of this case, the Association of American Colleges and Universities established a set of initiatives with an overall goal to:

> Help students develop a sense of personal and social responsibility that involves taking seriously the perspectives of others, grounding action in ethical considerations, and contributing to the larger society. (Nagda, Gurin, Sorensen, & Zuniga, 2009, p. 4)

Intergroup dialogue is a face-to-face facilitated conversation between members of two or more social identity groups. This method of diversity learning presents a proven effective technique of engaging students in meaningful interaction across group differences (Nagda, Gurin, Sorensen, & Zuniga, 2009). Intergroup dialogue is unlike a regular discussion or debate, in that a discussion implies that information will be passed back and forth with the intention of searching for the correct answer by one party, while a debate is characterized by an exchange of opinions in an argumentative means. Intergroup dialogue, however, is facilitated in a safe yet communal space where participants are guided through a self-governing process that acknowledges and respects all parties while reconfirming the fact that change is achievable (Dessel, Rogge, & Garlington, 2006).

Dessel et al describe intergroup dialogue as a public process designed to involve individuals and groups in an exploration of societal issues such as politics, racism, religion, and culture that often present the beginnings of social conflict and polarization

(2006). The experience is designed to achieve the goal of personal and community transformation, conflict resolution, advocacy, and social change (Dessel, Rogge, & Garlington, 2006). Throughout the intergroup dialogue process, facilitators encourage strong listening skills, the importance of valuing differences, and respect for all parties involved. The dialogue sessions allow students to make sense of singular (men and women) and intersecting (men of color and white men) identities. The topics of privilege and oppression are examined to formulate examples of ways in which students can identify areas of privilege that they possess individually as well as groups who may experience forms of oppression (Zuniga, 2003).

Dialogue groups can be scheduled as standalone activities or as a portion of a course. Zuniga believed that intergroup dialogue is built upon three interconnected pedagogical processes: sustained communication, critical social awareness, and bridge building (2003). Sustained communication describes the action of conducting face-to-face conversations that welcome listening and opportunities to question information received across differences. Through sustained communication over an extended period of time, students may reach a point of discernment when realizing that privilege and oppression truly exist. This defining moment can be described as the creation of critical social awareness. After sustained communication and reaching a point of critical social awareness, bridge building could potentially come about. When students are engaged in deep dialogue across differences and become aware of and acknowledge injustice, the process of bridge building begins to occur.

Stages of Intergroup Dialogue

Intergroup dialogue involves a four-stage process where each stage builds upon on the next and provides a sequential order of movement. As a model that has been widely used and adapted, Zuniga follows suit by beginning with *Creating an Environment for Dialogue*. In the first stage, the facilitator is focused on setting norms and creating an open and inclusive atmosphere for dialogue. Ground rules are typically established during this stage, and ideas are solicited from each participant concerning the rules that should be included as an effort to create buy-in by each individual. Each participant is encouraged to become acquainted with one another by sharing their hopes, fears, and expectations from participating in the dialogue session. A confidentiality agreement is usually developed during this stage. The second stage, *Learning about Differences and Commonalities of Experience*, involves the identification of differences and similarities amongst inter- and intra-groups. Group privilege and discrimination are examined as students learn to value their own unique experiences as well as the experiences of others. During this stage, students often grapple with their sense of power if they are members of the dominant groups, while students of oppressed groups struggle with previous difficult experiences. Overall, students are directed to explore other perspectives and begin acquiring understanding of the effect that group differences have on an individual's or group's quality of life (Zuniga, 2003).

The next progression of the Intergroup Dialogue Model moves to a period of exploration known as *Exploring Conflicts and Multiple Perspectives: Dialoguing About "Hot" Topics.* In this stage, students are encouraged to share dialogue from multiple

perspectives. Hot topic, real world issues are brought forth that often produce division, but allow for students to work through their differences in a respectful, open manner. The complexity of the topic is carefully selected in order to begin with the lighter controversial topics first, and then move to the more multifaceted historical issues related to topics such as discrimination and hate crimes. Facilitators offer questions that require deeper thinking and feeling, while participants are asked to examine any conflicting feelings or thoughts that come up. A goal of stage three is for group participants to learn to engage in a supportive and nonjudgmental way when discussing controversial topics.

The final stage, *Moving from Dialogue to Action: Action Planning and Alliance Building*, identifies opportunities for students to take action and become allies for others. While building upon lessons learned in the previous three stages, participants in the final stage have acquired skills to help them develop action plans and ways to build alliances for change in the inequalities of society. They identify ways in which the inter-groups can work together to achieve helpful and productive behaviors.

Findings from utilizing intergroup dialogue suggest that analytical skills, cultural awareness, and ability to consider others' perspectives were improved amongst participants (Dessel, Rogge, & Garlington, 2006). Zuniga found that dialogue participation reduced anxiety about intergroup contact and enhanced skills related to communication across differences (2003). In a multi-university research study, Nagda et al used a mixed-methods approach to determine the effects of intergroup dialogue on student learning outcomes. An experimental group of students that participated in intergroup dialogue on race/ethnicity and gender was used, as well as a control group of

students who did not participate in dialogue discussions. A comparison group that reflected students who took social science classes on race/ethnicity and gender in a lecture/discussion format was also reviewed in this study. Each study group participated in a series of dialogues or lectures depending upon their groups' learning pedagogy. Through the use of a pre- and post-test at the beginning and end of the term, one-year longitudinal survey, and supplemental qualitative methods, Nagda et al found that intergroup dialogue produced consistent positive effects across the following measured learning outcomes: intergroup understanding (awareness and understanding of both racial and gender inequalities and their structural causes), intergroup relationships (motivation to bridge differences and increased empathy), and intergroup collaboration and engagement (motivation to take action by challenging others on derogatory comments, participating in coalitions to address inequalities, and be actively engaged in post-college communities to influence social policy) (2009). Based on these findings, educators who provide guided interactions amongst students from various cultural backgrounds offer greater opportunities to develop individual and collective efficacy to influence the world around them (Nagda, Gurin, Sorensen, & Zuniga, 2009).

The Individual Diversity Development framework and intergroup dialogue intervention selected for the current study are indeed similar in theory. As the researcher revealed, individual diversity development, intergroup dialogue, and cultural competency all encourage the continuous development toward valuing others instead of indicating that development has a point of completion (Schoem & Hurtado, 2001; Chavez, Guido-DiBrito, & Mallory, 2003; Campinha-Bacote, 2012; Anand & Lahiri, 2004). All require a

commitment to listen, challenge, reflect, and continuously seek to have experiences with others. The terms used in the chosen framework, educational intervention, and the research concept of cultural competency are synonymous. The goal of each theory is for individuals to learn how to communicate, work, and live together effectively across different cultural backgrounds minimizing opportunities for privilege, oppression, and inequalities.

Federal and State Mandates That Impact Health Profession Education and Institutions

The cultural diversity education of health professionals has been inadequate which often times leaves room for stereotyping and developing biases (Brach & Fraserirector, 2000). Without proper cross cultural training, ideas and beliefs of cultures different from one's own may never be challenged. Cultural factors related to a healthcare professional's embedded prejudices and biases can result in misdiagnosis of culturally diverse patients (Campinha-Bacote, 2007). The integration of effective diversity training throughout the education of health profession students is critical to the needs of an increasingly diverse nation.

At the present, most health professional schools have implemented some form of cultural competency training, however, the methods, activities, and ways of assessing effectiveness vary. Healthcare providers, administrators, and educators have an increased attention on cultural competence as a strategy for reducing and/or eliminating the persistence of health and healthcare disparities (Betancourt, Green, Carrillo, & Park, 2005). This is partially due to the tasks of meeting federal and state mandates.

Considering the role of federal, state, and community governments, in implementing and funding accessible healthcare for diverse populations, cultural competence is viewed as the needed method for increasing quality care for all patients (Betancourt, Green, Carrillo, & Park, 2005). As an enforcer of civil rights law, the Federal government has a pivotal role in ensuring culturally competent healthcare services (National Center for Cultural Competence, 2003). One of the first examples of federal legislation that was passed with the purpose of providing healthcare facilities to poor and underserved communities was the Hill-Burton Act of 1946. This legislative act designated funding for hospitals to be renovated and expanded throughout the country. The government invested more than $3.7 billion into this project, revitalizing general hospitals and other health care institutions (Clark, Field, Koontz, & Koontz, 1980). The next legislation to be passed was Title VI of the Civil Rights Act of 1964 which mandates that:

> No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. (National Center for Cultural Competence, 2003)

While Title VI provides a legislative foundation for the concept of cultural competency in healthcare, it does not provide discrete guidance on what it means to provide culturally competent care (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006). Title VI, the Rehabilitation Act of 1973, and the Americans with Disabilities Act together, established the concept of communication-related rights (Teitelbaum, Cartwright-Smith,

& Rosenbaum, 2012). Each legislative act extended the basis of language access and prohibited discrimination against people with disabilities.

The United States Department of Health and Human Services established the Office of Minority Health in 1986, as a response to the Secretary's Task Force Report on Black and Minority Health which documented the existence of health disparities among racial and ethnic minorities in the United States (Office of Minority Health Resource Center, 2014). In the late 1990s, attention to racial and ethnic disparities in health and healthcare in the United States increased. The Health Professions Education Partnerships Act of 1998 was passed as an effort to make provisions for the education of health providers from disadvantaged backgrounds providing opportunities for grants that were to be used to increase applicant pools, enhance academic performance, faculty development, and train all health profession students to provide quality care to diverse patients (Congress.gov, 1998).

In 1997, the Office of Minority Health released national standards known as the Culturally and Linguistically Appropriate Services (CLAS) with the purpose of providing a common understanding and consistent definitions of culturally and linguistically appropriate services in healthcare. The standards outlined language access services that must be provided by any health institutions that are recipients of federal funding (Moy & Freeman, 2014). The CLAS Standards recommend cultural competent care and support for organizations efforts in providing such care (Moy & Freeman, 2014). While the CLAS standards were primarily aimed at healthcare institutions, individual clinicians are

also encouraged to use them to make their practices more culturally and linguistically accessible (Fortier & Bishop, 2004).

More recently, the government furthered their commitment by introducing the Healthy People 2020 initiative established by the Health and Human Services Secretary's Advisory Committee. This initiative was created based on the accomplishments of Healthy People 1990, Healthy People 2000, and Healthy People 2010. The goal of this initiative was to provide science-based, 10 year national objectives for improving the health of all Americans (Healthy People.gov). The Healthy People initiatives have successfully measured the impact of prevention activities, empowered individuals to make informed health decisions, and encouraged collaborations (Healthy People.gov). In the most recent attempt to help balance healthcare inequalities, President Barack Obama passed the Patient Protection and Affordable Care Act in 2010. This act was designed to ensure that all Americans had access to health insurance (Teitelbaum, Cartwright-Smith, & Rosenbaum, 2012).

In addition to federal and state healthcare system mandates, healthcare professional associations have established their own set of standards for educational institutions to address the changing face of our country. For instance, the American Medical Association (AMA) set forth five objectives:

1. To continue efforts to inform medical schools and residency programs about cultural competency resources and encourage the use of culturally effective healthcare in their curricula;

2. To continue research into the need for and effectiveness of cultural competence training;
3. To form an expert national advisory panel of consultants who will also develop a list of resources;
4. To help physicians obtain information and/or training through an online resource database; and
5. To seek external funding for a 5-year program for promoting cultural competence in collaboration with a number of national health-related organizations-the goal being to restructure medical education and staff/faculty development programs to deliberately emphasize cultural competence as a part of professional practice (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006).

