

CULTURAL DIVERSITY WORKSHOP SERIES

By Eileen M. Sharp

Wilkes University

AGENDA

Workshop I

Introduction to Cultural Competence

Workshop II

Health Care Disparities Based on Race and Ethnicity

Workshop III

Gender and Sexuality

Workshop IV

Religious Differences and Decision Making in Health Care

Workshop V

Ageism, Classism and Disabilities

NEED FOR CULTURAL COMPETENCE IN HEALTH CARE PROFESSIONS

- Respond to current and projected demographic changes in the US
- Eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds
- To improve the quality of services and health outcomes
- To meet legislative, regulatory and accreditation mandates
- To gain a competitive edge in the marketplace to decrease the likelihood of liability/malpractice claims

GOAL: To introduce participants to cultural diversity

Participants will explore issues of cultural diversity and will relate information gathered and insights acquired to medical practice in order to build positive inter-cultural communication practices with patients. Participants will complete five cultural competency training sessions and will compile a cross-cultural resource binder for future use.

SET RULES FOR DISCUSSION

- Purpose of establishing ground rules
- Provide 1-2 examples...**listen deeply** (understand another perspective rather than find flaws or develop counter arguments), **non-judgmental** (no dumping/blaming/putdowns), **open to hearing new information, confidentiality** (atmosphere of safety & trust...whatever said in room, stays in room), **self-responsibility** (use "I" statements rather than general statements), **participate at your own comfort level, take some risks to confront your own prejudices & biases** (you will gain the most), **"OUCH"** then educate (we may inadvertently hurt someone...that person should say, "what just happened was an ouch for me." Can be used as an opportunity to educate), **have fun** (freeing ourselves of emotional baggage, getting to know one another and bonding with group members is an added benefit)
- Have participants suggest rules they would like to abide by (post on board & prepare handout for 2nd session)
- Read through list and ask if any need clarification
- Have participants agree to abide by norms with a show of hands

SELF-DISCLOSURE INVENTORY

Complete and keep for your own reference

Compare answers before workshops begin and after workshops are completed

LEARNING OBJECTIVES: Upon completion of this workshop, students will be able to

1. Name the major dimensions of human diversity.
2. List the 5 major racial groups (African American, Asian American, Hispanic, Native American and White) of the U.S. and discuss, in broad terms, the changing demographics of these groups.
3. Identify, after some introspection, several personal characteristics that might be the result of cultural influences.
4. In small groups, discuss and list some differences and similarities among colleagues.
5. Explain the importance of building on similarities to enhance interpersonal rapport.
6. Explain the importance of building on differences to construct effective teams.
7. Identify some general areas of medical practice in which cross-cultural issues might influence the exchange of communication.
8. Give examples of specific situations in medical practice that might require cultural sensitivity and suggest ways of handling those situations in a culturally sensitive manner.
9. Define and discuss the importance of a patient's Health Belief Model (HBM).
10. Formulate non-judgmental responses to "non-compliant" patients.

RESOURCE LIST

BOOK TITLES

Unequal Treatment, Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, The National Academies Press, 2003
Confronting Racial and ethnic disparities in health care

Managing Diversity, Norma Carr-Ruffino, Pearson Custom Publishing, 2000
People Skills for Multicultural Workplace.

Toward a Caring Society, Paul M. Oliner and Samuel P. Oliner, Praeger, 1995
Ideas into Action, pages 79-99

Choosing Democracy, Duane E. Campbell, Merrill Prentice Hall, 2000
A Practical Guide to Multicultural Education, chapter 2 (pgs. 46-49), Chapter 3 (pgs. 77-87), Chapter 5 (pgs. 121-142)

Multicultural Education in a Pluralistic Society, Donna M. Gollnick and Philip C. Chinn, Merrill Prentice Hall, 2002
Chapter: Class, pgs 46-63, Chapter: Ethnicity & Race, pgs 78-96, Chapter: Gender, pgs 126-131, 136-145, Chapter: Religion, pgs 198-223, Chapter: Age, pgs 277-304

Communication Skills for the Health Care Professional, Gwen van Servellen, RN, PhD, FAAN, An Aspen Publication, 1977
Concepts and Techniques., Chapter 3, Beliefs About Majority & Minority Groups, Chapter 5, Communication – Trust & Mistrust of Providers and pgs 45-47

The Right Thing to Do, The Smart Thing to Do Enhancing Diversity in the Health Professions, Brian D. Smedley, Adrienne Y. Stith, Lois Colburn and Clyde H. Evans, National Academy Press, 2001
Summary of the Symposium on Diversity in Health Professions

Applying Multicultural and Global Concepts in the Classroom and Beyond, Susan C. Brown and Marcella L. Kysilka, Allyn and Bacon, 2002

