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Behaviors That Eliminate Health Disparities for Racial and Ethnic Minorities: A Narrative Systematic Review

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Within the health care provider-health care recipient relationship the communication must be culturally competent to eliminate barriers to equitable health care for all Americans. This assertion has conceptual grounding in Public Law 106-129 (the Health Care Research and Quality Act of 1999) and Public Law 106-525 (the Minority Health and Health Disparities Research and Education Act of 2000). This narrative systematic review examines this assertion by using selection and exclusion criteria to gather interventions, assessments, and testimonies conducted from 2000-2007. Reports that were not eliminated via these criteria were analyzed to determine the effect of specific practices that were undertaken in interventions, assessments, and testimonies. Which practices does research propose as indispensable to efforts to eliminate health disparities for racial and ethnic minority health care recipients? Findings indicate that culturally competent behaviors by providers and recipients promote effective intercultural communication that eliminates health care disparities, and removes obstacles to care.

Keywords: communication, medical; cultural competence; disparities, health care, racial; health care, culture of; health care, provider perspective and behavior; patient participation; prevention; quality of care; systematic reviews

Federal, state, and local agencies confront a grim reality where Americans do not have access to care, nor quality health care. In order to improve the situation the federal government acted when it passed Public Law 106-129 (the Health Care Research and Quality Act of 1999) and Public Law 106-525 (the Minority Health and Health Disparities Research and Education Act of 2000), which are a concerted effort to improve the dissemination of health care services between health care providers and health care recipients. An essential component of this effort involves initiatives to increase health care professionals' ability to interact with a citizenry that is increasingly diverse, with such efforts believed to reduce health disparities for the most vulnerable populations. These populations include racial and ethnic minorities, the poor, women, children and the elderly.

This narrative systematic review examines ways improving health communication can reduce health disparities affecting racial and ethnic minorities. This review is in response to a call to action, which is personified in the following excerpt from *Healthy People 2010—Objectives for Improving Health* (2000):

For health communication to contribute to the improvement of personal and community health during the first decade of the twenty-first century, stakeholders, including health professionals,

researchers, public officials, and the lay public, must collaborate on a range of activities. These activities include (1) initiatives to build a robust health information system that provides equitable access, (2) development of high-quality, audience-appropriate information and support services for specific health problems and health-related decisions for all segments of the population, especially underserved persons, (3) training of health professionals in the science of communication and the use of communication technologies, (4) evaluation of interventions, and (5) promotion of a critical understanding and practice of effective health communication. (Chapter 11, p. 10)

Effective health communication fosters a more productive health care provider-health care recipient relationship. This review addresses the effect that communication utilized in racially and ethnically diverse settings involving interaction between health care provider and health care recipient has on competence in the American health care system. The greater the ability of health care providers to provide care and prevention to health care recipients of various racial and ethnic identities then the greater the likelihood they will foster a proficient relationship that eliminates health care disparities. According to LaVeist (2005) health care disparities are “racial/ethnic differences in the outcomes or quality of care that are indicative of injustice within the health care system or in the behavior of health care providers” (p. 109). Elimination of health care disparities promotes health equity, the voidance of socially unjust or unfair health disparities (Braveman & Gruskin, 2003). Effective communication within the interpersonal relationship between health care provider and health care recipient has the propensity to reduce or eliminate health care disparities for racial and ethnic minorities, including African Americans (also referred to as Blacks), Hispanics (also referred to as Latino/a), Asian Americans, Native Hawaiian or Other Pacific Islanders and American Indians (also referred to as Native Americans and Alaska Natives).

The diversity of groups interacting in the American health care system increases the potential for differences to create different levels of care, whereby it becomes imperative to encourage cultural competence as a means to foster greater sensitivity to all recipients’ needs, and ensure the wellness of everybody (Allen & Easley, 2006). It is pivotal for health care providers and health care recipients to become aware of the effect differing racial and ethnic identities have on beliefs and values about health care, access to care, delivery of care and quality of care. “Unfortunately, modern Western health care systems tend to be very ethnocentric and bureaucratic, proselytizing consumers to ‘comply’ with formalized, often technologically based, and scientifically justified forms of treatment” (Kreps & Kunimoto, 1994, p. 9). The relationship between racially and ethnically diverse health care providers and health care recipients in the United States is complicated because it transpires within a modern Western health care system where “people who see the world differently than they do are seen as being misinformed and even dangerous” (Kreps & Kunimoto, 1994, p. 9). Health communication within this context involves the recognition of difference between members of the health care provider-health care recipient relationship during interaction and not allowing it to hinder access to care, nor quality health care. This article attempts to fill the gaps in the research literature

pertaining to behaviors and practices health care providers (clinicians and practitioners) can use to improve communication with racial and ethnic minorities.

Identifying Attributes of Identity Management Theory

Identity Management Theory (IMT) posits that understanding certain attributes of human interaction enable communicators from different cultural backgrounds to negotiate the relational, cultural and situational contexts of co-cultural communication (Cupach & Imahori, 1993; Wiseman, 2002). Co-cultural communication is communication between members of different cultural groups, who treat one another as equals, as they seek to attain goals through negotiation. Two co-cultural relationships are salient in this discussion about reducing or eliminating health disparities for racial and ethnic minorities, which include the health care provider-health care recipient relationship, as well as the intercultural communication occurring between individuals from various racial and ethnic backgrounds.

The “cultural role” of a health care provider in the United States is an “expert;” an expert who gives diagnoses that balance the risks and benefits of a certain course of action (Bodenheimer & Grumbach, 2005). The expert offers preventive treatment to the health care recipient that increases chances of recovery or survival (Williams, 1990). The health care provider focuses on the “cultural role” that avows him or herself as expert, sometimes with limited recognition of the impact his or her racial and ethnic identity have on the relationship between oneself and health care recipients from differing racial and ethnic identities.

Racial identity indicates identifying with a particular racial group. Although in the past racial groups were classified on the basis of biological characteristics, most scientists now recognize that race is constructed in fluid social and historical contexts (Martin & Nakayama, 2004, p. G-9). Ethnic identity is a set of ideas about one’s own ethnic group membership and a sense of belonging to a particular group and knowing something about the shared experience of the group (Martin & Nakayama, 2004, p. G-4). When issues of misunderstanding, miscommunication, conflict, and negotiation arise between the co-cultures of health care providers and health care recipients because of their varied and different racial and ethnic identities, it becomes fundamental to their relationship that they address the dysfunction in their intergroup relations in order to have goal attainment. Otherwise, during these circumstances a disconnect can develop between health care provider and health care recipient that produces undesired effects whereby, “inadequate use of medical care, especially preventive medical care, by the poor and members of racial/ethnic minority populations is generally viewed as an important determinant of their health status” (Williams & Collins, 1995, p. 372). IMT attributes can be used to examine co-cultural communication between providers and recipients with different ethnic and racial identities in order to identify “openings” in dialogue where intercultural communication can be improved.

Relational identity is an attribute of IMT that establishes identity within a self-conception of individual as a group member. Group affiliation is derived from intergroup social comparison where in-group and out-group distinctions provide depth in understanding

oneself. This process of social comparison involves social categorization, i.e., searching for differences between the in-group and out-group. Differences become distinguishing signifiers between groups, which provide members identities distinct amongst groups but reduces a realization of difference within a single group. Sometimes these realizations are psychologically indelible (Stets & Burke, 2000). Often when group members re-evaluate their attachment to a group their identity is inseparable from the salient group collective. Even if an individual wants to disassociate oneself from the group it can be difficult. This composite of self is often an outcome of cultural affiliation, which shapes another attribute of IMT, an individual's cultural identity.