In 2000, the Liaison Committee on Medical Education (LCME) of the AAMC, the responsible party for medical school accreditation, stated:

> Faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, disease, and treatments. Medical students should learn to recognize and appropriately address gender and cultural bias in healthcare delivery, while first considering the health of their patients. (Bloom S. F., 2005)

By implementing five institutional requirements for an effective cultural competence curriculum, the AAMC developed the *Tool for Assessing Cultural Competence Training* (TAACT), which was designed to help medical schools integrate cultural competence

content into their curricula and meet LCME requirements (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006).

The American Pharmacist Association (APhA), the American Society of Health-System Pharmacy (ASHP), and the American Association of Colleges of Pharmacy (ACCP) are just a few examples of organizations that provide recommendations to address the need for cultural competence training in the workplace and academic institutions (Evans E. , 2006). The code of ethics of the Society for Public Health Education (SOPHE) has direct relevance to cultural competency training. They provide guidelines for the health professional's obligation to the public and the delivery of health education (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006). With the numerous national organizations and healthcare institutions that have provided recommendations for addressing diversity issues in healthcare, it is unlikely that all of the recommended actions can be implemented. Focusing on actions that impact the individual healthcare providers and promotes continued advocacy could advance cultural competency and influence change individually, organizationally, and systematically (Mitchell & Lassiter, 2006).

Summary

This chapter provided a foundation of literature on how healthcare systems can increase in cultural competence. By defining the role of culture in the healthcare process, cultural differences held by the provider and patient were addressed. In addition, this chapter provided literature describing cultural differences and the importance of recognizing and managing them. A review of the Individual Diversity Framework model

was presented as a theoretical focal point for the entire study. The intended outcomes of this model are closely related to the intergroup dialogue learning pedagogy that was used as the educational intervention for this study. Finally, a review of federal and state mandates provided a historical timeline of legislation that has passed for the purpose of increasing the quality health outcomes for minority populations. The literature reviewed suggested that the most appropriate starting point for maximum change to take place in the overall healthcare system begins with the healthcare provider. In the next chapter, a description of this study's educational intervention, the "I Am…" Diversity Movement Project, will be provided to illustrate how cultural competency and individual diversity development is attainable through training that involves facilitated dialogue, self-reflection, an initial focus on identity, an acknowledgement and appreciation of differences, and finally, validation of others. In addition, the research methods used in this study are delineated.

CHAPTER 3: METHODOLOGY

"Current research within leadership education and development has shown that the strongest predictor of leadership outcomes for students is engagement in socio-cultural conversations across differences."—Amy Wilson, Ph.D.

This chapter highlights the research design, a description of the diversity training, an overview of the survey instrument, and limitations of the study. A description of the identified sample, variables, and anticipated data analyses are also reviewed.

The purpose of this study is to examine 1) the impact of the intergroup dialogue on the individual diversity development of health profession students and 2) determine the effect of gender on participant outcomes. Individual diversity development will be assessed by analyzing the growth in students' cultural sensibility, openness to learn how cultural perspectives shape interactions, affect transactions, thus contributing to the overall goal of culturally competent care provided in healthcare settings. This chapter contains a description of the sample, variables, data collection, data analysis and limitations to the study.

The following questions were investigated:

1. To what extent cultural sensibility outcomes of health profession students improve by participation in "I am…" Diversity Movement workshops?
2. Are there differences in cultural sensibility outcomes of health profession students by gender for those that participate in "I am…"Diversity Movement workshops?
3. Are there differences in the cultural sensibility gains of males that participate in "I am…" Diversity Movement workshops compared to females?

Through the examination of the impact of, "I am…" Diversity Movement workshops on the development of individual diversity, a greater understanding of effective methods for training future health professionals could emerge.

Overview of the "I Am…" Diversity Movement Workshops

Diversity is often the most unanticipated topic of discussion. In fact, it is most frequently avoided in most social and work environments. There are those who have become disgruntled with various training methods discounting them as ineffective, unnecessary, and in some cases unequivocally useless. Just as organizations are met with the challenge of providing quality, culturally competent care to an increasingly diverse nation, so are higher education institutions and the ever-evolving roles of student affairs professionals. Diversity education is no longer the responsibility of select individuals on campus. The "I am…" Diversity Movement project began as a response to a need for a more innovative diversity training method. Developed in 2010, the project's founding members sought to develop a fresh, new approach to diversity training focused on the concept of diversity ownership. The "I am…" Diversity Movement was created to enhance and ignite the campus community's conversations centered on diversity that were stagnating up until this point. Their belief was that "if we all felt ownership in a diversity conversation, all would also feel more connected to diversity and inclusion outcomes" (I am...Diversity Movement, 2010).

Current research within leadership education and development has shown that the strongest predictor of leadership outcomes for students is engagement in socio-cultural conversations across differences (Wilson A. , 2012). The opportunities that educators can

provide allowing students to engage in conversation about differences can challenge students from the majority to reflect on their own experiences, potentially causing them to question previously held inaccurate beliefs (Wilson A. , 2012).

The "I am…" Diversity Movement takes workshop participants through a four-stage model of facilitated discussions beginning with a focus on identity and moving toward dialogue around diversity, inclusivity, and community. By the Identity stage being the starting point, the model reframes critical diversity and inclusion conversations by establishing a foundation of shared language and reference points (I am...Diversity Movement, 2010). Members of the majority often feel that diversity conversations do not include them because of preconceived assumptions that diversity only involves race. The "I am…" Diversity project restructures previous concepts of diversity by utilizing video narratives that showcase a spectrum of identities of people who represent an array of cultures. Narratives are captured in a variety of ways. Oftentimes, the project members may be contacted by individuals or groups wishing to share their stories. There are also moments when project members go out into the community or capture narratives from attendees at a range of events within the state of Kentucky. Video narratives allow participants to connect with "others" by identifying relatable characteristics or traits with each narrator from the beginning. After viewing a short narrative, participants are led through a series of activities to begin the discussion of identity. Typically, participants are first asked for thoughts on what stood out to them regarding the narration or narrator's appearance. By encouraging the participants to reflect on the video, they are able to find points of connection across an assortment of differences. Videos help

participants to realize the significance of making assumptions about "others." The videos also enable participants to easily develop items of reference, which helps topics of diversity become more realistic.

From this point, a conversation around identity develops. The "I am…Diversity" Movement project is grounded on the belief that by establishing a common understanding of identity first, participants can build a foundation where crucial dialogues can take place across a spectrum of diversity issues and themes (I am...Diversity Movement, 2010). The project contends that the first group dialogue session may need to carefully neglect the topic of race in an effort to meet people where they are in order to take them where they need to be (2010). Verbalized connections shared with the group helps to break down barriers allowing participants to feel comfortable and safe during discussions.

After a foundation is established from dialogue about identity, participants move into the Diversity stage. In this stage, facilitators guide the group through exercises and activities that evoke conversations around "the evolution of who is included" with a look at how a focus on minorities evolved into multiculturalism, which then changed to the term diversity. Topics of privilege and oppression are reviewed during this stage. Participants take part in discussions concerning the "Isms": racism, sexism, heterosexism or homophobia, ageism, ableism, classism, and lookism (I am...Diversity Movement, 2010). Reflections on feelings from being the "only one" are shared based on different scenarios. The goal is to show participants how easily people can be treated differently from others based on human dimensions.

As the participant moves from realizing the various dimensions of identity into a deeper understanding of diversity, they begin the stage of Inclusivity. During this stage, participants begin to recognize the importance of valuing diversity and how it relates to individual and collective productivity. This stage draws from the Ally Development model created by the "I Am..." Diversity Movement project. This model presents a four-stage process of identity development:

- Pre-awareness
    - No real awareness of the challenges
    - "Nothing's wrong!" -- "They're just complaining!"
- Encounter
    - Becoming aware of the challenges
    - Recognizing discrimination and harassment
    - Feeling guilty over not knowing what to do and/or not doing anything in the past
- Immersion
    - Getting to know people
    - Learning about their communities
    - Understanding the effects of discrimination and harassment
- Integration
    - The zenith of ally development being a social activist (I am...Diversity Movement, 2010)

This model is very similar to the Individual Diversity Framework model created by Chavez et al in that it begins with a stage of unawareness of differences, but through time, practice, encounters, and understanding, individuals move toward advocacy and validation of others. Social activism or advocacy can take place in many forms: behind

the scenes, on the periphery, and front and center. Advocating for "others" behind the scenes could involve the usage of inclusive language, improving knowledge while keeping an open mind and willingness to learn from others, or even simply voting for various policies and procedures. Advocacy on the periphery could include writing letters of support when needed, attending diversity events, and indirectly confronting jokes or negative slurs. Finally, advocacy front and center describes one's ability to directly confront jokes or negative slurs, be directly involved with changes to policy, joining support organizations, and being a visible ally (I am...Diversity Movement, 2010). Though this list is not exhaustive, participants are able to realize the ways in which they can become advocates for others in their own environments and cultural groups.

The final stage of the "I Am…" Diversity Movement model is Community. In this stage, the participant has gained a sense of understanding in how important it is for "others" to feel a sense of belonging and be fully accepted and included in the "group." The facilitator guides discussion by soliciting ways in which participants can help others. The goal of this stage is developing an understanding that differences do exist but enhanced outcomes are produced from our differences.

Context of the Study

The "I am…" Diversity Movement Workshop was taught at a public comprehensive institution within the state of Kentucky. This coeducational university provides various undergraduate, master, and doctoral programs, as well as some professional programs. Located in the Central part of Kentucky, this institution states its

commitment to diversity in their overall mission statement as well as throughout the missions of each college and campus office units.

Study Design

This study utilizes a causal comparative research design. A pre- and post-test survey method was utilized to quantify the effects of a three-hour intergroup dialogue session on the individual diversity development of first-year health profession students.

Survey

Permission was obtained from Curcio et al to use the Cultural Sensibility Survey. This survey was designed to help guide educational institutions toward developing a systematic method of educating students in terms of how cultural perspectives shape provider-patient interactions, affect transactions, and influence the development of quality healthcare (Curcio, Ward, & Dogra, 2014). Using a 6-point Likert scale, the Cultural Sensibility Survey is composed of twenty-four questions related to cultural sensibility. The first quarter of the survey identifies the cultural experiences that have the greatest impact on the student's views of the U.S. healthcare system. The remaining questions relate to students' individual views on various questions examining the role of culture in the healthcare process. Cronbach's alpha for the Cultural Sensibility Survey is .842, which indicates a high degree of internal consistency and reliability (Curcio, Ward, & Dogra, 2014). Curcio et al identified factors that group the survey's intended findings into five different areas.

1. Factor one examines students' understanding of how culture influences healthcare providers' patients in the context of healthcare decision-making and patient-provider interactions.
2. Factor two assesses students' self-awareness about the role their cultural experiences play in their own perceptions of the Healthcare system.
3. Factor three looks at students' desires to learn how culture affects the healthcare process.
4. Factor four examines students' understanding of patient behaviors that may be based upon cultural practices different from their own.
5. Factor five looks at how students self-assess their ability to identify their own unconscious biases and stereotypes.