Principles of Human Communication, Paul Watzlawick, Janet H. Beavin, and Don D. Jackson, Aspen Publishers, Inc. 1982
Pgs. 3-62, 88-102, 104-117, 147-156, 175-186, 191-259, 284-301, 303-320 and 325-346

Cultural Competence Works, Health Resources and Services Administration and US Department of Health and Human Services, HRS, 2001

The Ethnic Cultures of America, P. R. Fischetti, Educational Extension Systems

Celebrating Diversity, Luther B. Clegg, Etta Miller, and William H. Vanderhoof, Jr., Delmar Publishers Inc., 1995

Multicultural Teaching, Pamela L. Tiedt and Iris M. Tiedt, Allyn and Bacon, 2002

Guidance for the National Healthcare Disparities Report, Elaine K. Swift, editor, The National Academies Press, 2002

Speaking of Health, Institute of Medicine, The National Academies Press, 2002

Comprehensive Multicultural Education, Christine I. Bennett, Allyn and Bacon, 2003
Chapter 4, Chapter 5 and Chapter 7

Intervention and Reflection, Ronald Munson, Wadsworth Thomson Learning, 2000

Ethnic Community Profiles, Manchester Health Department and Baylor University, Governor's Office of Energy and Community Services of NH, 2002

Women's Health USA 2002, US Department of Health and Human Services, HRSA 2002

A Casebook for Exploring Diversity, George L. Redman, Merrill Prentice Hall 1999

Issues and Ethics in the Helping Professions, Gerald Corey, Marianne Schneider Corey, and Patrick Callanan, Brooks/Cole Publishing Company 1984, 1979

Cultural Competency in Health Care, Rohini Anand, Ph.D., NMCI Publications 1999

The Spirit Catches You and You Fall Down, Anne Fadiman, Noonday Press, 1997

Explores the clash between western medicine and eastern religious beliefs

My Own Country, Abraham Vargehese

Discusses the flaws in health care delivery, the victimization of patients, role of privacy and confidentiality between Dr.'s and patients, ignorance and prejudice, and being foreign-born in America

Bad Medicine, Ron Querry

Based on facts of an actual virus outbreak in the southwest US in 1993...discusses the relationship between western medicine and Native American culture

Medicine and Western Civilization, D.J. Rothman, et al., eds.

Goal is to illustrate and illuminate the many ways in which medicine and culture combine to shape our values and traditions

Trials, Tribulations, and Celebrations: African-American Perspectives on Health, Illness, Aging and Loss, M.G. Secundy and L.L. Nixon, eds.

Anthology of poems, stories, excerpts and essays by African-American writers

Medical Progress and Social Reality: A Reader in Nineteenth-Century Literature and Medicine, L.R. Furst, ed.

Fiction and non-fiction with introductions to issues in nineteenth-century medicine and the larger culture in which it participated

WEBSITES

<http://endeavor.med.nyu.edu/lit-med/lit-med-db/titles.html>

More titles of medicine related literature

<http://www.cdc.gov/nchs/>

The report, "Trends in Racial and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990-1998"

<http://www.cdc.gov/mmwr/>

The report, "Recent Trends in Mortality Rates for Four Major Cancers, by Sex and Race/Ethnicity-United States, 1990-1998"

<http://www.health.gov/healthypeople/>

Information on a new study being worked on by Health and Human Services, Healthy People 2010, which aims at elimination of disparities in health among all population groups

<http://www.diversityresources.com>

Tips for culturally competent care

<http://www.Beliefnet.com>

Information about religions; health and healing and other subject areas

<http://www.asianamericanhealth.nlm.nih.gov/>
Source for Asian American health information

<http://statehealthfacts.kff.org>
Kaiser Family Foundation source for state health data

<http://www.elderabusecenter.org>
Signs and Symptoms of Elder Abuse

<http://www1.dshs.wa.gov/dvr/employers/etiquette.htm>
Disability Etiquette

<http://www.nda.ie/CntMgmt.nsf/Category/2294F824465D7C80256C7B005A49867OpenDocument>
Disability Language

<http://www.diversityresources.com/health2k/greet.html>
Greetings for Holidays

SELF-DISCLOSURE INVENTORY

INTRODUCTION:

In these Workshops, our discussions will revolve around the subject of culture and its relationship to social background and medical practice. Your self-disclosure via this inventory will help you and your classmates listen insightfully and discuss issues sensitively. You may share your self-disclosures if you wish. However, you will only have to disclose those elements of the self-disclosure that you feel comfortable sharing with the group. Please use additional paper to complete your response when necessary.