Cultural identity is identification with a group that adopts a specific set of symbols and meanings as norms or rules governing interaction. The relationship between self and culture engenders cultural identity, which is an understanding of the integration of the individual self and group-derived identity. According to Kim (1996), there are four characteristics of cultural identity: (1) characteristic involves an individual who develops in and belongs to one particular cultural identity, (2) the group that the individual derives a cultural identity from is perceived as similar and succinct, (3) once an individual is in a cultural group that embodies this cultural identity then group affiliation is static, and (4) the moral platitude, positivity, and righteousness associated with asserting a cultural identity materializes (Kim, 1996). Cultural identity is derived from both dialogue between in-group members and the in-group's interaction with the out-group. Co-cultures are defined by in-group and out-group interactions, and discerning that their relational and cultural identities are derivatives of these interactions provides insight into why co-cultures defend agendas that maintain group social norms.

IMT postulates that co-cultures engaged in intergroup relations must negotiate mutually acceptable identities for interaction to be successful. In response to intergroup relations co-cultural group members must embody intercultural communication competence. According to the Intercultural Communicators Approach intercultural communication competence is achieved when "successful intercultural interaction centers on communication processes among people from different cultures" (Chen & Starosta, 2005, p. 243), involving the effective exchange of verbal and nonverbal behaviors. The interdependence between IMT and intercultural communication competence has been used to analyze identity negotiation and its impact on goal attainment for various relationship types involving interethnic co-cultures (Imahori, 2002, 2003). Concepts mentioned thus far that construct meaning in IMT are competence and identity, which provide a conceptual foundation for exploration into the third attribute of IMT, facework.

Face and facework are also relevant concepts that construct meaning in interactions between health care providers and health care recipients. "Each person's socially situated identity is referred to as his or her face" (Imahori & Cupach, 2005, p. 198). While facework is an individual's effort and ability to maintain orderliness through the projection of appropriately deemed behaviors that meet expectations. A co-cultural group member will engage in facework to support the face of communication partner, and in return expects the same support from the communication partner. Facework is positive when an individual shows approval, liking, affection and understanding, while it is negative when it conveys tact, independence, dominance and submissiveness (Trees &

Manusov, 1998). Facework helps co-cultural group members communicate interest/disinterest and concern/deference for out-group members. Facework is necessary for goal attainment to occur.

IMT delineates the goal attainment process into attributes that affect interaction, agenda, and goal-setting. Attributes include relational identity, cultural identity, and facework (Cupach & Imahori, 1993; Wiseman, 2002). Health care providers and health care recipients' decipherment of both groups' relational and cultural identities enable them to engage in facework with realistic expectations for what can transpire. This narrative systematic review identifies attributes of IMT that are indicative of "openings" in dialogue between providers and recipients where intervention techniques (i.e., behavior and practices of providers) were implemented to promote intercultural communication competence, and other behavioral changes. This narrative systematic review examines twenty-first century interventions, assessments, and testimonies in multicultural settings, and attempts to answer this research question: Are communication obstacles to minority recipients' participation in the American health care system reduced by a culturally competent health care provider-health care recipient relationship? While previous research does not determine the specific behaviors and practices that are undertaken in interventions, assessments, and testimonies by providers and minority recipients to create effective intercultural communication this review seeks to fill this information gap for clinicians and practitioners.

Methodological Components for Narrative Systematic Review

Specific procedures of a narrative systematic review such as selection and exclusion criteria (established standards used to appraise study quality for inclusion or exclusion) and analytic techniques are used to analyze relevant studies and answer the research question (Rychetnik, Hawe, Waters, Barratt, & Frommer, 2004). The following procedures are employed within this review.

Focus is on peer-reviewed journals in public health, medicine, nursing, psychology and pharmacology. The process for selecting articles for review involves use of various electronic databases including MEDLINE, CINAHL, Health Source: Nursing/Academic Edition, and PsychINFO, with search criteria including text words 'physician,' 'doctor,' 'specialist,' 'resident,' 'nurse,' 'counselor,' 'therapist,' 'psychologist,' 'psychiatrist,' 'psychoanalyst,' 'pharmacist,' 'caregiver,' 'researcher' or 'expert' engaged in 'communication,' 'discussion,' 'interaction,' 'dialogue,' 'performance,' 'treatment,' 'medicine,' 'nursing,' 'psychology,' 'pharmacy,' 'health,' or 'care,' with a 'patient,' 'client,' 'customer,' or 'student' in a setting that is 'racial,' 'cultural,' 'multicultural,' or 'diverse' involving an 'intervention' or 'evaluation' to 'increase,' 'promote,' or 'encourage' 'communication,' 'communication competence,' 'culture,' 'cultural competency,' 'intercultural competence,' or 'intercultural communication competence.' Furthermore, full-text studies and abstracts of studies returned in the search are reviewed and coded to ensure that studies that are identified meet selection criteria. Any duplicate entries are deleted.

Studies are included if they are published from 2000 to 2007. Studies published within this time frame must address the need to become involved in the American health care system, particularly the interpersonal relationship between the health care provider and the minority health care recipient, to change its course and make it more effective by requiring sufficient knowledge, suitable motivations, and skilled actions in regard to perceptions and behaviors pervasive in its multicultural communication. These efforts can be targeted toward health care providers or minority health care recipients, whereby either co-culture is required to assess their competence in human interaction and make changes to enhance linkages amongst health care providers and between health care providers and minority health care recipients. Human interaction must be perceived as necessary for the operation of the American health care system, i.e., detection of disease incidence, prevalence and treatment efficacy.

Studies that meet the selection criteria are kept and those that do not are excluded from further consideration. Abstracts that meet selection criteria warrant procurement of the full-text and those that do not are excluded from further consideration. If the full-text meets selection criteria then these studies are kept and if not then they are excluded from further consideration. Studies are reports consisting of interventions, assessments, and testimonies that utilize quantitative and qualitative data to explain the impact various behaviors and practices have on their target populations. Interventions (primary source) consist of a plan, program or screening implemented with an intention to induce behavioral change among a target audience. An assessment (secondary source) is a humanistic inquiry or descriptive and inferential statistical analysis of a phenomenon affecting the health care provider-health care recipient relationship. A testimony (another secondary source) includes feedback from health care providers and minority health care recipients about their relationship, its impediments, and suggestions about overcoming the relationship's impediments in order to foster effective care. Some interventions, assessments, and testimonies are created solely to increase intercultural communication competence. While some interventions are supplemented by cultural competency to induce another specified behavioral change. This is neither an exhaustive review of all interventions, nor an exhaustive review of all supplemental data including evaluations, such as, assessments and testimonies, for the time period from 2000 through 2007.

However, this narrative systematic review uses an analytical procedure consisting of two techniques: coding, and an iterative process to ensure that it is substantive, comprehensive, and representative of similar, available reports. The collected reports consist of attributes of IMT that are relevant, useful and cogent markers of behaviors and practices used during interventions, assessments, and testimonies. During coding reports attributes of IMT including relational identity, cultural identity, and facework are marked. Then reports are examined to determine how these attributes are expressed in practices and negotiated in interaction. Practices are marked. Human behavior is analyzed to determine which associations between practices exist, and are used to attain intercultural communication competence. During the iterative process a comparison and contrast of practices across reports occurs, engendering thick description of provider and minority recipient behavior until saturation.