Sample

The sample includes a cohort of first year graduate students were enrolled in a health profession program during the 2014-2015 academic year. Considering that the students had been in the health profession program for less than 6 months, this cohort was selected due to their newness in the program, low involvement with cultural competency related graduate-level coursework, and lack of engagement amongst each based on being new students. The sample includes 51 students, of whom 65% are female and nearly 93% of the class was White. The group ranged in age from 20-45. Table 3-1 illustrates general characteristics of the participants in this study.

Table 3-1

Demographic Characteristics of Study Participants (N=51)

Gender		
	Frequency	Percent
Female	33	64.7
Male	18	35.3
Total	51	100
Ethnicity		
	Frequency	Percent
Asian	1	2
Black	3	5.9
White	47	92.2
Total	51	100
Age		
	Frequency	Percent
20-25	30	58.8
26-30	13	25.5
31-35	5	9.8
36-40	1	2

Data Collection

The survey was administered during a required course for a cohort of first-year health profession students. Students were provided with an overview of the study, the informed consent document, and the survey instruments. Students were given a clear option of participating by reviewing the informed consent document before acquiring the survey instruments. If at any time a student decided not to participate after signing the

informed consent document, the student would have been given an opportunity to exit the study at that time with no negative consequences.

Variables and Measures

To examine question one regarding the extent to which individual diversity development will improve, data was reported based on the five factors of cultural sensibility. The Five Factors of Cultural Sensibility served as the dependent variables and the pre- and post-test scores were represented as independent variables. For questions two and three, which assess the effect of gender on individual diversity development gains made from pre- to post-test levels, served as the dependent variables. Mean scores were calculated from pre- and post-tests on all five factors. For question two, the post scores based on gender was assessed. To address question three, the gain scores measuring the group's progress from the pre- to the post-test was used as the dependent variable. The independent variable is gender: (female=1, male=2) for questions two and three. Due to the small amount of participants from underrepresented backgrounds, race was not considered a significant independent variable.

Factor one is made up of questions 8, 9, 10, 11, 13, 16, 18, and 21 from the Cultural Sensibility Survey. Factor two includes questions 2 through 7. Factor three includes questions 14 and 24. Factor four includes questions 15 and 19. Finally, Factor 5 includes questions 17 and 20. It is important to acknowledge that the survey used in this study was unable to measure all five dimensions of individual diversity development framework. Given the various researchers perspectives on the concept of cultural competency, the author determined difficulty in measuring the concept of cultural

competency in its entirety due to no consensus on an exact definition. Instead of attempting to measure all aspects of cultural competence, the author identified three dimensions from the framework model that were able to be measured through the Cultural Sensibility Survey. The dimensions are Dualistic Awareness, Questioning/Self-Exploration, and Risk Taking/Exploration of Otherness. The questions related to Factor Two from the survey measured the Questioning/Self-Exploration and Dualistic Awareness dimensions. Factor Three measured Risk Taking/Exploration of Otherness. Factor Four measured Dualistic Awareness. Finally, Factor Five measured both Questioning and Risk Taking. This information is indicated in Table 3-2.

Table 3-2

Individual Diversity Framework Dimensions Measured by the Cultural Sensibility Survey

Individual Diversity Framework Model	The Cultural Sensibility Survey
Unawareness/Lack of Exposure to the Other	Dimension cannot be measured by any factors.
Dualistic Awareness	Factor Two & Factor Four
Questioning/Self-Exploration	Factor Two & Factor Five
Risk Taking/Exploration of Otherness	Factor Three & Factor Five
Integration/Validation	Dimension cannot be measured by any factors.

Reliability

A reliability test was performed using Cronbach's Alpha. Tables 3-2, 3-3, 3-5, and 3-6 state that the items have a high degree of consistency given that the number is

above .65. Table 3-4 indicates a low reliability with a Cronbach Alpha of .584. In the survey instrument study performed by Curcio et al, Factor three included three questions. One question was removed from Factor three due to the specific question being unrelated to the focus of the current study. This caused the reliability to be lower.

Table 3-3

Factor One Reliability Test

Reliability Statistics

Cronbach's Alpha	N of Items
.728	9

Table 3-4

Factor Two Reliability Test

Reliability Statistics

Cronbach's Alpha	N of Items
.779	6

Table 3-5

Factor Three Reliability Test

Reliability Statistics

Cronbach's Alpha	N of Items
.584	2

Table 3-6

Factor Four Reliability Test

Reliability Statistics

Cronbach's Alpha	N of Items
.785	2

Table 3-7

Factor Five Reliability Test

Reliability Statistics

Cronbach's Alpha	N of Items
.683	2

Data Analyses

Using the Cultural Sensibility Survey, participants' openness to learning about the role culture plays in the healthcare process, awareness of how culture affects others, and awareness of how culture affects them was analyzed to examine whether an individual diversity development intervention affects the attitudes of health profession students had toward a culturally competent healthcare system (Curcio, Ward, & Dogra, 2014). Openness refers to thought processes and behavior that typically takes place during culturally diverse experiences. The Pre and Post surveys requested that each student provide personal information to create a unique identifier. Each student was asked for the first two letters of their mother's maiden name, the last two digits of the year they graduated high school or finished their GED, the number of siblings they have, and the day portion of their date of birth. Pretest and post-test survey results will be analyzed

using a paired sample t-tests for question one and independent samples t-tests for questions two and three. All analyses were conducted using SPSS 22.0.

Limitations of the Study

There are various limitations to mention with this study. First, due to the fact that this study took place at one institution in Central Kentucky, the results may not be generalized to health profession students at other institutions. Often times when sensitive issues are measured such as cultural beliefs, attitudes, or behaviors, participants may provide a socially desirable response instead of an answer that reflects their true behaviors, thoughts, or actions. Students may also experience a lack of cultural awareness, which may greatly affect the answers provided in this study. Limited students were available to participate in this study due to the timing of the diversity workshops. Workshops took place during the summer academic term when the student population on a college campus is much lower, resulting in a smaller sample size. Smaller sample sizes may lack the statistical power to find differences that actually exist. The variety of health profession programs offered at the university include nursing, dentistry, public health, health sciences, pharmacy, and medical degree programs. While the study will be open to students from one particular health profession program at the university, the results will only be reflective of the participants that chose to take part in the study. The framework for this study begins with a dimension of Unawareness, however, it is important to note a worse dimension than being unaware of others and that is, being aware, yet hate individuals who are different from you. Along the same lines, the goal from participation in intergroup dialogue is for individuals to change their behavior and model a behavior of

advocacy for others. Unfortunately, participants may never realize the value of those individuals that are different from themselves, therefore, these individuals may never change their worldview nor will they willingly become advocates for others as long as they remain close-minded. Finally, changes to beliefs, attitudes, and behaviors take place over an extended period of time. Some changes may occur after data collection but still is attributed to the intervention.

CHAPTER 4: RESULTS

Chapter 3 provided the methodology for the research study conducted amongst first year health profession students. Chapter 4 begins with a restatement of the purpose and research questions addressed for the study. The presentation of findings will be presented in this chapter and will include summaries of the frequencies of responses for the individual survey items and descriptive statistics on variables created from these items. Following a presentation of descriptive data from the Cultural Sensibility Survey, the results from the data analyses are presented as responses to the three research questions presented in Chapter 1.

The purpose of this study was to determine if students enrolled in a specific health profession program changed in their individual diversity development as a result of participation in an intergroup dialogue session. Elements of individual diversity development was assessed by analyzing changes in students' openness to consider cultural perspectives in healthcare, thus contributing to the overall goal of culturally competent care provided in healthcare settings.

The results reported in this section address the following research questions:

1. To what extent does individual diversity development of health profession students improve by participation in "I am…" Diversity Movement workshops?
2. Are there differences in individual diversity development of health profession students by gender for those that participate in "I am…" Diversity Movement workshops?

3. Are there differences in the individual diversity development gains of males that participate in "I am…" Diversity Movement workshops compared to females?

Sample Selection Process

Data were collected from one health profession program at a coeducational, public university located in the central part of Kentucky. This university holds a large focus on excellence in educating future healthcare providers for the state of Kentucky. There were 51 first year students that participated in the study and the total population of identified first year health profession students in the selected health program was 58. The study was approved by the Institutional Review Board at the University of Kentucky in partnership with Eastern Kentucky University (see Appendix A). Participants older than eighteen years of age were recruited. Only first year health profession students in a particular health profession program were recruited. Each participant made an informed decision to participate in the research study; however, individuals had the option to not participate in the study. Participants were reminded of that participation in the study was voluntary and that they could withdraw or stop taking the survey at any time. Each member of the sample population, excluding those who decided to not participate, had an equal chance of being recruited to complete a survey.

In this study, individual diversity development was determined using the Framework for Individual Diversity Development created by Chavez et al. This framework described in Chapter 2, was administered to a class of 51 first year health profession students as a pre- and post-test to determine change in individual diversity

development. Demographic questions were also administered to address the gender, age, and ethnic variables of the study, and to thoroughly describe the participants.

The individual surveys were distributed in one classroom at the beginning of a required course (one in which all of the students in this particular program were required to attend). All students in this health profession program were eligible to participate and none of the students present requested to be excused; however, there were 7 students that turned in blank surveys. A brief explanation of the purpose of the study was given a week prior to the actual study date and then again on the date of the study. The students completed the pre-test survey within a 15-minute time period. The post-test survey was completed within a 20-30-minute time frame.

Analyses of Data

The Cultural Sensibility Survey is made up of twenty-three questions that measure students' self-assessments of their knowledge about how culture affects health providers' and patients' perceptions and reactions, as well as students' understandings of how different value systems and communication styles may affect health providers' interpretation of clients' reactions and behaviors (Curcio, Ward, & Dogra, 2014). The survey looks at students' awareness of how their own culture plays into the healthcare process and assesses their abilities to apply their understanding of the effects of culture in the healthcare process to situations where the health providers' perspectives may be affected by misunderstandings. The following is a breakdown of the number of questions related to each variable of the survey instrument. Factor One: Decision Making (9), Factor Two: Self-Awareness (6), Factor Three: Desire (2), Factor Four: Understanding of

Patient Behavior (3), and Factor Five: Self-Assessment (3). For questions 2-7, the Likert scale used included the anchors: 1= Not Influential, 2= Slightly Influential, 3= Moderately Influential, 4= Influential, 5= Strongly Influential and 6= Very Strongly Influential. Questions 8-24 included a Likert scale using the following anchors: 1= Strongly Disagree, 2= Disagree, 3= Slightly Disagree, 4= Slightly Agree, 5= Agree and 6= Strongly Agree.

Students' Understanding of Cultural Influences: Item Frequencies, Factor One

Table 4-1 reflects the frequency of responses for the nine questions from the Cultural Sensibility Survey Pretest that make up the Cultural Influences and Decision-Making factor. The questions that were reversed coded are indicated by an (rc) listed beside the question. This table shows that prior to the educational intervention, (86.3%) of students agree that patients look at health problems through their own cultural lens while (88%) of students believe that healthcare providers look at health problems through their own cultural lens. When students were asked if they personally view health problems through their own cultural lens, the responses were split indicating that only (49%) of respondents believed that they did not view health problems through their own cultural lens.