1. Name: _____
2. Specialization: _____
- 3a. Sex: Male Female
- 3b. Age: _____ 3c. Race and/or Ethnicity: _____
- 3d. Religious Affiliation, if any: _____
- 4a. Are you fluent in any language other than English? Yes No
If yes, please specify: _____
- 4b. What languages were spoken in your childhood home? _____

5. How long has your family/ancestors (both sides) been in the United States? _____

6. Where did your family/ancestors (both sides) come from before arriving in the United States?

7. What is the name of your hometown/city and state? _____
8. Indicate the distance of your hometown/city from the Wyoming Valley.
 less than 50 miles between 100 and 200 miles
 between 50 and 100 miles more than 200 miles
- 9a. Check all of the adjectives that describe the type of community in which you spent most of your time growing up:
 rural low-income
 suburban working class
 urban middle class
 upper middle class
- 9b. Was this community either racially/ethnically segregated or predominantly of one racial/ethnic group? YES NO
If NO: skip to 9c
If YES: What was the predominant racial/ethnic group?
- 9c. Was this community racially/ethnically integrated? YES NO
If NO: skip to question 9d
If YES: What racial/ethnic groups were present and in what proportions/percentages?

- 9d. Provide other descriptors of the community in which you spent most of your time growing up:
10. Indicate the highest level of education completed by your parents or guardians.
11. Indicate the occupations of your parents/guardians.
12. Please check the option that best describes the social class background of your household.
- | | |
|--|---|
| <input type="checkbox"/> low income | <input type="checkbox"/> middle class |
| <input type="checkbox"/> working class | <input type="checkbox"/> upper middle class |
13. How many siblings do you have? _____
14. Have you traveled outside of your home state? YES NO
If YES, please indicate where:
- 15a. Please identify an author, book, film that you have especially enjoyed or was significant to your life.
Why?
- 15b. If any religious texts such as the Bible, Koran, or Torah are particularly significant in your life, please discuss how any why they are significant.
16. Please describe a ritual or significant event that you value or has been especially important in your life. Explain why this is the case.
17. Have you ever experienced interpersonal conflict because of your race, ethnicity, gender, cultural group, or an organization you were active in? If so, please describe one or more of these conflicts. Was this conflict resolved in any way and, if so, how?

18. Do you feel that your racial, ethnic, and/or cultural group membership (and the latter includes gender) has been a positive feature in your life? If so, briefly explain why.
- 19a. How many CLOSE friends do you have? _____
- 19b. How many of these close friends are of a different racial/ethnic background than you? _____
If more than zero, to what racial/ethnic groups do they belong?
- 19c. How many of these close friends are of a different social class background than you? _____
- 20a. Why do you think students fail in medical school?
- 20b. Why do you think students succeed in medical school?
- 21a. In what ways (if any) do you think you were advantaged in medical school?
- 21b. In what ways (if any) do you think you were disadvantaged in medical school?
22. Briefly discuss your most memorable role model/teacher. Please explain why this was the case.
23. Briefly describe the kind of medical practice in which you would like to work. Please include the following competitiveness, focus, public vs. private, demographics, and location (e.g. urban, suburban, rural, etc.) plus any other factors that would be important to you.

WORKSHOP I

INTRODUCTION TO CULTURAL COMPETENCE

OVERHEAD: DEFINITION OF CULTURE

OVERHEAD: THE AMERICAN IDEAL

INTERACTIVE ACTIVITY:

Venn Diagram

Complete in 3's and discuss similarities and differences.

BROAD OVERVIEW:

- Culture
- Diversity
- Multiculturalism

CULTURAL COMPETENCE IN HEALTH CARE

(From, "Cultural Competence Works," 2001)

- Health care dispensed to INDIVIDUALS
Other characteristics in addition to race, language and ethnicity contribute to person's sense of self in relation to others
- Workshops intended to help individuals become more aware of appropriate & inappropriate behaviors
- Awareness, knowledge, skills, role models needed for changing behaviors

IMPORTANCE OF CULTURAL COMPETENCE WORK FOR HEALTH CARE PROVIDERS

- Prejudice
Impact on the delivery of health care
- Ethnocentrism
Cultural beliefs are ONLY correct ones & are superior to others
- Possible results of Medical Ethnocentrism
Consumers refuse to communicate beliefs/behaviors
Physicians interpret situation using own beliefs & may be incorrect
Physicians with little experience with patients of particular cultural groups, likely to prejudge based on stereotypes

MINORITY GROUPS' SIZE INCREASING

Predictions

- By 2020, White non-Hispanics will comprise only 64% of the population
- By 2020, African Americans are predicted to comprise about 13% of our population
- In percentage terms, Asians are the most rapidly growing minority group in the US (6.5% by 2020)
- In terms of absolute numbers, the most rapidly growing group is Hispanics. (37% of the population by 2020)