Coding and the iterative process were used to examine primary sources, first, since interventions focus on changing minority recipients' specified behaviors to foster well being and reduce or eliminate health disparities. Then secondary sources that investigate the effect of intercultural communication competence on the health care provider-health care recipient relationship went through the same analysis as primary sources.

Behaviors That Reduce/Eliminate Health Disparities

After examination of 4,230 reports, 69 remained after exclusions because of irrelevance of the title or content (See secondary reference list). These reports (n = 69; 28 from MEDLINE, 20 from CINAHL, 10 from Health Source: Nursing/Academic Edition, and 11 from PsychINFO) are categorized as primary sources or secondary sources. Primary sources consisted of interventions which were 48% of the reports, while the composition of secondary sources was 35% assessments and 17% testimonies. The purpose of primary and secondary sources entailed delivering health messages to a target audience. Providers use behavior and practices to elicit adherence to prevention and treatment initiatives by racial and ethnic minority health care recipients. Recipients use behavior and practices to improve their health and well being. Moreover, these co-cultures both use these identified behaviors to improve minority recipients' health and reduce or eliminate health disparities: (1) to participate in training, (2) to promote health literacy, (3) to use communication aids, (4) to involve a third party, and (5) to tailor the design of interventions and assessments. There was considerable overlap between reports. Hence, citations are representative rather than comprehensive (Secondary reference list is comprehensive).

To Participate in Training

Training includes interactions with more seasoned, culturally competent professionals, who provide advice, feedback, and leadership in group discussion and site visits. These professionals explain the relationship between increased cultural competency in the American health care system and improved delivery of health services to racial and ethnic minority health care recipients (Murphy, Censullo, Cameron, & Baigis, 2007; Shapiro, Hollingshead, & Morrison, 2002). Improved delivery of health services enhances providers' ability to inquire about symptoms, diagnose the problem, and recommend appropriate care for members of racially and ethnically targeted populations (Rosen, Spatz, Gasserud, Abramovitch, Weinreb, Wenger et al., 2004). Intercultural communication is also improved with a greater emphasis on language competency of languages, dialects and accents used among racial and ethnic minority recipients (Medrano, Setzer, Enders, Costello, & Benavente, 2005). Furthermore, recipients and providers recognize the need for providers to speak Spanish, Arabic, and other languages because an inability to do so creates a physical barrier that erodes providers' ability to deliver health services.

Many providers are shifting their focus towards language acquisition, as a means to enhance verbal communication between provider and recipient. For example, implementation of the practice the "Spanish minute" was used during classes to teach health profession students phrases in Spanish, on which they were tested during

examinations for extra credit (Amerson & Burgins, 2005). Students engaged in similar practices as the “Spanish minute” noticed greater language fluency in Spanish, which evoked satisfaction in Spanish-speaking recipients, who felt providers were more responsiveness to their problems and concerns. Other practices can be implemented to appeal to a non-English speaking group, such as Spanish-speakers. These practices shift away from students learning grammatical structure of languages, like Spanish, toward training that teaches medical terminology in Spanish to students (Bloom, Timmerman, & Sands, 2006). The goal is to increase the likelihood that students explain basic nursing care to recipients. Practices similar in structure and content as the “Spanish minute” build confidence in basic conversation in Spanish while using medically related expressions. These practices enhance providers’ ability to articulate and respond to recipient concerns, to conduct basic interviews in Spanish, and to understand cultural and social factors that influence provider-recipient communication with Latinos. Alternative practices are available to providers who are unable to speak the language of racial and ethnic minority health care recipients who are predominate in their area such as: ask for assistance from an interpreter; use hand gestures, pictures, and repetition to deliver messages while using communication strategies including politely asking recipients to repeat themselves, to talk slower, to describe something, or to spell their name (Upvall & Bost, 2007).

Providers usually learned these practices during their student training. Training takes many forms and challenges providers to discuss how their own preconceptions and prejudices about recipients could affect recipient care (Flood, 2007; Moffat & Tung, 2004; Seibert, Stridh, & Zimmerman, 2002; Roysircar, 2004). Faculty in various health professions use literature reviews, handbooks, case studies, group discussions, online dialogs, narrative storytelling, instructional videos, culturally sensitive websites, role playing, cultural awareness checklists, workshops, and study abroad and cultural immersion to simulate cultural and linguistic differences between family members and providers. Throughout this process providers learn to always show respect for cultural differences. When practices learned during cultural competency training are successfully implemented, and minority recipients feel respected, their desire to return for subsequent appointments increases.

To Promote Health Literacy

Health literacy involves increasing comprehension of information exchanged within the health care provider-health care recipient relationship. The exchange is complicated when it occurs between a health care provider and health care recipient with different cultural identities. Some providers assert that understanding individual recipients and their decisions about their health is a greater priority than understanding the effect that a recipient’s cultural identity has on recipient decision-making. However, minority health care recipients assert that their decisions about care, and the health services they are offered are affected by provider and recipient prejudice, stereotyping, language barriers, lack of intercultural communication competence, and classism. When providers consciously or unconsciously resist the influence cultural identity has on human behavior between themselves and minority recipients the outcome is dire. Minority recipients lack motivation for visiting providers, participating in screenings, and adhering to intervention messages, recommendations, and treatments. In order for the American health care

system to provide equitable care, providers and minority recipients are encouraged to implement practices to become health literate (De Ruiter & Larsen, 2002; Haddad, 2001; Honda & Gorin, 2005; Owen & English, 2005; Price, Boyd, Watkins, Fleming & DeBaun, 2006; Shrank, Kutner, Richardson, Mularski, Fischer, & Kagawa-Singer, 2005; Yeo, Fetters, & Maeda, 2000). Being health literate combats ignorance.

Racial and ethnic minority health care recipients and predominately White providers and minority community members mentioned a mutual lack of knowledge about each other as the problem. Many providers have a lack of knowledge about the cultural rules, religious values, and gender and family customs of racial and ethnic minority health care recipients (Bennett, Switzer, Aguirre, Evans, & Barg, 2006; Carrese & Rhodes, 2000; Hong, Mitchell, Peterson, Latkin, Tobin, & Gann, 2005; Kulwicki, Miller, & Schim, 2000; Roysircar, 2004; Seibert, Stridh, & Zimmerman, 2002; Zuniga, Sidelinger, Blaschke, Silva, Broyles, Nader et al., 2006). Some minority recipients admit to limited knowledge about the American health care system (Benkert, Pohl, & Coleman-Burns, 2004; Shapiro, Hollingshead, & Morrison, 2002). Lack of knowledge enables communication barriers to develop and grow. These communication barriers are removed by co-cultures learning about themselves and their communication partners.