Table 4-1

Factor One Relative Frequency Pretest

Survey Item for Factor One	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
Patients look at health problems through their own cultural lens.	31.4%	54.9%	7.8%	2.0%	2.0%	2.0%
Healthcare providers look at health problems through their own cultural lens.	11.8%	37.3%	39.2%	2.0%	9.8%	
I do not view the healthcare system through a culturally-biased lens. (rc)		19.6%	31.4%	23.5%	19.6%	5.9%
A healthcare provider's socioeconomic background influences how the provider perceives a patient's behavior.	3.9%	43.1%	35.3%	5.9%	9.8%	2.0%
Healthcare administrators do not look at health problems through their own cultural lens. (rc)	11.8%	45.1%	27.5%	9.8%	5.9%	

Table 4-1 (continued)

Survey Item for Factor One	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
How a healthcare provider communicates with his or her patient is not influenced by the provider's cultural background. (rc)	7.8%	58.8%	19.6%	9.8%	3.9%	
Healthcare providers belonging to racial and ethnic minorities bring culturally-biased assumptions into the provider/ patient relationship.		15.7%	37.3%	13.7%	31.4%	2.0%
White healthcare providers bring culturally biased assumptions into the provider/ patient relationship.		19.6%	35.3%	21.6%	21.6%	2.0%
How a patient communicates with his or her healthcare provider is not influenced by the patient's cultural background. (rc)	29.4%	41.2%	15.7%	3.9%	7.8%	

Table 4-2 reveals that after students participated in the intergroup dialogue intervention, (100%) of students agreed that patients view health problems through their own cultural lens. Only (4.1%) of students slightly disagreed that healthcare providers view health problems through their own cultural lens. The remaining students agreed that healthcare providers look at health problems through their own cultural lens. Interestingly, almost (70%) of students agreed that their personal views of health problems were perceived through their own cultural lens which is a dramatic increase from the pretest results.

Table 4-2

Factor One Relative Frequency Posttest

Survey Item for Factor One	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
Patients look at health problems through their own cultural lens.	36.7%	59.2%	4.1%			
Healthcare providers look at health problems through their own cultural lens.	20.4%	55.1%	20.4%	4.1%		
I do not view the healthcare system through a culturally-biased lens. (rc)	2.0%	34.7%	32.7%	20.4%	8.2%	2.0%

Table 4-2 (continued)

Survey Item for Factor One	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
A healthcare provider's socioeconomic background influences how the provider perceives a patient's behavior.	13.7%	41.2%	37.3%		3.9%	
Healthcare administrators do not look at health problems through their own cultural lens. (rc)	12.2%	51.0%	22.4%	10.2%	4.1%	
How a healthcare provider communicates with his or her patient is not influenced by the provider's cultural background. (rc)	8.3%	56.3%	29.2%	4.2%	2.1%	
Healthcare providers belonging to racial and ethnic minorities bring culturally-biased assumptions into the provider/ patient relationship.		32.7%	42.9%	12.2%	8.2%	4.1%

Table 4-2 (continued)

Survey Item for Factor One	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
White healthcare providers bring culturally biased assumptions into the provider/ patient relationship.	2.1%	67.3%	6.1%			2.0%
How a patient communicates with his or her healthcare provider is not influenced by the patient's cultural background. (rc)	24.5%	67.3%	6.1%			2.0%

Self-Awareness About the Role Culture Plays in Students' Own Perceptions of the Healthcare System: Item Frequencies, Factor Two

Table 4-3 shows that in Factor Two, which measures students' greatest influences over their view of the U.S. healthcare system, students believed their socio-economic background (54.6%) had the greatest influence over their views of the healthcare system. Students stated that their racial (74.5%) and ethnic identity (74.5%) had the least amount of influence on their views of the U.S. healthcare system. Table 4-4 reveals the post-test scores for the item frequencies of Factor Two.

Table 4-3

Factor Two Relative Frequency Pretest

Survey Item for Factor Two	Very Strongly Influential	Strongly Influential	Influential	Moderately Influential	Slightly Influential	Not Influential
Experiences from racial identity	2.0%	2.0%	21.6%	17.6%	27.5%	29.4%
Experiences from ethnic identity	2.0%	5.9%	17.6%	7.8%	31.4%	35.3%
Experiences from religious identity	9.8%	13.7%	15.7%	13.7%	15.7%	31.4%
Experiences from socio-economic background	3.9%	29.4%	21.6%	25.5%	7.8%	11.8%
Experiences from gender	2.0%	7.8%	29.4%	17.6%	17.6%	25.5%
Experiences from sexual orientation		2.0%	11.8%	7.8%	17.6%	60.8%

Table 4-4

Factor Two Relative Frequency Posttest

Survey Item for Factor Two	Very Strongly Influential	Strongly Influential	Influential	Moderately Influential	Slightly Influential	Not Influential
Experiences from racial identity	2.0%	14.3%	18.4%	20.4%	24.5%	20.4%

Table 4-4 (continued)

Survey Item for Factor Two	Very Strongly Influential	Strongly Influential	Influential	Moderately Influential	Slightly Influential	Not Influential
Experiences from ethnic identity	2.0%	12.2%	20.4%	16.3%	28.6%	20.4%
Experiences from religious identity	10.2%	18.4%	12.2%	20.4%	24.5%	14.3%
Experiences from socio-economic background	8.2%	20.4%	24.5%	20.4%	22.4%	4.1%
Experiences from gender	2.0%	16.3%	14.3%	18.4%	26.5%	22.4%
Experiences from sexual orientation		10.2%	6.1%	16.3%	20.4%	46.9%

Tables 4-5 through 4-16 show the pre- and post-test results of the frequencies of responses for Factors Three through Five. The instructions for Factors One, Three, Four, and Five of the survey were: “Please indicate the extent to which you agree with the following statements”. Instructions for Factor Two were: “Please indicate the degree to which the following influences your views about the U.S. healthcare system”. The questions that were reversed coded are indicated by an (rc) listed beside the question. Table 4-5 and 4-7 revealed before the intervention, 2% of students slightly agreed that health education should not include education about cultural issues that may arise when providing healthcare services to people from different cultural backgrounds. After the

intervention, all students slightly disagreed, disagreed, or strongly disagreed with this statement. Table 4-9 and 4-11 indicate an 11.8% increase in students that disagreed that a healthcare provider should assume that a patient's visible lack of emotion means that the patient does not feel strongly about what is being discussed.

Openness to Learning About Culture in the Healthcare Process: Item Frequencies, Factor Three

Table 4-5

Factor Three Question One Relative Frequency Pretest

Health education should not include education about cultural issues that may arise when providing healthcare services to people from different cultural backgrounds. (rc)

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly agree	1	2	2
	Slightly disagree	2	4	6
	Disagree	16	32	38
	Strongly disagree	31	62	100
	Total	50	100	

Table 4-6

Factor Three Question Two Relative Frequency Pretest

A health profession student's ability to recognize cultural diversity issues as they relate to the healthcare process should be assessed during health profession school.

		Frequency	Valid Percent	Cumulative Percent
Valid	Disagree	1	2	2
	Slightly agree	7	13.7	15.7
	Agree	25	49	64.7
	Strongly agree	18	35.3	100
	Total	51	100	

Table 4-7

Factor Three Question One Relative Frequency Posttest

Health education should not include education about cultural issues that may arise when providing healthcare services to people from different cultural backgrounds. (rc)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Slightly disagree	2	3.9	4.1	4.1
	Disagree	17	33.3	34.7	38.8
	Strongly disagree	30	58.8	61.2	100
	Total	49	96.1	100	
Missing	System	2	3.9		
Total		51	100		

Table 4-8

Factor Three Question Two Relative Frequency Posttest

A health profession student's ability to recognize cultural diversity issues as they relate to the healthcare process should be assessed during health profession school.

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly disagree	1	2	2
	Slightly agree	4	8.2	10.2
	Agree	21	42.9	53.1
	Strongly agree	23	46.9	100
	Total	49	100	

Understanding Differing Cultural Backgrounds and Healthcare Provider Perceptions About Patient Behaviors: Item Frequencies, Factor Four

Table 4-9

Factor Four Question One Relative Frequency Pretest

A healthcare provider should assume that a patient's visible lack of emotion means that the patient does not feel strongly about what is being discussed. (rc)

		Frequency	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	2	2
	Agree	1	2	3.9
	Slightly agree	2	3.9	7.8
	Slightly disagree	3	5.9	13.7
	Disagree	20	39.2	52.9
	Strongly disagree	24	47.1	100
	Total	51	100	

Table 4-10

Factor Four Question Two Relative Frequency Pretest

When a patient refuses to look his or her healthcare provider in the eyes, the provider should assume the patient is not being truthful. (rc)

		Frequency	Valid Percent	Cumulative Percent
Valid	Agree	1	2	2
	Slightly agree	2	3.9	5.9
	Slightly disagree	7	13.7	19.6
	Disagree	27	52.9	72.5
	Strongly disagree	14	27.5	100
	Total	51	100	

Table 4-11

Factor Four Question One Relative Frequency Posttest

A healthcare provider should assume that a patient's visible lack of emotion means that the patient does not feel strongly about what is being discussed. (rc)

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly agree	2	4.1	4.1
	Slightly disagree	3	6.1	10.2
	Disagree	25	51	61.2
	Strongly disagree	19	38.8	100
	Total	49	100	

Table 4-12

Factor Four Question Two Relative Frequency Posttest

When a patient refuses to look his or her healthcare provider in the eyes, the provider should assume the patient is not being truthful. (rc)

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly agree	2	4.1	4.1
	Slightly disagree	3	6.1	10.2
	Disagree	25	51	61.2
	Strongly disagree	19	38.8	100
	Total	49	100	

Identifying Own Unconscious Biases and Stereotypes: Item Frequencies, Factor Five

Table 4-13

Factor Five Question One Relative Frequency Pretest

In general, I am able to recognize when my reactions to others are based on stereotypical beliefs.

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly disagree	1	2	2
	Slightly agree	21	41.2	43.1
	Agree	26	51	94.1
	Strongly agree	3	5.9	100
	Total	51	100	

Table 4-14

Factor Five Question Two Relative Frequency Pretest

In general, I can accurately identify my culturally-biased assumptions about others who are from cultures different from my own.

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly disagree	1	2	2
	Slightly agree	25	49	51
	Agree	22	43.1	94.1
	Strongly agree	3	5.9	100
	Total	51	100	

Table 4-15

Factor Five Question One Relative Frequency Posttest

In general, I am able to recognize when my reactions to others are based on stereotypical beliefs.

		Frequency	Valid Percent	Cumulative Percent
Valid	Slightly disagree	2	4.1	4.1
	Slightly agree	15	30.6	34.7
	Agree	29	59.2	93.9
	Strongly agree	3	6.1	100
	Total	49	100	

Table 4-16

Factor Five Question Two Relative Frequency Posttest

In general, I can accurately identify my culturally-biased assumptions about others who are from cultures different from my own.

		Frequency	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	2	2
	Disagree	1	2	4.1
	Slightly agree	23	46.9	51
	Agree	22	44.9	95.9
	Strongly agree	2	4.1	100
	Total	49	100	

Individual Diversity Development Factors and Outcomes, Item Means

Table 4-17 and 4-18 display the means and standard deviations for each of the responses for Factor One of the Cultural Sensibility survey. Additionally, it shows the means (M) and standard deviations (SD) for these variables: 1= Strongly disagree, 2= Disagree, 3=Slightly disagree, 4= Slightly agree, 5= Agree, 6= Strongly agree.