- By 2020, 42% of California's population will be of Hispanic origin, Asians will comprise 18% and White non-Hispanics will account for 1/3

Predictions' significance

- Minority groups disproportionately affected by disease and health care problems

IMPORTANCE OF CULTURAL COMPETENCE WORK FOR HEALTH CARE SYSTEM

- Providers must learn the skills required to address the needs of diverse patient groups
Resentment of shift from biological focus on individual to that of cultures Difficult to incorporate a patient's world view into the treatment plan
(World view - described as a set of assumptions, values and beliefs that are related logically to one another. This set of assumptions affects the way people perceive and experience the world, including the way they experience sickness) {Jones, W. J. (1976). "World views and Asian medical systems." UCLA Press}.

INTERACTIVE ACTIVITY II:

Cultural Identity Worksheet

Complete and share some descriptors with others

OVERHEAD: ICEBERG MODEL OF CULTURAL INFLUENCES ON COMMUNICATION

Discuss

IMPORTANCE OF COMMUNICATION

- Fundamental cause of miscommunication - frequently difference in values

THINGS THAT GET IN WAY OF EFFECTIVE CROSS-CULTURAL COMMUNICATION:

Assumed Similarity

- Assume that words and gestures have a set meaning)

Nonverbal Communication

Approximately 70% of communication affected by nonverbal cues

Smiling, silence, gestures, nodding, eye contact, body language, touch, etc.

- Nonverbal cues mean different things in different cultures - cautious of interpretations
- Many cultures context bound - communication in physical context of situation, rather than verbal transmission
- Beware of own nonverbal language as well as comfort levels with different nonverbal communication patterns

Verbal Language

- Language - most obvious barrier to cross-cultural communication
- Language misunderstandings - result from use of nuances, slang and idioms, technical jargon and accents
- Assumptions made about pacing and timing
- Important to take responsibility for - message sent is not just heard, but understood

Tendency to Evaluate

- Differences in values - result in different communication style - can result in negative judgments about another person.
- Negative judgments - cause communication shut-off - a message is not even heard

Preconceptions and Stereotypes

- Judge people based on learned concepts (mental tapes)
- Distinction between cultural patterns and stereotypes
 - Cultural patterns - used to understand groups of people - patterns not static - subject to exceptions
 - Stereotypes - short cuts - see what we expect to see, even if reality differs
- Barrier between stereotypes bridged by:
 - Acknowledging existence of preconceptions
 - Understanding how they impact us
 - Knowing labels and to whom we relegate them
 - Slowing down, checking out situation and getting more information

“CONVERGENCE OF MULTIPLE MEMBERSHIPS IN VARIOUS CULTURAL AND SUB-CULTURAL GROUPS CONTRIBUTES TO INDIVIDUAL’S PERSONAL IDENTITY & SENSE OF OWN “CULTURE”

Understanding how factors affect **HOW A PERSON SEEKS AND USES MEDICAL CARE & CULTURE GROUP’S HISTORICAL RELATIONSHIP TO MEDICAL ESTABLISHMENT** - integral part of providing culturally competent health care

INTERACTIVE ACTIVITY III:

Cultural Self-Assessment (Identifying your World View)
Complete and share some descriptors with others

DIMENSIONS OF DIVERSITY – (BRAINSTORM IDEAS ON BOARD)

Discuss in conjunction with Dimensions of Diversity Overhead

OVERHEAD: DIMENSIONS OF DIVERSITY (INTERNAL, EXTERNAL)

Once group has discussed ideas of what distinct factors create diversity, show overhead of “Dimensions”

Discuss where each factor falls in relation to internal or external influences

OVERHEAD: LAYERS OF DIVERSITY (INTERNAL, EXTERNAL & ORGANIZATIONAL)

Doctors must work with colleagues in “team” effort

Doctors taught to function primarily on own (self-sufficient, autocratic, able to make independent decisions, etc.)

Discuss how factors affect and influence ability to work well with each other as well as all patients

CENSUS

CHANGING DEMOGRAPHICS (& DEMOGRAPHIC IMPERATIVE)

Impact of changing demographics on need for multi-cultural knowledge

OVERHEAD: US POPULATION – AS OF YEAR 2000 CENSUS ESTIMATES

Discuss impact of changing demographics health care providers

OVERHEAD: PA DEMOGRAPHICS

Discuss population demographics of Pennsylvania

OVERHEAD: WVHCS PATIENT DEMOGRAPHICS (IF AVAILABLE)

(Brainstorm ideas on board about WWHCS patient demographics, if not)

- Cultural competence - demonstrated by extent to which a program is able to
LEARN ABOUT & VALUE target community's knowledge, attitudes and beliefs about health care
- Competence - reflected in extent to which information applied to program to **IMPROVE ACCESS TO & QUALITY OF CARE** while **RESPECTING CULTURAL HEALTH BELIEFS & PRACTICES**
- Effective communication with patients - providers must understand **HOW TO TALK ABOUT SENSITIVE ISSUES**

NON-JUDGMENTAL CARE

Providers - learn how **NOT TO REACT NEGATIVELY** when patient responses differ from one's own belief system

INTERACTIVE ACTIVITY IV:

Non-judgmental Responses
Discuss

WRAP UP: ???????????