Interventions and assessments in psychology exhaustively reviewed the negative effects providers had on their minority recipients if they did not know their cultural, social, and political worldviews. The proposition asserted was that on a conscious or unconscious level providers would deliver care based on their beliefs and needs, disregarding the needs of their minority recipients, who come from a different worldview (Johnson, Roter, Rowe, & Cooper, 2004; Moffat & Tung, 2004; Murphy, Censullo, Cameron, & Baigis, 2007). Beyond the psychological worldview of providers, minority recipients also need to determine if they have reservations or grievance with their provider that can be attributed to their own cultural, social, and political worldview. Consider that some minority health care recipients attribute the attitudes and behavior of their providers, especially White providers, to their race (Cooper, Roter, Johnson, Ford, Steinwachs, & Powe, 2003; Kim, Ng, & Ahn, 2005; Mallinckrodt, Shigeoka, & Suzuki, 2005; Tandon, Parillo, & Keefer, 2005). They become cautious about how to tailor their communication to their providers. This caution breeds miscommunication and mistrust about provider and recipient motives. However, over time trust can develop when the health care provider-health care recipient relationship is recipient-centered. While psychological determinants can create miscommunication, such an outcome is not inevitable, especially if each party knows their worldview and its effect on intercultural communication.

Despite grievances with providers, or contrasting worldviews most minority recipients recognize providers as “experts,” so recipients still seek and value their diagnosis and recommendations. Providers and minority recipients can also remove communication barriers and deconstruct cultural barriers by confronting non-psychological determinants such as understanding purpose and use of communication, space, time, social organization, environmental control, and biological variations. These determinants are often encountered for the first time by providers as health profession students participating in clinical rotations in various health settings, including racial and ethnic minority neighborhoods (Furuta, Petrini, Davis, 2003; Medrano, Setzer, Enders, Costello,

& Benavente, 2005). Within these settings students often develop a multicultural awareness about different perspectives, values, beliefs, and behaviors that affect their encounters. For instance, these encounters over the long-term usually stimulate providers' introspective processes about their moral positions and political agendas, which is important before they move further in their relationships with recipients or implement culturally sensitive interventions that may impact on the recipient's view of illness and ability to address a culture-related issue. Here is a student's commentary about the effect of these encounters on providers' cultural awareness and sensitivity:

I learned how much culture plays a role in health care with the diversity of so many ethnic groups right here in our area: Hispanics, Turks, Pennsylvania Dutch, Caucasians, and the list goes on. There are staples in their diets, based on their ethnicity, and due to health reasons, they may be asked to change. I find this difficult, because this is a direct link to their culture and heritage. At the same time, it needs to be explained that they will be improving their quality of life.... I will certainly be much more aware of the cultural differences and what changes in lifestyle may mean to them. (Sensenig, 2007, p. 377)

Over time these experiences instill the need for providers to communicate with racial and ethnic minority health care recipients in a compassionate, caring, kind, and respectful manner. While it is important for health care providers to become culturally aware, sensitive, knowledgeable, and competent about racial and ethnic minority health care recipients, it is also crucial that minority health care recipients become health literate about medical culture. The following statement is indicative of the reality that health care providers also have a culture, which affects their communication with recipients, so far as minority recipients and health profession students need to be culturally aware and sensitive to medical culture:

The activity helped participants to better understand the existence of a medical culture and the day-to-day realities of physicians including long hours and limited amount of time to work with individual patients. (DasGupta et al, 2006, p. 16)

The overlap between medical culture and racial and ethnic minority health care recipients' cultures can complicate the provider-recipient relationship. Recipients need to be literate about medical culture as much as providers need to be literate about minority recipients' cultural backgrounds in health settings and the community. The following narrative is indicative of a health care provider-health care recipient relationship where neither providers nor minority recipients were health literate:

Whereas a daily prenatal vitamin with folic acid is routinely prescribed in the United States, this is not the case in Japan. Iron supplements are prescribed only if iron deficiency anemia is identified. Many participants reported taking a prenatal vitamin as one of the most puzzling and uncomfortable instructions during the

pregnancy, and Japanese couples regularly resisted doctors' orders to comply. In their mind, taking a vitamin supplement rather than eating a nutritionally balanced meal was believed to be a shortcut and incompatible with ideal motherhood. (Yeo et al, 2000, p. 194)

Oftentimes differing cultural worldviews between provider and minority health care recipient harm the quality of care received by minority recipients. The narrative addresses friction between American medical culture and the Japanese culture of American foreign nationals, which undermined trust within the health care provider-health care recipient relationship. Both provider and minority recipient practices referred to in this narrative are commonplace, with these practices being the specified behavior practitioners seek to analyze or change in interventions, assessments, and testimonies. Behavioral change emphasizes cultural awareness, cultural sensitivity, and cultural competence for both co-cultures. Moreover, providers are instructed to respectfully gather information about the worldview of their minority recipient, in this instance, pregnant Japanese American women.

This practice would have revealed early during prenatal care that these women would like to abide by the Japanese community's cultural and medical practices in regards to their nutrition during pregnancy. Throughout this process the provider must cease being adamant about enforcing American medicine onto Americans with a non-Western cultural orientation. The provider should examine whether it is ethical and feasible for an American provider to follow the advocated Japanese cultural practices. Furthermore, the Japanese couple must recognize that American providers have a Hippocratic Oath that governs their interaction; so Japanese couples have to carefully explain to American providers why the recommended treatment is prohibited by their worldview. Both co-cultures are responsible for making an effort to seek concordance between providers' and recipients' worldviews so shared meaning has an opportunity to emerge and foster effective care.

To Use Communication Aids

Communication aids promote dialogue between providers and recipients. They enable tasks providers normally perform, such as completing forms with recipients, taking medical histories, giving diagnosis, and prescribing treatment (Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004; Upvall & Bost, 2007). Various communication aids are effective with racial and ethnic minority recipients including listening, use of an interpreter, use of technology, and translation of important medical terminology into the language spoken by minority recipients or members of the recipient's household.

Listening and translation increase recipient engagement and participation, which is more important to minority recipients than overall time spent with providers during medical visits. Listening and translation improves language usage between providers and racial and ethnic minority health care recipient (Fernandez, Schillinger, Grumbach, Rosenthal, Stewart, Wang et al., 2004; Howard, Andrade, & Byrd, 2001; Satterfield, Lofton, May, Bowman, Alfaro-Correa, Benjamin et al., 2003). Dialogue ensues that involves meaningful, descriptive and elaborate messages. Recipient-centered communication,

including recipient input into the medical dialogue, has been associated with better recall of information, prevention and treatment adherence, satisfaction with care and health outcomes. Use of a translator facilitates recipient-centered communication between providers unable to speak the language of the minority health care recipient seeking care (Sensenig, 2007). Providers need to recognize that translators usually come from the same cultural background as the health care recipients seeking care. The translator can offer a provider insight into the cultural background of minority recipients, which can reduce language and cultural misunderstanding and promote other communication aids such as listening and translation. Therefore, it is extremely beneficial for the provider to develop an interpersonal relationship with the translator, especially, if the translator and provider work together on a continuous basis.

Many clinicians and practitioners use technology on a continuous basis to reduce medical errors associated with intercultural communication between themselves and minority health care recipients. For instance, pharmacists who need to provide linguistically appropriate information to recipients with limited proficiency in English use computer systems that translate prescription instructions to the language of the minority recipient (Sharif, Lo, & Ozuah, 2006). The American health care system is increasingly using technology, such as these computer systems, as communication aids to alleviate providers and minority recipients language and cultural disconnect. What if the computer incorrectly translates the instructions? If this incident occurred a minority recipient's well being is in danger. Technology cannot replace culturally competent providers, so pharmacies are encouraged, for instance, to have a Spanish-speaking pharmacist that can check the accuracy of computer generated Spanish translations of English terms.