Patients look at health problems through their own cultural lens. Participants responses indicated a higher posttest mean (M=5.33, SD=0.555) than the pretest mean (M=5.06, SD=.99) after participation in an intergroup dialogue session.

How a patient communicates with his or her healthcare provider is not influenced by the patient's cultural background. (rc) Participants responses indicated

a higher posttest mean (M=5.102, SD=.797) than the pretest mean (M=4.82, SD=1.16) after participation in an intergroup dialogue session.

How a healthcare provider communicates with his or her patient is not influenced by the provider's cultural background. (rc) Participants responses indicated a higher posttest mean (M=4.6458, SD=.78522) than the pretest mean (M=4.57, SD=.92) after participation in an intergroup dialogue session.

Healthcare administrators do not look at health problems through their own cultural lens. (rc) Participants responses indicated a higher posttest mean (M=4.5714, SD=.97895) than the pretest mean (M=4.47, SD=1.03) after participation in an intergroup dialogue session.

Healthcare providers look at health problems through their own cultural lens. Participants responses indicated a higher posttest mean (M=4.92, SD=.759) than the pretest mean (M=4.39, SD=1.06) after participation in an intergroup dialogue session.

A healthcare provider's socioeconomic background influences how the provider perceives a patient's behavior. Participants responses indicated a higher posttest mean (M=4.63, SD=.883) than the pretest mean (M=4.2, SD=1.1) after participation in an intergroup dialogue session.

White healthcare providers bring culturally biased assumptions into the provider/patient relationship. Participants responses indicated a higher posttest mean (M=3.98, SD=1.082) than the pretest mean (M=3.49, SD=1.1) after participation in an intergroup dialogue session.

I do not view the healthcare system through a culturally-biased lens. (rc) Participants responses indicated a higher posttest mean (M=3.9592, SD=1.07934) than the pretest mean (M=3.39, SD=1.18) after participation in an intergroup dialogue session.

Healthcare providers belonging to racial and ethnic minorities bring culturally-biased assumptions into the provider/patient relationship. Participants responses indicated a higher posttest mean (M=3.92, SD=1.077) than the pretest mean (M=3.33, SD=1.14) after participation in an intergroup dialogue session.

Table 4-17

Means and Standard Deviations for Factor One Pretest

	N	Mean	Std. Deviation
Patients look at health problems through their own cultural lens.	51	5.06	.99
How a patient communicates with his or her healthcare provider is not influenced by the patient's cultural background. (rc)	50	4.82	1.16
How a healthcare provider communicates with his or her patient is not influenced by the provider's cultural background. (rc)	51	4.57	.92
Healthcare administrators do not look at health problems through their own cultural lens. (rc)	51	4.47	1.03
Healthcare providers look at health problems through their own cultural lens.	51	4.39	1.06
A healthcare provider's socioeconomic background influences how the provider perceives a patient's behavior.	51	4.20	1.10

Table 4-17 (continued)

	N	Mean	Std. Deviation
White healthcare providers bring culturally biased assumptions into the provider/patient relationship.	51	3.49	1.10
I do not view the healthcare system through a culturally-biased lens. (rc)	51	3.39	1.18
Healthcare providers belonging to racial and ethnic minorities bring culturally-biased assumptions into the provider/patient relationship.	51	3.33	1.14

Table 4-18

Means and Standard Deviations for Factor One Posttest

	N	Mean	Std. Deviation
Patients look at health problems through their own cultural lens.	49	5.33	.555
How a patient communicates with his or her healthcare provider is not influenced by the patient's cultural background. (rc)	49	5.1020	.79700
Healthcare providers look at health problems through their own cultural lens.	49	4.92	.759
How a healthcare provider communicates with his or her patient is not influenced by the provider's cultural background. (rc)	48	4.6458	.78522

Table 4-18 (continued)

	N	Mean	Std. Deviation
A healthcare provider's socioeconomic background influences how the provider perceives a patient's behavior.	49	4.63	.883
Healthcare administrators do not look at health problems through their own cultural lens. (rc)	49	4.5714	.97895
White healthcare providers bring culturally biased assumptions into the provider/patient relationship.	48	3.98	1.082
I do not view the healthcare system through a culturally-biased lens. (rc)	49	3.9592	1.07934
Healthcare providers belonging to racial and ethnic minorities bring culturally-biased assumptions into the provider/patient relationship.	49	3.92	1.077

Table 4-19 and 4-20 display the means and standard deviations for each of the responses for Factor Two of the Cultural Sensibility survey. Additionally, it shows the means (M) and standard deviations (SD) for these variables: 1= Not influential, 2= Slightly influential, 3=Moderately influential, 4= Influential, 5= Strongly influential, 6= Very strongly influential.

Experiences arising from your racial identity: Participants responses indicated a higher posttest mean (M=2.88, SD=1.42) than the pretest mean (M=2.45, SD=1.29) after participation in an intergroup dialogue session.

Experiences arising from your ethnic identity: Participants responses indicated a higher posttest mean (M=2.82, SD=1.41) than the pretest mean (M=2.33, SD=1.38) after participation in an intergroup dialogue session.

Experiences arising from your religious identity: Participants responses indicated a higher posttest mean (M=3.27, SD=1.60) than the pretest mean (M=2.94, SD=1.75) after participation in an intergroup dialogue session.

Experiences arising from your socio-economic identity: Participants responses indicated a lower posttest mean (M=3.59, SD=1.37) than the pretest mean (M=3.61, SD=1.40) after participation in an intergroup dialogue session.

Experiences arising from your gender: Participants responses indicated an equal posttest mean (M=2.82, SD=1.47) than the pretest mean (M=2.82, SD=1.41) after participation in an intergroup dialogue session.

Experiences arising from your sexual orientation: Participants responses indicated a higher posttest mean (M=2.12, SD=1.35) than the pretest mean (M=1.76, SD=1.14) after participation in an intergroup dialogue session.

Table 4-19

Means and Standard Deviations for Factor Two Pretest

	N	Mean	Std. Deviation
Experiences from socio-economic background	51	3.61	1.40
Experiences from religious identity	51	2.94	1.75
Experiences from gender	51	2.82	1.41

Table 4-19 (continued)

	N	Mean	Std. Deviation
Experiences from racial identity	51	2.45	1.29
Experiences from ethnic identity	51	2.33	1.38
Experiences from sexual orientation	51	1.76	1.14

Table 4-20

Means and Standard Deviations for Factor Two Posttest

	N	Mean	Std. Deviation
Experiences from socio-economic background	49	3.59	1.37
Experiences from religious identity	49	3.27	1.60
Experiences from racial identity	49	2.88	1.42
Experiences from gender	49	2.82	1.47
Experiences from ethnic identity	49	2.82	1.41
Experiences from sexual orientation	49	2.12	1.35

Table 4-21 and 4-22 display the means and standard deviations for each of the responses for Factor Three of the Cultural Sensibility survey. Additionally, it shows the means (M) and standard deviations (SD) for these variables: 1= Strongly disagree, 2= Disagree, 3=Slightly disagree, 4= Slightly agree, 5= Agree, 6= Strongly agree.

Health education should not include education about cultural issues that may arise when providing healthcare services to people from different cultural

backgrounds. (rc) Participants responses indicated a higher posttest mean (M=5.57, SD=0.58) than the pretest mean (M=5.54, SD=.68) after participation in an intergroup dialogue session.

A health profession student's ability to recognize cultural diversity issues as they relate to the healthcare process should be assessed during health profession school. Participants responses indicated a higher posttest mean (M=5.35, SD=.72) than the pretest mean (M=5.16, SD=.81) after participation in an intergroup dialogue session.

Table 4-21

Means and Standard Deviations for Factor Three Pretest

	N	Mean	Std. Deviation
Health education should not include education about cultural issues that may arise when providing healthcare services to people from different cultural backgrounds. (rc)	50	5.54	.68
A health profession student’s ability to recognize cultural diversity issues as they relate to the healthcare process should be assessed during health profession school.	51	5.16	.81

Table 4-22

Means and Standard Deviations for Factor Three Posttest

	N	Mean	Std. Deviation
Health education should not include education about cultural issues that may arise when providing healthcare services to people from different cultural backgrounds. (rc)	49	5.57	.58
A health profession student's ability to recognize cultural diversity issues as they relate to the healthcare process should be assessed during health profession school.	49	5.35	.72

Tables 4-23 and 4-24 display the means and standard deviations for each of the responses for Factor Four of the Cultural Sensibility survey. Additionally, it shows the means (M) and standard deviations (SD) for these variables: 1= Strongly disagree, 2= Disagree, 3=Slightly disagree, 4= Slightly agree, 5= Agree, 6= Strongly agree.

A healthcare provider should assume that a patient's visible lack of emotion means that the patient does not feel strongly about what is being discussed. (rc) Participants responses indicated a higher posttest mean (M=5.24, SD=0.75) than the pretest mean (M=5.20, SD=1.08) after participation in an intergroup dialogue session.

When a patient refuses to look his or her healthcare provider in the eyes, the provider should assume the patient is not being truthful. (rc) Participants responses indicated a higher posttest mean (M=5.04, SD=.84) than the pretest mean (M=5.00, SD=.87) after participation in an intergroup dialogue session.

Table 4-23

Means and Standard Deviations for Factor Four Pretest

	N	Mean	Std. Deviation
A healthcare provider should assume that a patient's visible lack of emotion means that the patient does not feel strongly about what is being discussed. (rc)	51	5.20	1.08
When a patient refuses to look his or her healthcare provider in the eyes, the provider should assume the patient is not being truthful. (rc)	51	5.00	.87

Table 4-24

Means and Standard Deviations for Factor Four Posttest

	N	Mean	Std. Deviation
A healthcare provider should assume that a patient's visible lack of emotion means that the patient does not feel strongly about what is being discussed. (rc)	49	5.24	.75
When a patient refuses to look his or her healthcare provider in the eyes, the provider should assume the patient is not being truthful. (rc)	49	5.04	.84

Tables 4-25 and 4-26 display the means and standard deviations for each of the responses for Factor Five of the Cultural Sensibility survey. Additionally, it shows the means (M) and standard deviations (SD) for these variables: 1= Strongly disagree, 2= Disagree, 3=Slightly disagree, 4= Slightly agree, 5= Agree, 6= Strongly agree.

In general, I am able to recognize when my reactions to others are based on stereotypical beliefs. Participants responses indicated a higher posttest mean (M=4.67, SD=0.66) than the pretest mean (M=4.61, SD=.635) after participation in an intergroup dialogue session.

In general, I can accurately identify my culturally-biased assumptions into the provider/patient relationship. Participants responses indicated a higher posttest mean (M=4.53, SD=.644) than the pretest mean (M=4.43, SD=.84) after participation in an intergroup dialogue session.