Final Questions And Discussion

HANDOUT:

PERSPECTIVES ON EQUITY

By: Julian Waters, Printed in "Many Waters", Fall 1993
Center for Educational Change in Mathematics & Science,
UC-Santa Barbara 93106

PERSONAL SKILLS FOR RESOLVING CONFLICTS

IDENTIFYING YOUR WORLD VIEW

As we have seen, the first step in dealing effectively in cross-cultural disputes is to know what your beliefs and values are, and how they affect your behavior. This may give some insight into how another person's very different beliefs and values influence the relationship.

Let's start with a relatively simple cultural self-assessment.

The purpose of this cultural self-assessment is to give you an opportunity to begin the process of knowing yourself and some of your own cultural values. It is the first step in being able to make the most effective use of your personal conflict-resolution style.

CULTURAL SELF-ASSESSMENT

For each of the pairs of statements below, circle either A or B as most representative of your experience.

1. A. I have always worked with people like myself.
B. My work has required me to deal with diverse groups of people.
2. A. I only know English and believe it is up to limited-English speakers to learn this language.
B. I'm interested in other languages and communicate easily with limited-English speakers.
3. A. I feel uncomfortable around people with disabilities.
B. I reach out to people with disabilities because I am interested in others.
4. A. I go with my first impressions of people.
B. I realize first impressions are not enough to make a judgment.
5. A. If someone's name is very unfamiliar to me, I suggest that I call that person by a nickname.
B. When someone's name is unfamiliar, I try to pronounce it correctly.
6. A. I see nothing wrong with using words like "girl", "boy", or "honey" when referring to my coworkers.
B. I'm aware that "girl", "boy", and "honey" may be offensive to some people.
7. A. I believe that people from backgrounds different from my own must learn "our ways" quickly.
B. I realize that different perspectives can contribute greatly to good decision-making.
8. A. I believe differences make it harder for people to work together.
B. I'm willing to consider differences as a positive contribution.
9. A. I do not enjoy trying food or drinks that are unfamiliar.
B. I am open to all kinds of new food experiences.
10. A. I am not comfortable being the "only" in a group.
B. I am aware that it is difficult to be the "only" in a group, yet find it challenging.

COUNT THE NUMBER OF A'S AND B'S: NO. OF A'S _____
NO. OF B'S _____

You have just identified your general world view. Obviously this view affects how you will deal with conflicts across cultures.

If most of your answers were A, you probably have an outlook that is ethnocentric and believe that your culture is not only best for you but also best for most other people. This makes resolving cultural disputes more difficult. Our goal is not to change your values but to give you some new insights and information about communication that may help in resolving disagreements with people from other cultures.

If most of your answers were B, your outlook is likely to be one that is flexible and accepting of different cultures. We hope you will gain some additional understanding and new skills from this book for dealing with the cultural complexities present in most disputes.

Resource: www.diversity.com

CULTURAL SELF-ASSESSMENT

DESCRIPTORS

The four dominant cultural descriptors that make up my cultural identity are:

1. _____

2. _____

3. _____

4. _____

POSITIVES

The most positive thing about each of these descriptors is:

1.

2.

3.

4.

NEGATIVES

The most negative or difficult thing about each of these descriptors is:

1.

2.

3.

4.

CULTURE

The collective programming of individual's minds that determines how a group of individuals perceives reality