To Involve a Third Party

Third parties are “indigenous leadership” in the American health care system, and are also referred to as community lay health workers, network members, peer educators, community workers, family and close friends. Third parties share a common frame of reference with recipients since third parties typically come from the same environment, and belong to the same cultural and social groups. They are used to create and disseminate health messages that sanitize mainstream intervention programs for racial and ethnic minority health care recipients through removal of adversarial cultural, social and historical depictions of members of minority communities (Kuhajda, Cornell, Brownstein, Littleton, Stalker, Bittner et al., 2006; Prado, Pantin, Briones, Schwartz, Feaster, Huang et al., 2007; Prather, Fuller, King, Brown, Moering, Little et al., 2006).

Third parties enlighten health care providers about the altruism and negative consequences of programs that are created for mainstream audiences or without community input. They work to ensure that providers become more culturally competent toward racial and ethnic minority health care recipients, as well as understand the nuances of recipients' geographic areas and neighborhoods. The incentive for third parties is the elimination of health care disparities that plague their communities. Providers use third parties as intermediaries because they improve communication between provider and recipient (Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002; Kegler & Malcoe, 2004). Essentially, third parties become a defacto provider once they

receive training to facilitate the intervention. Third parties probe providers and trainers for more information, ask for input, suggest the recipient inquire about health services, and holds the recipient accountable for their action or inaction in regards to adherence to care.

There are various types of indigenous leadership that providers and minority health care recipients use to eliminate health care disparities. Parents, other family members and close friends are third parties who use life-saving practices among recipients that are especially helpful when recipients are youth or the elderly (Brody, Murry, Gerrard, Gibbons, Molgaard, McNair et al., 2004; Garbers & Chiasson, 2006; Kummerer, Lopez-Reyna, & Hughes, 2007). They help enhance rapport between the provider and recipient by underscoring cultural understanding between all parties, entering homes and neighborhoods to record and collect data, while persuading recipients to comply with preventative measures or treatment. The following commentary from a researcher explains the importance of family as a third party for a racial minority group, African Americans:

The African-American members were more likely to suggest that extended family members ought to participate in end-of-life conversations. Five statements in the African-American groups supported participation from the patient's friends, while participants from the non-Hispanic white groups explicitly stated that friends should not participate. Even among family, non-Hispanic white members frequently expressed that some family members are "more trustworthy" or "closer" than others, and that only the "closest" family ought to be permitted to participate. (Shrank et al, 2005, p. 705)

For racial and ethnic minority health care recipients extended family is an unwavering support group, which is exemplified in the community, where recipients depend upon their support network for assistance and well being. Community level, cultural and gender specific interventions disseminate health promotion messages that are designed to influence individual behavior change as well as to strengthen the social norms that support and reinforce such change. This change only occurs because of the resilience of community lay health workers, who play an essential role at the partnership, community, cultural, and gender levels (Grindel, Brown, Caplan, & Blumenthal, 2004; Holkup, Tripp-Reimer, Salois, & Weinert, 2004; Jemmott, Jemmott III, & O'Leary, 2007; Lauby, Smith, Stark, Person, & Adams, 2000). Community lay health workers help providers select convenient community locations, and teach intervention curricula at that location in various languages, which increases the frequency of visits by recipients. Trained community residents are the course instructors trained to use empowerment approaches to increase the likelihood of successfully delivering the intervention curriculum. Trained interviewers are recruited from the intervention and comparison communities in order to gain access to recipients and increase their likelihood to participate in prevention programs and health disparities research.

In intervention and comparison communities a coordinated relationship between health care providers, community lay health workers, peer educators, social service institutions and referral agencies constitutes a community partnership. It is the most potent and effective third party for brokering recipients' adherence to behavioral interventions. The REACH Detroit Intervention provides a good indication of why clinicians and practitioners find partnerships pivotal in the war to end health disparities for racial and ethnic minorities:

The intervention was planned and implemented with guidance from the REACH Detroit steering committee, which is composed of community health leaders, clinical providers, researchers, and REACH Detroit staff. Because of the legacy of distrust in the community about research, at the intervention's inception, the committee recommended a nonrandomized study. (Two Feathers et al, 2005, p. 1553)

The community partners recognized that members of the community would have been suspicious of sample segmentation and dissemination of differential care for those who would have participated in the intervention, had it been randomized. These community partnerships are necessary because they determine which practices are deemed appropriate in interaction between clinicians, practitioners, racial and ethnic minority health recipients, and members of minority recipients' support system. Partnerships also increase interaction among these parties by contributing to the proportion of defacto providers of a racial or ethnic group in a particular area resulting in a local health care system with the same demographics and cultural background as the recipients provided care.

To Tailor the Design of Interventions and Assessments

Tailored communication involves practitioners researching a specific ethnic or racial minority community's knowledge, attitudes, and practices regarding a specified behavior. During this process, formative research is used to match intervention or assessment materials with messages infused with recipients' cultural and social beliefs (Prado, Pantin, Briones, Schwartz, Feaster, Huang et al., 2007; Wingood, DiClemente, Harrington, Lang, Davies, Hook et al., 2006). Furthermore, tailored communication allows practitioners to use interventions or assessments for predominately White or mainstream comparative populations for a racial or ethnic minority target population (Jones, 2004; Kohn, Oden, Robinson, & Leavitt, 2002; Kreuter, Skinner, Steger-May, Holt, Bucholtz, Clark et al., 2004; Kulis, Marsiglia, Elek, Dustman, Wagstaff, & Hecht, 2005).

Many of the interventions that were targeted toward members of racial and ethnic communities were preexisting interventions. An intervention would be for cancer screening, prenatal care, safe sex and HIV/AIDS prevention, nutrition, depression, and other specified behaviors, but these interventions were not as successful in eliciting compliance or adherence among non-White populations. Hence, assessments were conducted to determine why certain behaviors and practices addressed in intervention

materials or the health care provider-health care recipient relationship were perceived differently by recipients from different cultural backgrounds. Perception affected how recipients of different cultural backgrounds would respond to uniform messages pertaining to these behaviors and practices. Testimonies of health care providers and minority health care recipients also contextualized why in many instances uniform messages were not as effective in eliciting the specified behavior.

Conceptual barriers were the culprit, undermining members of racial and ethnic minority communities' ability to understand the intervention message in the same manner as predominately White or mainstream comparative populations. Practitioners came to the realization that they needed to remove conceptual barriers, such as meaning incompatibility and cultural misunderstanding from mainstream interventions and assessments, to increase minority recipients' susceptibility to the intervention message. The following testimonial represents commentary between researchers exploring how confounding a conceptual barrier can be in regards to tailoring an American English-speaking intervention for the elimination of worry for a target population with a large proportion of Mexican Spanish-speakers:

We realized that in some cultures it may be admirable to worry, and therefore interventions that attempt to alleviate worry, may have a negative effect. Therefore, a team composed of nurses from different cultures and languages who are able to communicate and collaborate will be more likely to develop nursing knowledge that is cross-cultural and reflects accuracy for more than one culture.
(Frederickson et al, 2005, p. 292)

Differences in perception of worry for people raised in Mexico instead of the United States exist. Consider the implications of this conceptual barrier for interventions targeting people along the United States-Mexico border or Mexican immigrant populations in American cities. Therefore, clinicians, interventionists, researchers, and instructors participating in the creation, tailoring, and implementation of interventions along the United States-Mexico border, or elsewhere must look for commonality. In this instance commonality is that worry means losing control, even though how this meaning manifests in human behavior in these two cultures is different. Clinicians and practitioners must identify conceptual barriers to the language of care (whether English, Spanish, or Spanglish), in order to make communication used in interventions and assessments effective.