Table 4-25

Means and Standard Deviations for Factor Five Pretest

	N	Mean	Std. Deviation
In general, I am able to recognize when my reactions to others are based on stereotypical beliefs.	51	4.61	.635
In general, I can accurately identify my culturally-biased assumptions about others who are from cultures different from my own.	51	4.53	.644

Table 4-26

Means and Standard Deviations for Factor Five Posttest

	N	Mean	Std. Deviation
In general, I am able to recognize when my reactions to others are based on stereotypical beliefs.	49	4.67	.66
In general, I can accurately identify my culturally-biased assumptions about others who are from cultures different from my own.	49	4.43	.84

Improvements in Individual Diversity Development of Health Profession Students by Participation in "I am…" Diversity Movement Workshops

For research question one, pre- and post-test scores were analyzed to evaluate whether individual diversity development improved after students participated in an intergroup dialogue session. When comparing the post-test scores to the pre-test scores, there are three possibilities for change. Scores could change in a negative direction, show no change, or change in a positive direction. Increased post-test scores indicate growth in the development of individual diversity skills. A decrease in post-test scores would suggest a decline in individual diversity development skills. No difference between the pre- and post-test scores would indicate that the intergroup dialogue session had no effect on the development of individual diversity skills.

Tables 4-27 and 4-28 display the results of paired-samples t-tests that were conducted to compare if Factors One-Five of the Five Factors of Cultural Sensibility were affected through participation in intergroup dialogue. Before completing the

intergroup dialogue session, students had a total mean score of 4.16 for Factor One, 2.67 for Factor Two, 5.31 for Factor Three, 5.07 in Factor Four, and 4.55 in Factor Five. Upon completing the session, the same group of students showed a significant increase in Factors One and Two. Factor One mean score increased to 4.58 while Factor Two mean score increased to 2.91.

Table 4-27

Paired Samples Test

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Factor One Pretest	4.16	46	.61	.09
	Factor One Posttest	4.58	46	.45	.07
Pair 2	Factor Two Pretest	2.67	49	.98	.14
	Factor Two Posttest	2.91	49	1.11	.16
Pair 3	Factor Three Pretest	5.31	48	.62	.09
	Factor Three Posttest	5.45	48	.53	.08
Pair 4	Factor Four Pretest	5.07	49	.90	.13
	Factor Four Posttest	5.14	49	.71	.10
Pair 5	Factor Five Pretest	4.55	49	.56	.08
	Factor Five Posttest	4.55	49	.57	.08

Table 4-28

Paired Differences for Factors 1-5

		Paired Differences			t	df	Sig (2-tailed)
		Mean	Std. Deviation	Std. Error Mean			
Pair 1	Factor 1 Pretest & Posttest	-.42	.48	.07	-5.98	45	.000
Pair 2	Factor 2 Pretest & Posttest	-.24	.83	.12	-2.05	48	.046
Pair 3	Factor 3 Pretest & Posttest	-.14	.58	.08	-1.61	47	.113
Pair 4	Factor 4 Pretest & Posttest	-.07	.78	.11	-.64	48	.523
Pair 5	Factor 5 Pretest & Posttest	0.0	.57	.08	0.0	48	1.000

Differences in the Individual Diversity Development of Students by Gender for Those that Participated in "I am…" Diversity Movement Workshops

For research questions two and three, independent Sample T-Tests were run to compare the post and gain scores of factors 1-5 of the Five Factors of Cultural Sensibility in males and females. For question two, the results shown in Table 4-29 revealed no significant difference in pre and posttest scores. There were no differences in individual

diversity development of health profession students by gender after participation in "I am…" Diversity Movement workshops.

Table 4-29

Independent Samples Test

		Levene's Test for Equality of Variances		t-Test for Equality of Means				
		F	Sig.	t	df	Sig (2-tailed)	Mean Diff.	Std. Error Diff.
Factor 1 Posttest	Equal variances assumed	.112	.739	1.310	45	.197	.18	.13
Factor 2 Posttest	Equal variances assumed	2.479	.122	1.021	45	.313	.35	.34
Factor 3 Posttest	Equal variances assumed	.945	.336	1.112	45	.272	.18	.16
Factor 4 Posttest	Equal variances assumed	1.687	.201	1.160	45	.252	.22	.19
Factor 5 Posttest	Equal variances assumed	1.577	.216	-.311	45	.757	-.05	.16

A presentation of the results from the t-test comparison of posttest scores by gender is located in Table 4-30.

Table 4-30

Independent t-Test for Factors 1-5 Posttest Scores by Gender

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Factor One Posttest	Female	30	4.64	.46	.08
	Male	17	4.46	.42	.10
Factor Two Posttest	Female	30	3.06	1.20	.22
	Male	17	2.71	.99	.24
Factor Three Posttest	Female	30	5.53	.49	.09
	Male	17	5.35	.61	.15
Factor Four Posttest	Female	30	5.28	.68	.12
	Male	17	5.06	.56	.13
Factor Five Posttest	Female	30	4.57	.58	.11
	Male	17	4.62	.45	.11

Differences in the Individual Diversity Development Gains of Males that Participate in "I am…" Diversity Movement Workshops Compared to Females

Research question three was analyzed using independent Sample T-Tests for all Five Factors. The T-Tests were run to compare gain scores of Factors One through Five of the Five Factors of Cultural Sensibility in males and females. The results indicated in

Table 4-31 revealed no significant difference in gain scores by gender. There were no differences in individual diversity development gains of males after participation in "I am…" Diversity Movement workshops compared to females.

Table 4-31

Participant Gain Scores for Factors 1-5

		Levene's Test for Equality of Variances		t-Test for Equality of Means				
		F	Sig.	t	df	Sig (2-tailed)	Mean Diff.	Std. Error Diff.
Factor 1 Gain	Equal variances assumed	2.334	.134	1.355	43	.183	.20	.15
Factor 2 Gain	Equal variances assumed	.011	.916	-.082	43	.935	-.02	.26
Factor 3 Gain	Equal variances assumed	2.293	.137	-.707	43	.483	-.13	.18
Factor 4 Gain	Equal variances assumed	.763	.387	.108	43	.914	.03	.25
Factor 5 Gain	Equal variances assumed	.004	.950	.774	43	.443	.13	.17

A presentation of the results from the t-test comparison of gain scores by gender is located in Table 4-32.

Table 4-32

Independent Samples t-Test Factors 1-5 Gain Scores by Gender

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Factor One Gain	Female	29	.49	.53	.10
	Male	16	.29	.36	.09
Factor Two Gain	Female	29	.27	.82	.15
	Male	16	.29	.89	.22
Factor Three Gain	Female	29	.12	.53	.10
	Male	16	.25	.68	.17
Factor Four Gain	Female	29	.12	.69	.13
	Male	16	.09	.97	.24
Factor Five Gain	Female	29	.07	.55	.10
	Male	16	-.06	.54	.14

CHAPTER 5: DISCUSSION

"The creation of truly engaging learning communities requires individual as well as community diversity development."—Judith H. Katz, Ph.D.

Overview

The present study focused on questions regarding the individual diversity development of health profession students. This chapter presents the findings of three research questions that guided this study, provides a summary of the study, a discussion of the findings of the research, and implications for practice and future research. The study involved a critical look at the concept of cultural competency and the effect that intergroup dialogue has on individual diversity development. The results of this study provide imperative information to help health profession school administrators, faculty, and staff make informed decisions regarding effective cultural competency training methods. Analyses related to research question one examined the improvement in individual diversity development of health profession students that participated in the "I am…" Diversity Movement workshop. Question two analyses examined the differences by gender of the students that participated in the workshop. Finally, question three focused on the differences in gain scores of the male and female students that participated in the workshop. This chapter concludes with recommendations for practice, policy, and future research.

Summary of the Study

The overall goal of this study was to determine the effect of an intergroup dialogue session on the development of cultural competency in health profession

students. Many authors agree that cultural competency development begins with an awareness of self and the perspectives of others. (Tervalon & Murray-Garcia, 1998) When health providers are unaware of the effects that their own cultural biases and assumptions can have on the clinical encounter as well as failing to take into consideration the beliefs and preferences of their patients, healthcare disparities may be created. The study was designed to assess the effectiveness of an intergroup dialogue intervention by measuring particular dimensions of the individual diversity framework in first year health profession students. The survey used for this study was knowledge based. Though research indicates that knowledge is necessary for increased cultural competency development, knowledge without a change in attitude or behavior will not produce the needed results for positive change. The goal is for these findings to be useful in implementing the appropriate intervention into educational curriculum to initiate positive change in the cultural competency development of health profession students.

The analyses of results revealed a statistical significance in the improvement of students' understanding of how culture influences the healthcare decision-making process and the role that their cultural experiences play in their own perceptions of the healthcare system. Given the persistence of health disparities and the federal mandates placed on health profession programs, it is vital for administrators to place considerable efforts on programs that offer proven measures of success in positively developing its students. In addition to examining the impact of intergroup dialogue on the individual diversity development of health profession students, this study provides insight on health

profession students' openness to learning about others which begins the initial, ongoing journey toward cultural competence.

Findings

Factor One of the Cultural Sensibility Survey focused on students' understanding of how healthcare providers, patients, and health profession students view the role of culture in the healthcare process. The highest means of the posttest survey revealed students agreeing more that patients view the healthcare system through their own cultural lens (M=5.33, SD=.555). Interestingly, the lowest means from Factor One are all related to cultural lens from a racial perspective. The statements: "White healthcare providers bring culturally-biased assumptions into the provider/patient relationship" (M=3.98, SD=1.082) and "Healthcare providers belonging to racial and ethnic minorities bring culturally-biased assumptions into the provider/patient relationship" (M=3.92, SD=1.077) were among the lowest ranked means. Students were less likely to agree with the impact that race had on the healthcare process. More so, even though the majority of students believed that patients viewed the healthcare system through their own cultural experiences, in contrast, they were less likely to agree that healthcare providers did so as well. As future healthcare providers, the following statement presented an interesting discovery: "I do not view the healthcare system through a culturally-biased lens" (M=3.9592, SD=1.07934). Students were less likely to acknowledge that they personally used cultural biases in their view of healthcare. From a practical standpoint, these results could be problematic for the patient-provider relationship. By stating that healthcare providers are less likely to use their personal cultural experiences in the healthcare

process, as compared to patients, the conclusion could be drawn that participants feel as if healthcare providers are better at keeping their assumptions and biases in check. If this observation is correct, then students may not feel the need to improve their cultural competency because they believe that the patient is more culturally biased than the healthcare provider.

Factor Two measured the students' self-assessment of whether experiences arising from their own cultural backgrounds influenced their view of the U.S. healthcare system. Students were asked about their experiences in relation to their racial, ethnic, and religious identities as well as their gender, socioeconomic status, and sexual orientation. The results related to religious experiences were intriguing. Ranked pre (M=2.94. SD=1.75) and posttest (M=3.27, SD=1.60) means showed that students placed a high emphasis on experiences arising from their religious identity. It is possible that students were driven from a moral standpoint according to their value system in regards to their view of the U.S. healthcare system. Future studies could be explored concerning how religious beliefs dictate healthcare providers' views of the healthcare process. Surprisingly, on both the pre (M=2.45, SD=1.29) and posttest (M=2.88, SD=1.42) means racial and ethnic identity were ranked amongst the lowest. A factor that may account for this result is the demographics of the sample. With at least 90% of the student sample identifying as White, research states that students from a dominant background would be less likely to acknowledge their race or ethnicity as a salient factor in their cultural lens. This information is parallel with the research that Brown et al revealed regarding White

Americans having difficulty viewing themselves as members of a cultural group (Brown, Thomas, & Yonker, 1996).