CONTENT OF CULTURE

Consensus reality of a group

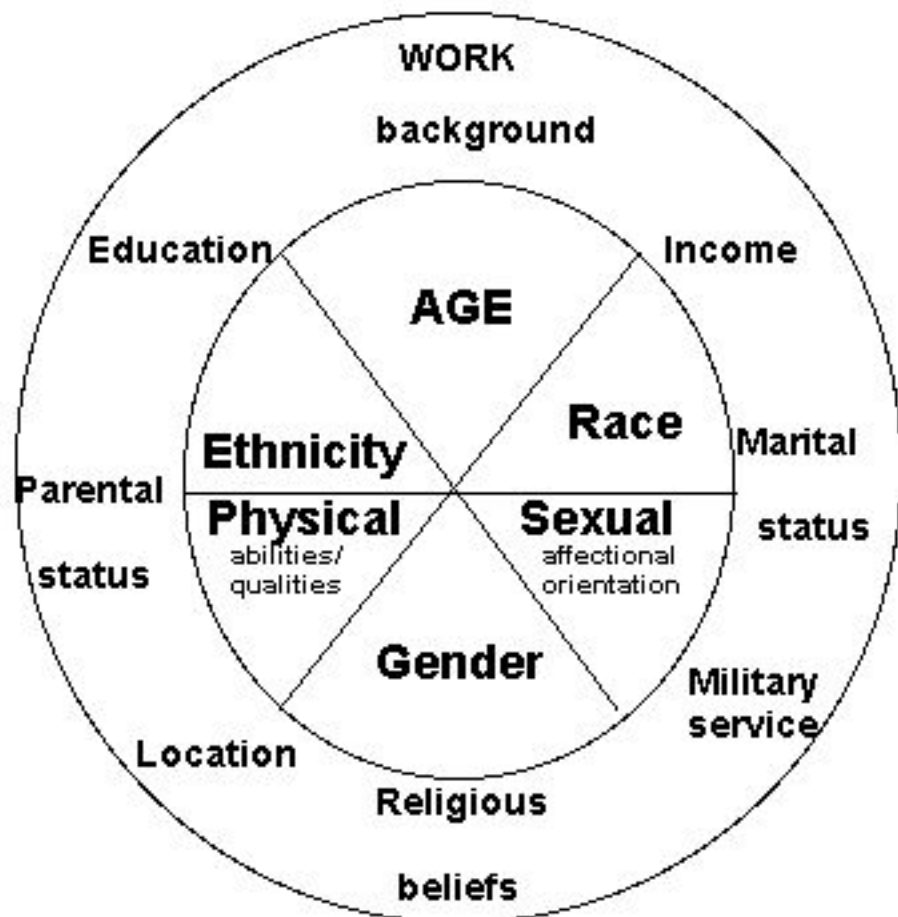
How we agree to create our reality

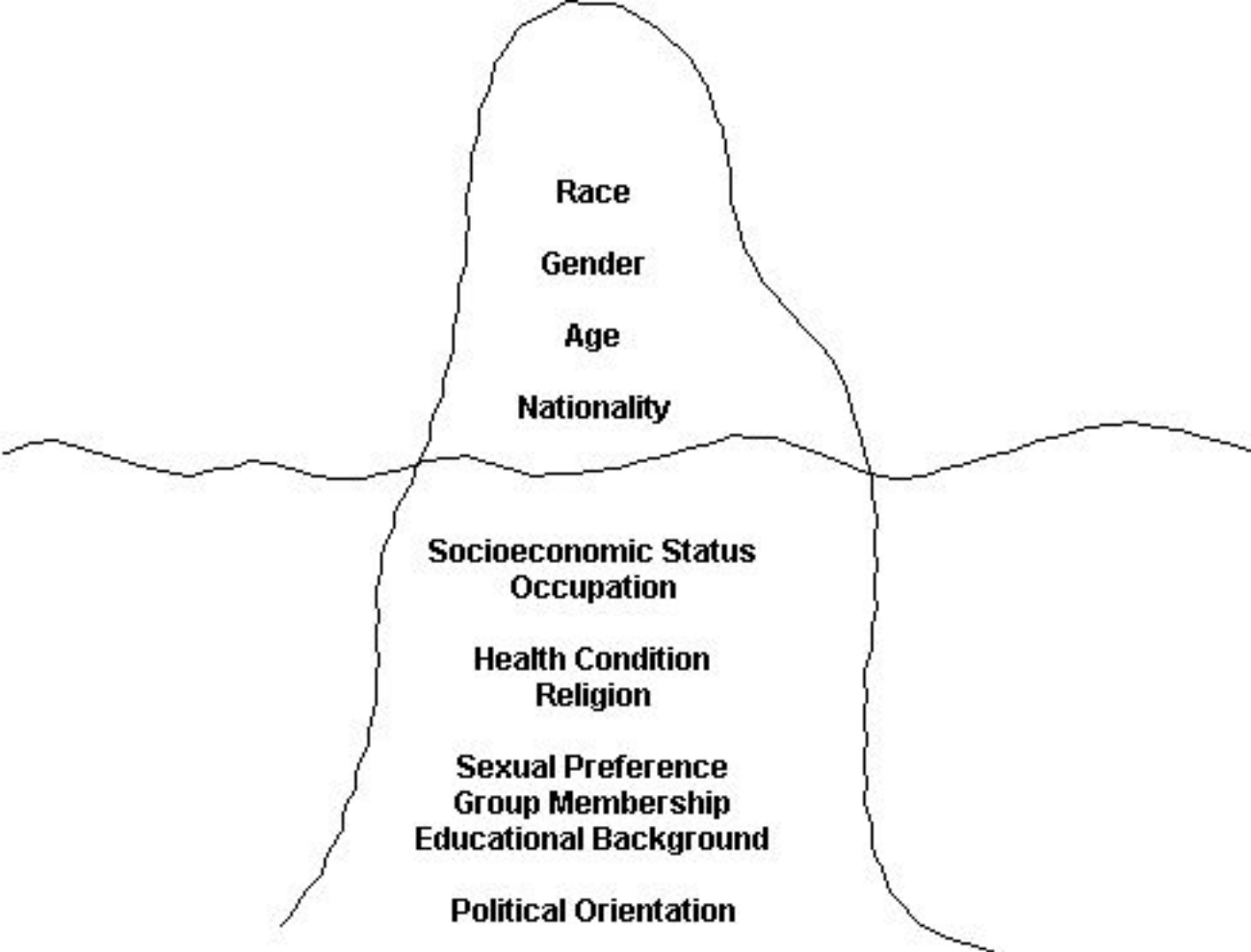
Ways of thinking, feeling, speaking & acting