While tailored communication can create shared meaning between intervention and assessment materials that were not originally intended for another target population, some interventions and assessments are designed from inception for a racial or ethnic minority community. For example, tailored communication was used from inception to create the intervention SISTA, which promotes a more culturally competent relationship between health care provider and minority health care recipient:

The overall goals of the intervention were to increase knowledge of HIV and risk reduction methods, empower women to become

more assertive, enhance their communication with their sexual partner around condom use, and increase partner support of consistent condom use. The five sessions of the intervention were Ethnic and Gender Pride, HIV/AIDS Education, Self-Assertiveness Skills Training, Behavioral Self-Management, and Coping. The first session on ethnic and gender pride focused on what it meant to be an African American, a woman, having pride in oneself, and valuing oneself. (Prather et al, 2006, p. 151)

SISTA incorporates cultural (Afrocentric), as well as gender-relevant practices to empower African American women. They are encouraged to make healthy life choices that prevent contraction of HIV/AIDS. Trainers infuse their teaching and activities with Afrocentric practices to persuade these women to participate in HIV prevention. For instance, opening and closing teaching and activities with an Umoja (unity) circle, and “ice breakers” and activities that infused culturally specific and historically relevant details. The CDs included poetry from Maya Angelou and Kikki Giovanni. The intervention coupled a culturally relevant (Afrocentric) HIV prevention intervention with a culturally relevant diffusion strategy utilizing trained staff from community-based organizations. Community partnerships helped enhance community responsiveness, which increased the exposure of African American women to the SISTA intervention.

Discussion

The research literature theorizes about which behaviors and practices health care providers and racial and ethnic minority health care recipients should use to foster meaningful intergroup relations. However, no past efforts examined alternative courses of action used in practice, such as behavioral modification negotiated in interventions, assessments, and testimonies, to make relations between these co-cultures more efficient. Therefore, this narrative systematic review sought a better understanding of changes that can be made in the health care provider-health care recipient relationship, as implemented in interventions, assessments, and testimonies to induce effective intercultural communication.

A plethora of behaviors and practices were identified that compose human interaction within the health care provider-health care recipient relationship. These behaviors and practices were used by providers and minority recipients engaged in intercultural communication. Enacted, they had the ability to induce behavioral change and foster equitable health care. Behavioral modification was achieved when provider and minority recipient practices (facework) were used to negotiate decision-making, participation in care regimen, and adherence to prevention or treatment. Ignored, the circumstances that remained, i.e., overlapping and conflicting relational and cultural identities, thwarted opportunities for an effective dissemination of health services.

The need for implementation of behavioral outcomes including cultural competency training, health literacy, communication aids, third parties, and tailored communication, is warranted if the goal is the health and well being of racially and ethnically targeted populations. These behaviors and practices engender effective intercultural

communication between providers and minority recipients. Intercultural communication becomes more competent, culturally aware, and sensitive. Intercultural communication competence ensues. Co-cultures may not completely understand one another, but putting forth effort matters. Instead of hearing sound, co-cultures listen to one another. Respect and trust form over time. Health care providers are viewed as caregivers instead of elitists, racists or accomplices in the broken American health care system.

Caveat

The narrative systematic review is not an exhaustive review of all interventions, assessments, and testimonies, so behaviors and practices emergent from this analysis are only applicable to circumstances similar to those addressed within this review. Also this qualitative method does not consist of humanistic inquiry, i.e., observation of health care providers and health care recipients in the field. Instead an analysis is conducted, which gleans from researchers' findings what transpired in settings where interventions and evaluations were implemented.

References

- Allen, C. E., & Easley, C. E. (2006). Racial and ethnic minorities. In B. S. Levy & V. W. Sidel (Eds.), *Social injustice and public health* (pp. 46-68). New York: Oxford University Press.
- Bodenheimer, T., & Grumbach, K. (2005). *Understanding health policy: A clinical approach*. New York: McGraw-Hill.
- Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health, 57*, 254-258.
- Chen, G. M., & Starosta, W. (2005). *Foundations of intercultural communication*. Lanham: University Press of America, Inc.
- Cupach, W. R., & Imahori, T. T. (1993). Identity management theory: Communication competence in intercultural episodes and relationships. In R. L. Wiseman & J. Koester (Eds.), *Intercultural communication competence* (pp. 112-131). Newbury Park, CA: Sage.
- Imahori, T. T. (2002, November). *Facework strategies for identity management in real intercultural relationships: An extensive interview study*. Paper presented at the annual meeting of the National Communication Association, New Orleans, LA.
- Imahori, T. T. (2003, November). *Relational development and identity management facework strategies in intercultural relationships*. Paper presented at the annual meeting of the National Communication Association, Miami, FL.
- Imahori, T. T., & Cupach, W. R. (2005). Identity management theory: Facework in intercultural relationships. In W.B. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp. 195-210). Thousand Oaks, CA: Sage.

- Kim, Y. Y. (1996). Identity development: From cultural to intercultural. H. B. Mokros (ed.). *Interaction & Identity* (pp. 347-369). New York: Translation Publishers.
- Kreps, G. L., & Kunimoto, E. N. (1994). *Effective communication in multicultural health care settings*. Thousand Oaks, CA: Sage.
- LaVeist, T. A. (2005). *Minority populations and health: An introduction to health disparities in the United States*. San Francisco: Jossey-Bass.
- Martin, J. N., & Nakayama, T. K. (2004). *Intercultural communication in contexts* (3rd ed.). New York: McGraw-Hill.
- Rychetnik, L., Hawe, P., Waters, E., Barratt, A., & Frommer, M. (2004). A glossary for evidence based public health. *Journal of Epidemiology and Community Health*, 58, 538-545.
- Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, 63(3), 224-237.
- Trees, A. R., & Manusov, V. (1998). Managing face concerns in criticism: Integrating nonverbal behaviors as a dimension of politeness in female friendship dyads. *Human Communication Research*, 24, 564-583.
- United States Department of Health and Human Services (2000). *Healthy People 2010: Objectives for Improving Health* (2nd ed.). Washington, DC: Government Printing Office.
- Williams, D. R. (1990). Socioeconomic differentials in health: A review and redirection. *Social Psychology Quarterly*, 53, 81-99.
- Williams, D. R., & Collins, C. (1995). US socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology*, 21, 349-386.
- Wiseman, R. L. (2002). Intercultural communication competence. In W. B. Gudykunst & B. Mody (Eds.), *Handbook of international and intercultural communication*. (2nd ed., pp. 207-224). Thousand Oaks, CA: Sage.

Secondary References: Narrative Systematic Review Sources (N=69)

- Allen, A., Harris, W., & Kennedy, K. (2007). A diabetes pharmaceutical care clinic in an underserved community. *Journal of Health Care for the Poor and Underserved*, 18, 255-261.
- Amerson, R., & Burgins, S. (2005). Hablamos Espanol: Crossing communication barriers with the Latino population. *Journal of Nursing Education*, 44(5), 241-243.