Factor Three was related to students' openness to learning about the role culture plays in the healthcare process. Students strongly agreed that health education should include cultural issues that may arise when providing healthcare services to people from different cultural backgrounds (M=5.57, SD=.58). Students also strongly agreed that health profession students' ability to recognize cultural diversity issues related to the healthcare process should be assessed in health profession school (M=5.35, SD=.72). While this is positive information that students believe that they should be educated on cultural competency, there seems to be a disconnect between the results of Factor One, which revealed that students tend to have a strong disagreement with viewing the healthcare process using their own cultural experiences.

Factor Five assessed students' openness and willingness to identify their own unconscious biases and stereotypes. There was no significant movement between the pre and posttest scores measuring whether students were able to recognize when their reactions to others were based on stereotypical beliefs and when measuring students' ability to identify culturally-biased assumptions in the patient/provider relationship. These results show that while the intervention had very little effect on the students' ability to recognize stereotyping, more cultural competency training is needed to positively impact this issue.

Research Question #1

The first research question examines whether individual diversity development improves by participation in the "I am…" Diversity Movement workshop. The study revealed significant results for Factor One which measures the students' understanding of how culture influences the perceptions, views, and communication for health providers and clients. Factor One also looks at students' understanding of the fact that all providers, regardless of race or ethnicity, bring culturally-biased assumptions to the patient-provider relationship. It brings to light students' perceptions of whether they, as future health providers, bring culturally-biased assumptions to the healthcare process.

A paired samples t-test was used to examine if Factors One-Five were affected through participation in the intergroup dialogue session. The study revealed significant change for Factor One ($t=-5.98$, $p<.000$) and Factor Two ($t=-2.05$, $p<.046$). Posttest results for Factor One showed that students increased their understanding of the impact that cultural influences have on the healthcare decision-making process. For Factor Two, the results revealed that students increased their ability to assess their awareness of the role that culture plays in their perception of the healthcare system. These findings are consistent with existing research regarding increased awareness outcomes in students who participate in intergroup dialogue (Workmeister Rozas, 2007; Zuniga, 2003; Nagda, Gurin, Sorensen, & Zuniga, 2009). For example, Humphreys (2012) reported on a study performed by Nagda et al which revealed that 93% of 175 students participating in intergroup dialogue identified the most important learning in the course consisted of self-awareness, including the development of taking on and learning experiences from the

perspectives of other social groups; increased awareness of social inequality; and a deeper consciousness of how social group membership impacts one's own personal identity (Humphreys, 2012).

The results of the paired samples t-test for Factor Three through Factor Five were statistically insignificant in this study. The means of the pretest for Factors Three and Four were above 5.00. With a mean this high, there is less room for growth causing what some researchers refer to as a ceiling effect. This result could be more of a function of the statistic instead of a true assessment of the program. Another point to mention is in regards to Factor One and Two. Since the results of the posttest for Factor One and Two significantly increased an interesting assessment could be made to determine if there were aspects about these two factors in particular that allowed change to take place at a quicker pace than in Factor Three-Five. Regardless of the statistical gains in Factors One and Two, it is important to mention that there is still room for improvement since the majority of the means for these two factors rank below 4.00. In Factor Five, there was hardly any movement, however the questions for this factor were more targeted toward the student's personal ability to identify stereotypes and assumptions whereas the questions from the other factors are more generally focused on the provider and patient. This finding relates back to the previous finding in this study where students were less likely to acknowledge that they personally used cultural biases in their view of healthcare.

Research Questions #2 and #3

For research question two, an independent samples t-test was employed for each of the Five Factors of Cultural Sensibility to measure the differences in pre and posttest scores of individual diversity development between male and female students that participated in the "I am…" Diversity Movement workshop. The test revealed that there were no significant differences by gender in individual diversity development pre and posttest scores. For research question three, an independent samples t-test was conducted for each of the Five Factors of Cultural Sensibility to measure the differences in pre and posttest gain scores of individual diversity development between male and female students that participated in the workshop. Again, there was no significant difference in pre and posttest gain scores between men and women that participated in the workshop. This information is somewhat unanticipated due to the fact that more likely than not, research indicates that men express higher levels of intolerance, greater endorsements of social dominance, and negative evaluations of policies designed to promote increased representation in the workplace (Neville, Lewis, Poteat, & Spanierman, 2014). Yet, this study revealed no significant differences in regards to gender.

It is possible that race played a factor in the results since White students accounted for almost 93% of the study population. Brown et al states that most often White Americans see themselves as simply being an American or a person with no regard for race (Brown, Thomas, & Yonker, 1996). Brown et al continue to explain that White counselors are typically less likely to recognize and understand the worldviews and perspectives of clients who embrace their racial identity which can produce

misinterpretations and misunderstandings in the healthcare process. Patients who embrace various aspects of their culture with special emphasis on their racial identity may experience challenges with a health provider that has a monocultural worldview (Brown, Thomas, & Yonker, 1996).

Federal and state mandates have established directives for health providers to actively integrate knowledge, attitudes, and behaviors that address diversity and cultural competency. However, the literature continues to identify inconsistencies in the implementation of diversity training efforts. The implications from this study suggest that intergroup dialogue had a positive effect on the individual diversity development of first year health profession students. However, the study also implies that gender did not play a factor in the effect of intergroup dialogue on the individual diversity development of participants. Contributing to the body of intergroup dialogue research, the present study shows that integrating cultural competence learning with intergroup dialogue can enhance students' understanding of the impact of cultural influences. Therefore, understanding how intergroup dialogue influences participants to engage with one another across cultural differences is key, since interactions are crucial elements in an individual's diversity development process. Tervalon and Garcia (1998) state that opportunities to engage in an ongoing, courageous, and honest process of self-critique and self-awareness of physician trainees should be at the heart of the education process (Tervalon & Murray-Garcia, 1998). Not only would increased cultural competency benefit the individual students, future patients and healthcare systems would also reap the benefits as well from increased cultural competency. Therefore, it is recommended that administrators review

their current cultural competency pedagogy and implement multiple opportunities for intergroup dialogue to be facilitated amongst students starting with their first year. A step in this direction would help educational institutions move toward successfully meeting the requirements and recommendations of federal and state mandates.

Implications for Practice

The findings of this study suggest that the inclusion of intergroup dialogue sessions in the curriculum is important to the development of cultural competence skills in students. Results from this study show that students are aware that culture impacts the healthcare decision-making process. Students indicated positive results in regards to health education including cultural issues that may arise when providing services during the healthcare process. An intentional focus on cultural competence training at health profession educational institutions is imperative and ultimately has a direct impact on future healthcare providers. In the context of race, ethnicity, class, sexual orientation, and other diverse factors, health professionals must be taught to repeatedly identify and correct power imbalances with humility and sensibility (Tervalon & Murray-Garcia, 1998). Therefore, engaging students in structured activities that challenge their personal beliefs and values system allowing for power imbalances to be corrected is of great value to the healthcare system as a whole. As Anand and Lahiri (2004) indicate, healthcare workers are confronted with the need to develop cultural competencies that allow them to recognize their own cultural norms, understand the patient's viewpoint, and effectively adjust their behaviors to maximize care. Not only would an increase in cultural competence impact the student's individual diversity development, patients would reap

the benefits of effective clinical encounters that actually help to maximize care, furthermore, health profession institutions would be better capable of implementing more intentional strategic tactics toward meeting the federal and state mandates that have been set regarding cultural competency. It is recommended that health profession institutions modify their cultural competency training methods and curriculum to include opportunities for facilitated intergroup dialogue sessions. Based on the results of this study, it is suggested that healthcare providers that participate in intergroup dialogue have a greater openness to understanding the influence of culture in the healthcare decision-making process as well as a greater sense of assessing the role that their own culture plays in their perceptions of the system.

For intergroup dialogue to truly be effective at challenging cultural biases and assumptions, research states that it is important to have participants that are reflective of at least two or more social identity groups. The small number of minority participants precluded the ability to examine race as a factor. As mentioned previously, the majority of the sample was White. This is due to the racial make-up of the state, community, and student population at the institution. Due to the demographic make-up of the students in this particular program at the university, this result was expected. Though most intergroup dialogues focus on discussions of race, Schoem and Hurtado (2001) reveal that multiple issues of social identity that extend beyond race should be discussed. Even though most dialogues bring together two or more groups of people to discuss issues of conflict, there is also a need for intragroup dialogues that bring together individuals from several different subgroups that are a part of the same larger identity group (Schoem &

Hurtado, 2001). Dialogues can also take place for a group that has individuals represented from many different backgrounds such as a dialogue with community leaders. The outcomes of these types of dialogue sessions are just as impactful as dialogue sessions that happen amongst two identity groups.

In the case of this study, it is recommended for future practice that a more racially diverse sample be selected to enhance the dialogue of the intergroup session but in order for this to happen, educational institutions must diversify their programs. Previous literature has shown that 28% of the US population is made up of minorities, yet the numbers in health profession institutions is staggering (Betancourt, Green, & Carrillo, 2002). Without the capability of providing an opportunity for various racial identities to interact, it is impossible to challenge preconceived beliefs and ideas related to race and ethnicity. As indicated by Katz in Chavez et al, (2003) development of the Individual Diversity model, the creation of truly engaging learning communities requires individual as well as community diversity development. When students are engaged in deep dialogue across differences and become aware of and acknowledge injustice, the process of bridge building begins to occur (Chavez, Guido-DiBrito, & Mallory, 2003). Existing research also shows that students who interact with those that are different from their own background will inspire individual diversity development (Schoem & Hurtado, 2001).

Implications for Policy

On some college campuses, intergroup dialogue sessions are co-led by two trained facilitators who identify with each social group involved in the dialogue session. These facilitators are typically trained peers, graduate students, faculty and student affairs staff

members. Therefore, a required training should be implemented for those who will employ the intergroup dialogue intervention with students. Though knowledge of various cultural groups is discussed in areas of health professions curriculum, as mentioned previously, leaders of the campus community must be specifically trained on how to deliver this content. Diversity learning outcomes are set by the educator, but the question should be raised regarding who teaches the teacher. As Curcio et al (2014) pointed out; both curricular and learning outcomes are shaped by the educators' own world views and educational philosophies. It is recommended that faculty and student affairs staff not only participate in intergroup dialogue facilitation training but also as participants in intergroup dialogue for their own professional development. Keeping in mind that cultural competency development is continuous as individuals and identities develop and change, intergroup dialogue sessions should be provided in a campus-wide scope meeting the needs of faculty and staff at all levels. If faculty and staff are confused about what culturally competent education is, they will be less likely to implement innovative interventions to meet federal and state mandates.

A major part of intergroup dialogue and individual diversity development is allowing participants an opportunity to reflect on their attitudes and beliefs. This reflective activity is critical in the transformational learning process (Mezirow, 1990). Those that will be facilitating exchanges, critical reflection, and critical analysis of personal assumptions, biases, values, and perspectives are expected to model the same type of reflective approaches in their teaching style (Kumagi & Lypson, 2009). According to Kumagi and Lypson (2009), the University of Michigan Medical School

implemented a creative faculty development program in collaboration with a theater troupe. The Medical School and the actors worked together to design a workshop for faculty instructors to prepare them for facilitation of potentially argumentative discussions around diversity. Within small groups, the theater troupe performed a brief sketch of a heated debate about race. After each scene the actors would freeze to allow faculty an opportunity to share their personal thoughts, feelings, and perspectives. The actors then performed a replay using suggestions from the faculty participants. The results of this faculty development method led to heightened awareness in the classroom of students of color and women as well as reported personal growth in faculty members (Kumagi & Lypson, 2009). The researchers state, the goals that students are expected to reach are modeled after the professional development activities that faculty are participating in (Kumagi & Lypson, 2009).