Obvious aspects and hidden aspects

High priority beliefs = values, the roots or foundation of culture

Dimensions of Diversity





Iceberg Model of Multicultural Influences on Communication.
From Krepp, G.L. *Effective Communication in Multicultural Health Care Settings*. New York, Safe Publications, Inc., (c) 1994.
Reprinted by permission of Sage Publications, Inc.)

NONJUDGMENTAL RESPONSE EXERCISE

1. "I'm doing twice as much work as Joe is, and it's just not fair."
Interest: _____
Nonjudgmental response: _____
2. "Hey, it wasn't my fault. People never tell me anything around here."
Interest: _____
Nonjudgmental response: _____
3. "I refuse to attend any more evening meetings."
Interest: _____
Nonjudgmental response: _____
4. "The Docs are always complimenting Stella but never say anything to me."
Interest: _____
Nonjudgmental response: _____
5. "You're doing it wrong!"
Interest: _____
Nonjudgmental response: _____
6. "You never call when you say you will."
Interest: _____
Nonjudgmental response: _____
7. "If you're late one more time, you can just find your own ride to work."
Interest: _____
Nonjudgmental response: _____
8. "Quit looking at me like that!"
Interest: _____
Nonjudgmental response: _____

PA STATISTICS VS US STATISTICS

<u>CATEGORY</u>		<u>PA</u>	<u>%</u>	<u>US</u>	<u>%</u>
<u># Residents</u>		<u>12,071,710</u>	<u>100</u>	<u>281,293,330</u>	<u>100</u>
Racial Distribution	White	10,325,940	86	194,254,300	69
	Black	105231	9	34578090	12
	Hispanic	443820	4	37350280	13
	Other	249630	2	15110650	5
Population by Age	18/under	2955120	24	76552180	27
	19 – 64	7478000	62	170970870	61
	65+	1538590	14	33770280	12
	65 – 74	855160	7	18099260	6
	75+	783430	6	15671010	6
Population by Gender	Female	6252520	52	1444116160	51
	Male	5819190	48	137177170	49
Adults with Children		6220440	52	154675710	55
Adults with no Children		5851270	48	126617620	45

PERSPECTIVES ON EQUITY

1. No one is born prejudiced. All forms of bias, from extreme bigotry to unaware cultural biases, are acquired (actually imposed on the young person) and are dysfunctional.
2. All humans are very much alike. We are one species.
3. In many societies the assumptions, values, and practices of people and institutions from the dominant culture serve to the disadvantage of students from the nondominant culture.
4. Racism is *more* than the sum of individual prejudices. It is a complex social and economic phenomena that affects all aspects of U.S. society, in particular, education.
5. Racism, sexism, and classism are serious issues facing U.S. society and education that are usually not discussed. Talking about them is necessary, not to lay blame, but to figure out better ways of educating *our* children.
6. In the U.S., the lack of acceptance and support of a variety of forms of leadership is an impediment to the development of teacher leadership among people of color, women, and the working class.
7. It will be necessary to improve alliances between white educators and educators of color, between males and females, and between people of different class backgrounds, in order to make progress on this very complex problem.
8. Discussing and gaining new understandings about the existence and effects of bias and discrimination will usually be accompanied by strong emotions.
9. Changed attitudes and actions will be facilitated if we are listened to attentively and allowed to release *our* emotions as we attempt to make sense of what we and others have experienced (are experiencing).

What are your thoughts about this?