- Ayala, G. X., Elder, J. P., Campbell, N. R., Engelberg, M., Olson, S., Moreno, et al. (2001). Nutrition communication for a Latino community: Formative research foundations. *Family Community Health, 24*(3), 72-87.
- Benkert, R., Pohl, J. M., & Coleman-Burns, P. (2004). Creating cross-racial primary care relationships in a nurse-managed center. *Journal of Cultural Diversity, 11*(3), 88-99.
- Bennett, I., Switzer, J., Aguirre, A., Evans, K., & Barg, F. (2006). 'Breaking it down': Patient-clinician communication and prenatal care among African American women of low and higher literacy. *Annals of Family Medicine, 4*(4), 334-340.
- Bloom, M., Timmerman, G. M., & Sands, D. (2006). Developing a course to teach Spanish for health care professionals. *Journal of Nursing Education, 45*(7), 271-274.
- Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., et al. (2004). The strong African American families program: Translating research into prevention programming. *Child Development, 75*(3), 900-917.
- Brown, S. A., Kouzekanani, K., Garcia, A. A., & Hanis, C. L. (2002). Culturally competent diabetes self-management education for Mexican Americans. *Diabetes Care, 25*(2), 259-268.
- Carrese, J. A., & Rhodes, L. A. (2000). Bridging cultural differences in medical practice: The case of discussing negative information with Navajo patients. *Journal of General Internal Medicine, 15*, 92-96.
- Chin, J. J., Kang, E., Kim, J. H., Martinez, J., & Eckholdt, H. (2006). Serving Asians and Pacific Islanders with HIV/AIDS: Challenges and lessons learned. *Journal of Health Care for the Poor and Underserved, 17*, 910-927.
- Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine, 139*, 907-915.
- Crosson, J. C., Deng, W., Brazeau, C., Boyd, L., & Soto-Greene, M. (2004). Evaluating the effect of cultural competency training on medical student attitudes. *Family Medicine, 36*(3), 199-203.
- DasGupta, S., Meyer, D., Calero-Breckheimer, A., Costley, A. W., & Guillen, S. (2006). Teaching cultural competency through narrative medicine: Intersections of classroom and community. *Teaching and Learning in Medicine, 18*(1), 14-17.
- De Ruiter, H., & Larsen, K. E. (2002). Developing transcultural patient care web site. *Journal of Transcultural Nursing, 13*(1), 61-67.

- Ell, K., Vourlekis, B., Muderspach, L., Nissly, J., Padgett, D., Pineda, D., et al. (2002). Abnormal cervical screen follow-up among low-income Latinas: Project SAFe. *Journal of women's Health & Gender-Based Medicine, 11*(7), 639-651.
- Fernandez, A., Schillinger, D., Grumbach, K., Rosenthal, A., Stewart, A. L., Wang, F., et al. (2004). Physician language ability and cultural competence: An exploratory study of communication with Spanish-speaking patients. *Journal of General Internal Medicine, 19*, 167-174.
- Flood, L. S. (2007). Using a capstone cultural diversity paper for program outcomes evaluation. *Nursing Education Perspectives, 28*(3), 130-135.
- Frederickson, K., Acuna, V. R., Whetsell, M., & Tallier, P. (2005). Cross-cultural analysis for conceptual understanding: English and Spanish perspectives. *Nursing Science Quarterly, 18*(4), 286-292.
- Furuta, B. S., Petrini, M.A., Davis, A. J. (2003). Growth in a context of cultural marginality: North American nurse educators in Japan. *International Nursing Review, 50*, 139-147.
- Garbers, S., & Chiasson, M. A. (2006). Breast cancer screening and health behaviors among African American and Caribbean women in New York City. *Journal of Health Care for the Poor and Underserved, 17*, 37-46.
- Grindel, C. G., Brown, L., Caplan, L., & Blumenthal, D. (2004). The effect of breast cancer screening messages on knowledge, attitudes, perceived risk, and mammography screening of African American women in the rural South. *Oncology Nursing Forum, 31*(4), 801-808.
- Haddad, A. (2001). Ethics in action. *RN, 64*(3), 21-24.
- Hodge, F. S., Pasqua, A., Marquez, C. A., & Geishirt-Cantrell, B. (2002). Utilizing traditional storytelling to promote wellness in American Indian Communities. *Journal of Transcultural Nursing, 13*(1), 6-11.
- Holkup, P. A., Tripp-Reimer, T., Salois, E. M., & Weinert, C. (2004). Community-based participatory research: An approach to intervention research with a Native American community. *Advances in Nursing Science, 27*(3), 162-175.
- Honda, K., & Gorin, S. S. (2005). Modeling pathways to affective barriers on colorectal cancer screening among Japanese Americans. *Journal of Behavioral Medicine, 28*(2), 115-124.
- Hong, Y., Mitchell, S. G., Peterson, J. A., Latkin, C. A., Tobin, K., & Gann, D. (2005). Ethnographic process evaluation: Piloting an HIV prevention intervention program among injection drug users. *International Journal of Qualitative Methods, 4*(1), 1-10.

- Howard, C. A., Andrade, S. J., & Byrd, T. (2001). The ethical dimensions of cultural competence in border health care settings. *Family Community Health, 23*(4), 36-49.
- Jemmott, L. S., Jemmott III, J. B., & O'Leary, A. (2007). Effects on sexual risk behavior and STD rate of brief HIV/STD prevention interventions for African American women in primary care settings. *American Journal of Public Health, 97*(6), 1034-1040.
- Johnson, R. L., Roter, D., Rowe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health, 94*(12), 2084-2089.
- Jones, L. V. (2004). Enhancing psychosocial competence among Black women in college. *Social Work, 49*(1), 75-84.
- Kegler, M. C., & Malcoe, L. H. (2004). Results from a lay health advisor intervention to prevent lead poisoning among rural Native American children. *American Journal of Public Health, 94*(10), 1730-1735.
- Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects of client expectation for counseling success, client-counselor worldview match and client adherence to Asian and European American cultural values on counseling process with Asian Americans. *Journal of Counseling Psychology, 52*(1), 67-76.
- Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal, 38*(6), 497-504.
- Kreuter, M. W., Caburnay, C. A., Chen, J. J., & Donlin, M. J. (2004). Effectiveness of individually tailored calendars in promoting childhood immunization in urban public health centers. *American Journal of Public Health, 94*(1), 122-127.
- Kreuter, M. W., Skinner, C. S., Steger-May, K., Holt, C. L., Bucholtz, D. C., Clark, E. M., et al. (2004). Responses to behaviorally vs. culturally tailored cancer communication among African American women. *American Journal of Health Behavior, 28*(3), 195-207.
- Kuehn, A. F., Chircop, A., Downe-Wamboldt, B., Sheppard-LeMoine, D., Murnaghan, D., Elliott, J., et al. (2005). Exploring nursing roles across North American borders. *The Journal of Continuing Education in Nursing, 36*(4), 153-162.
- Kuhajda, M. C., Cornell, C. E., Brownstein, J. N., Littleton, M. A., Stalker, V. G., Bittner, V. A., et al. (2006). Training community health workers to reduce health disparities in Alabama's Black belt: The Pine Apple Heart Disease and Stroke project. *Family & Community Health, 29*(2), 89-102.