Another example of professional development programs that increase faculty and staff's individual diversity development took place at the University of Maryland in the Intergroup Dialogue and Leadership Program coordinated by the Office of Human Relations Programs. This program was piloted as group-specific intergroup dialogue sessions for staff members at the university. The chosen groups for the pilot had known conflict within the working environment at the university. Since its inception, the intergroup dialogue sessions have been proven to reduce cross-cultural tensions amongst the cultural groups (Clark, 2003). Now, as an ongoing professional development event held annually, participants are brought together for (6) two and a half hour sessions to discuss cultural differences and issues in an effort to forge relationships between groups.

The dialogues have proven affected for the campus community and interest is raised each year. (Clark, 2003).

Intergroup dialogue for professional development of faculty and staff, ensure a continuation of acknowledgement to the fact that as members of the higher education community, individuals may not be as culturally evolved as they think. Clark (2003) states that this form of professional development typically reveals that there are still issues of discrimination toward groups of otherness. The lack of such professional development programs available for higher education administrators, faculty, and staff present the opportunity for individual biases and assumptions to be converted into institutionally supported systems of oppression and privilege and policies that support the dominant social identity groups at the expense of the traditionally underrepresented groups (Clark, 2003). Systems such as this will be less likely to implement intergroup dialogue interventions amongst students throughout the campus community. Instituting more time for faculty and staff development in cultural competence will show what the institution truly values. More importantly, interprofessional approaches to enhance both the practitioners' and students' abilities to understand how to provide culturally competent care is essential (Purden, 2005).

The researcher also suggests intergroup dialogue interventions for current health professionals. Though the current research focused on the development of students that are future healthcare providers as well as the faculty and staff that teach them, the study also implies that continuous development in cultural competence is needed as cultures evolve. It is suggested that current health professionals participate in intergroup dialogue

for professional development opportunities. Considering the importance of culturally competent healthcare systems and the benefits that intergroup dialogue provides, participation in these sessions should be mandatory as a part of yearly employee performance evaluations or licensure update requirements. In order for such change to be implemented, institutional mandates are needed handed down from key stakeholders in policy that dictate the needs of the entire healthcare system.

Implications for Future Research

This study indicated that intergroup dialogue positively impacts students' understanding of how culture influences the perceptions, views, and communication for health providers and clients as well as their self-assessment of whether experiences arising from their own cultural backgrounds influenced their view of the U.S. healthcare system. The study adds to the body of research developed exploring the effects of intergroup dialogue on individual diversity development and contributes to the general knowledge base in the field of cultural competence.

Due to the focus of this study, participants were only asked to attend (1) intergroup dialogue session that lasted for a period of three hours. By only offering one session this played a crucial role in the outcomes of the study. Schoem and Hurtado (2001) suggest that dialogue sessions continue for several weeks at a time (Schoem & Hurtado, 2001). Regular meetings over the course of three to six weeks, three to six months, or a year or more are suggested, however, the researchers state that dialogues that meet just a few times can still be impactful but not as powerful as the long term meetings (Schoem & Hurtado, 2001). Nagda also suggests sustained encounters with

participants that meet regularly over an extended period of time (Nagda B. A., 2006). Though there were obvious gains considering the length of this intervention, greater results could have been achieved with more of a longitudinal approach that followed continued dialogic encounters with the same group of participants. A longitudinal approach would have allowed for a greater number of encounters which would produce a greater sense of comfort between the individuals. Another reason for a longitudinal approach refers to the need for reflection. Mezirow states that reflective action is thoughtful and involves a pause to reassess information by asking, what am I doing wrong? He further states that reflection is an integral part of the decision making process and allows one to best decide how to proceed in any given circumstance (Mezirow, 1990). Though Mezirow confirms that a reflective pause may last only a split second in the decision-making process, it is important to allow participants of intergroup dialogue extended time to reflect on their previous assumptions and biases as well as the content and their interpretations from the dialogue session. Intergroup dialogue is typically a rare experience for most students. With this in mind, students need time to reflect, absorb, and decide how to make use of this new found information. Schoem and Hurtado (2001) state that reflection time is needed to allow students time to resonate or conflict with previous beliefs, values, and assumptions (Schoem & Hurtado, 2001). In order for individuals to grow and transition through the Individual Diversity Framework, they must be able to self-assess where they are currently to allow for an acknowledgement of needed change to occur. This can be a tough realization to take place. Eva and Regeher state that self-assessment functions both as a mechanism for identifying one’s weaknesses and as a

mechanism for identifying one's strengths (Eva & Regehr, 2005). In reflecting on one's practice in general, the ability to identify weaknesses through reflection can serve the function of helping the individual set suitable learning goals.

Future research might also include an exploratory study of students participating in an intergroup dialogue program from various health profession programs. This method would increase the sample size of the study, provide ample data to analyze, and hopefully provide a greater pool of racially and ethnically diverse participants for comparison. A qualitative study could also strengthen the research on the effect of intergroup dialogue on individual diversity development by examining the participants' perceptions of the influence that the intervention had on the development of cultural competence or lack thereof. Future research could also provide a voice for patients and their experiences with healthcare providers that have participated in intergroup dialogue. Conducting a mixed methods study with a sample of healthcare providers who participate in an intergroup dialogue program and examining their patients' perceptions before and after the intervention would provide data to assess whether the patients' views are congruent with the outcomes of the healthcare providers. Research showing the difference in outcomes between participants that volunteer to take part in intergroup dialogue as compared to those that are required to attend would provide needed feedback for further methods of implementation. The researcher suggests that there may be differences in the impact of the educational intervention of participants based upon attending as a volunteer or required action. When individuals are asked to volunteer for participation in the intergroup dialogue sessions, the impact may be lessened. Therefore, the results of this

study recommend an examination of the differences between cultural sensibility outcomes of individuals that are required to attend the sessions as compared to those that are asked to volunteer.

Finally, the variables assessed for this study focused on gender differences in the pre and posttest scores of the Cultural Sensibility Survey. The results showed that gender was an insignificant predictor of cultural sensibility in all five factors. Although research has shown that women typically achieve higher scores than men in relation to communication skills during the clinical encounter, the findings from this study were unanticipated. In a study conducted by Holladay et. al., (2003) the researchers assessed the perceptions that males and females had toward participating in a diversity training program. Data was collected from 72 men and 88 women. Participants were asked to read a description of a diversity training course and answer questions assessing their attitudes about the course. Results revealed that men reacted more negatively than women to the diversity training course. Males perceived greater backlash which researchers state is due to the males' beliefs that the training was offered as a personal attack against them. Males also believed that the provided training would offer no benefit to them personally (Holladay, Knight, Paige, & Quinones, 2003). Gender and attitudes about diversity has not fully been explored though most research shows that women are more supportive of implementing diversity initiatives than men are. Since white male workers are rarely the receiver of discrimination, they rarely agree to the need for a diversity training program (Holladay, Knight, Paige, & Quinones, 2003). The results from this study indicate that men and women see diversity training through different lenses. Based on these results,

one may hypothesize that male scores on the Cultural Sensibility Survey would be lower than females scores. The researcher's findings were contradictory to this previous study. These findings show the importance of continued research on gender attitudes related to cultural competency trainings.

Previous research on intergroup dialogue has concentrated on racial and ethnic variables. Based on the results of this study, a recommendation is made for an emphasis on other variables such as religion, sexual orientation, socio-economic status, and other dimensions of diversity to be assessed. This study presented an interesting finding in regards to the influence that religion has on students' perceptions of the U.S. healthcare system. On both the pre and posttest of the study, religion ranked second amongst the highest means of the variables assessed in Factor Two. This finding indicates that it may be beneficial to examine why religion of all variables has considerable influence on a health provider's perception of the healthcare system.

Conclusion

Culturally diverse populations are at a high risk of premature death, disease, and disability as well as significantly higher rates of morbidity and mortality (Kim-Goodwin, Clarke, & Barton, 2001). These populations have significant barriers to receiving quality care including lack of health insurance, lack of income, culturally linguistic barriers, and cultural conflicts with healthcare provider which breed a lack of trust. Cultural factors related to a healthcare provider's personal biases and prejudices can result in misdiagnosis of culturally diverse patients (Campinha-Bacote, 2007). The previous education that health profession students have received focused on learning information

about target groups, yet this method has proven to be inadequate and leaves room for stereotyping and reinforced biases (Kumagi & Lypson, 2009). Health disparities will continue to persist as long as healthcare providers are unequipped with the attitude, knowledge, and skill of providing quality care across culturally diverse patient populations. The results from this quantitative study indicate that a further review of cultural competency curriculum and interventions in health profession programs is invaluable for the future health of this nation. As Shaya and Gbarayor convey, the education of health profession students must be enhanced with curricula that addresses health disparities and cultural competence (Shaya & Gbarayor, 2006). Health professionals must acknowledge and empathize with patients who bring diverse beliefs, preferences, and cultural influences into the clinical encounter.

The Cultural Sensibility Survey instrument has emerged as a possible tool for measuring the diversity learning outcomes of students. While there is still no consensus among researchers around the meaning of becoming culturally competent, the Individual Diversity Framework, Cultural Sensibility Survey, and Intergroup Dialogue intervention provide a clear plan toward improving characteristics of cultural competence.

The goal of this study was to examine an innovative technique of building advocacy in health profession students. Tervalon and Murray-Garcia provided a quote by JR Evans where the researcher stated that at least a small amount of the responsibility of a physician should extend beyond caring for individual patients in order to take on the role of advocacy for policy and practice changes that influence determinants of health (Tervalon & Murray-Garcia, 1998). Health profession education needs a new direction

away from expecting students to complete mastery of every group's assumed beliefs, attitudes, and values to instead teaching students and current health professionals to listen with an open mind to each patient as they share information about their worldviews and preferences. The findings of this study reveal that health professionals and administrators should strive for competency in advocacy rather than competency in culture. Intergroup dialogue is a proven, effective means to reach this goal. Studies represented on the national, institutional, and classroom level using various research methods show that college students' engagement in intergroup dialogue has significant and positive effects on their understanding of others, increased motivation and skills for engaging with others, and strengthened confidence in taking action toward greater social justice (Zuniga, Nagda, Chesler, & Cytron-Walker, 2011). Use of information from this study could assist health profession institutions in creating more effective curriculums that help students toward continuous cultural competence development.

As presented in this study, students need continual opportunities to engage with others, challenge their paradigms, and reflect on new information received in order for sustained growth to occur. Intergroup dialogue provides the perfect platform for change to take place with the goal for all participants to take responsibility for validating the rights, beliefs, and ideas of others. Those who are in the healthcare field have an immense obligation to realize the impact that culture has in the healthcare process. Disregarding the necessity of this duty perpetuates an ongoing system of privilege and oppression, racism, classism, and discrimination. This study proves that there is an abundant need for

interventions that will enhance together the faculty, staff, students, curricula, and overall campus community.

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