- Kulis, S., Marsiglia, F. F., Elek, E., Dustman, P., Wagstaff, D. A., & Hecht, M. L. (2005). Mexican/Mexican American adolescents and *keepin' I REAL*: an evidence-based substance use prevention program. *Children & Schools, 27*(3), 133-145.
- Kulwicki, A. D., Miller, J., & Schim, S. M. (2000). Collaborative partnership for culture care: Enhancing health services for the Arab community. *Journal of Transcultural Nursing, 11*(1), 31-39.
- Kummerer, S. E., Lopez-Reyna, N. A., & Hughes, M. T. (2007). Mexican immigrant mothers' perceptions of their children's communication disabilities, emergent literacy development, and speech-language therapy program. *American Journal of Speech-Language Pathology, 16*, 271-282.
- La Roche, M. J., D'Angelo, E., Gualdron, L., & Leavell, J. (2006). Culturally sensitive guided imagery for allocentric Latinos: A pilot study. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 555-560.
- Lauby, J. L., Smith, P. J., Stark, M., Person, B., & Adams, J. (2000). A community-level HIV prevention intervention for inner-city women: Results of the women and infants demonstration projects. *American Journal of Public Health, 90*(2), 216-222.
- Mallinckrodt, B., Shigeoka, S., & Suzuki, L. A. (2005). Asian and Pacific Island American students' acculturation and etiology beliefs about typical counseling presenting problems. *Cultural Diversity and Ethnic Minority Psychology, 11*(3), 227-238.
- McKay, M. M., Chasse, K. T., Paikoff, R., McKinney, L., Baptiste, D., Coleman D., et al. (2004). Family-level impact of the CHAMP family program: A community collaborative effort to support urban families and reduce youth HIV risk exposure. *Family Process, 43*(1), 79-93.
- Medrano, M. A., Setzer, J., Enders, S., Costello, R. M., & Benavente, V. (2005). Self-assessment of cultural and linguistic competence in an ambulatory health system/practitioner application. *Journal of Healthcare Management, 50*(6), 371-387.
- Moffat, J., & Tung, J. (2004). Evaluating the effectiveness of culture brokering training to enhance cultural competence of independent living center staff. *Journal of Vocational Rehabilitation, 20*, 59-69.
- Murphy, S. T., Censullo, M., Cameron, D. D., & Baigis, J. A. (2007). Improving cross-cultural communication in health professions education. *Journal of Nursing Education, 46*(8), 367-372.
- O'Donnell, L., Stueve, A., Agronick, G., Wilson-Simmons, R., Duran, R., & Jeanbaptiste, V. (2005). Saving sex for later: An evaluation of a parent education intervention. *Perspectives on Sexual and Reproductive Health, 37*(4), 166-173.

- Owen, C. L., & English, M. (2005). Working together as culture brokers by building trusting alliances with bilingual and bicultural newcomer paraprofessionals. *Child Welfare, 84*(5), 669-688.
- Perez, M., Findley, S. E., Mejia, M., & Martinez, J. (2006). The impact of community health worker training and programs in New York City. *Journal of Health care for the Poor and Underserved, 17*, 26-43.
- Prado, G., Pantin, H., Briones, E., Schwartz, S. J., Feaster, D., Huang, S., et al. (2007). A randomized controlled trial of a patient-centered intervention in preventing substance use and HIV risk behaviors in Hispanic adolescents. *Journal of Consulting and Clinical Psychology, 75*(6), 914-926.
- Prather, C., Fuller, T. R., King, W., Brown, M., Moering, M. Little, S., et al. (2006). Diffusing an HIV prevention intervention for African American women: Integrating Afrocentric components into the SISTA diffusion strategy. *AIDS Education and Prevention, 18*(suppl. A), 149-160.
- Price, C. L., Boyd, J. H., Watkins, A. R., Fleming F., & DeBaun, M. R. (2006). Mailing of a sickle cell disease educational packet increases blood donors within an African American community. *Transfusion, 46*, 1388-1393.
- Quinn, G., Hauser, K., Bell-Ellison, B. A., Rodriguez, N. Y., Frias, J. L. (2006). Promoting pre-conceptional use of folic acid to Hispanic women: A social marketing approach. *Maternal and Child Health Journal, 10*(5), 403-412.
- Rosen, J., Spatz, E. S., Gassserud, A. M. J., Abramovitch, H., Weinreb, B., Wenger, N. S., et al. (2004). A new approach to developing cross-cultural communication skills. *Medical Teacher, 26*(2), 126-132.
- Roysircar, G. (2004). Cultural self-awareness assessment: Practice example for psychology training. *Professional Psychology: Research and Practice, 35*(6), 658-666.
- Satterfield, D. W., Lofton, T., May J. E., Bowman, B. A., Alfaro-Correa, A., Benjamin, C., et al. (2003, November). Learning from listening: Common concerns and perceptions about diabetes prevention among diverse American populations. *Journal of Public Health Management and Practice, Suppl.*, S56-S63.
- Seibert, P. S., Stridh,Igo, P., & Zimmerman, C. G. (2002). A checklist to facilitate cultural awareness and sensitivity. *Journal of Medical Ethics, 28*(3), 143-146.
- Sensenig, J. A. (2007). Learning through teaching: Empowering students and culturally diverse patients at a community-based nursing care center. *Journal of Nursing Education, 46*(8), 373-379.

- Shapiro, J., Hollingshead, J., & Morrison, E. H. (2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education, 36*, 749-759.
- Sharif, I., Lo, S., & Ozuah, P. O. (2006). Availability of Spanish prescription labels. *Journal of Health Care for the Poor and Underserved, 17*, 65-69.
- Shrank, W. H., Kutner, J. S., Richardson, T., Mularski, R. A., Fischer, S., & Kagawa-Singer, M. (2005). Focus group about the influence of culture on communication preferences in end-of-life care. *Journal of General Internal Medicine, 20*, 703-709.
- Tandon, S. D., Parillo, K. M., & Keefer, M. (2005). Hispanic women's perceptions of patient-centeredness during prenatal care: A mixed-method study. *Birth, 32*(4), 312-317.
- Taylor, J. Y., & Holtrop, T. G. (2007). Yemeni families and child lead screening in Detroit. *Journal of Transcultural Nursing, 18*(1), 63-69.
- Two Feathers, J., Kieffer, E. C., Palmisano, G., Anderson, M., Sinco, B., Janz, N. et al. (2005). Racial and ethnic approaches to community health (REACH) Detroit partnership: Improving diabetes-related outcomes among African American and Latino adults. *American Journal of Public Health, 95*(9), 1552-1560.
- Upvall, M. J., & Bost, M. L. (2007). Developing cultural competence in nursing students through their experiences with a refugee population. *Journal of Nursing Education, 46*(8), 380-383.
- Wingood, G. M., DiClemente, R. J., Harrington, K. F., Lang, D. L., Davies, S. L., Hook, E. W., et al. (2006). Efficacy of an HIV prevention program among female adolescents experiencing gender-based violence. *American Journal of Public Health, 96*(6), 1085-1090.
- Yeo, S., Fetters, M., & Maeda, Y. (2000). Japanese couples' childbirth experiences in Michigan: Implications for care. *Birth, 27*(3), 191-198.
- Zuniga, M. L., Sidelinger, D. E., Blaschke, G. S., Silva, F. A., Broyles, S. L., Nader, P. R., et al. (2006). Evaluation of residency training in the delivery of culturally effective care. *Medical Education, 40*, 1192-1200.