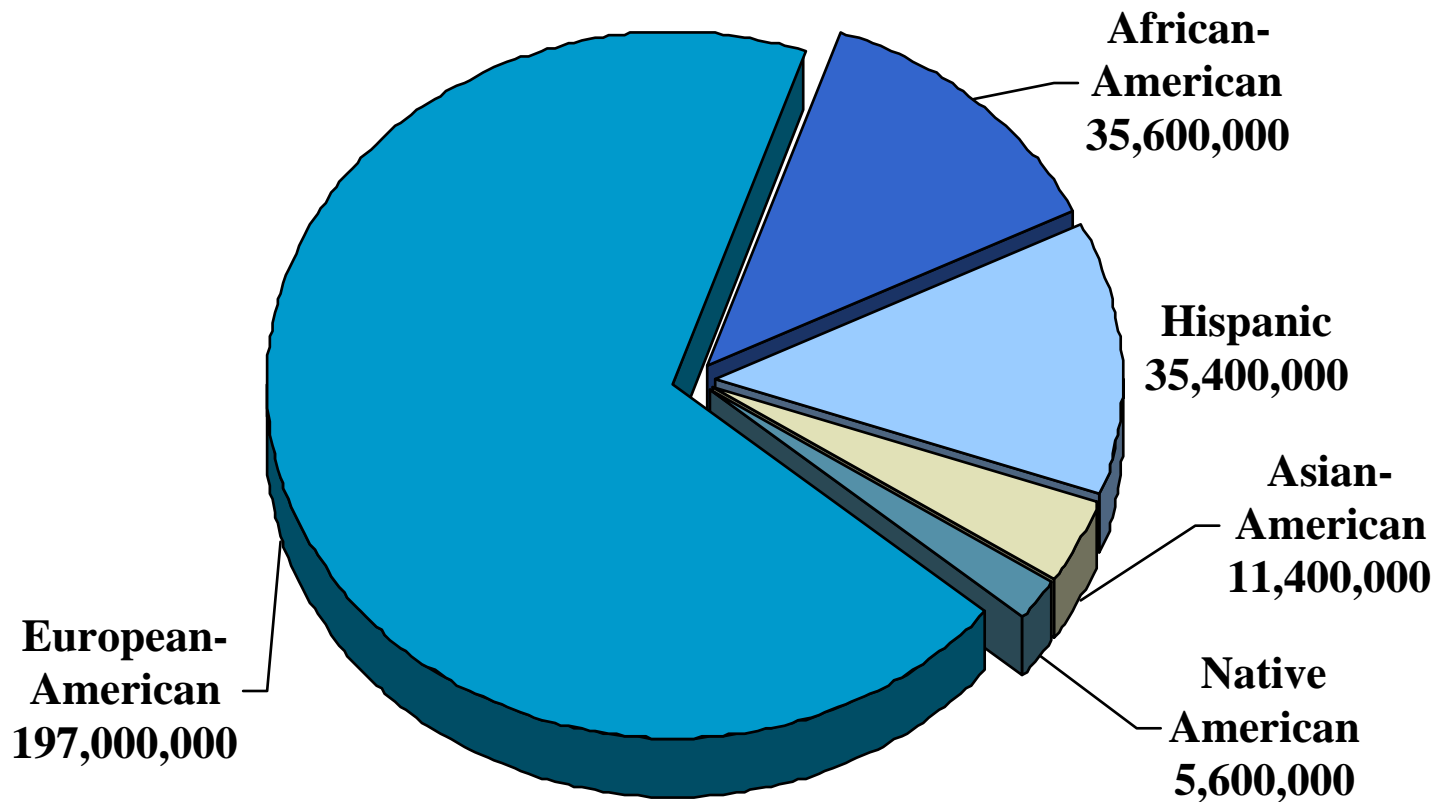
Julian Weissglass

THE AMERICAN IDEAL IS NOT THAT WE WILL AGREE WITH EACH OTHER, OR EVEN LIKE EACH OTHER, EVERY MINUTE OF THE DAY. IT IS RATHER THAT WE WILL RESPECT EACH OTHER'S RIGHTS, ESPECIALLY THE RIGHT TO BE DIFFERENT, AND THAT, AT THE END OF THE DAY, WE WILL UNDERSTAND THAT WE ARE ONE PEOPLE, ONE COUNTRY, AND ONE COMMUNITY, AND THAT OUR WELL-BEING IS INEXTRICABLY BOUND UP WITH THE WELL-BEING OF EACH AND EVERY ONE OF OUR FELLOW CITIZENS.

The late **Arthur J. Kropp**
President of People For the American Way
1987-1995

US Population

2000 Census Estimates: 285,000,000



Workshop II

HEALTHCARE DISPARITIES/RACE & ETHNICITY

HEALTH CARE DISPARITIES

(From: The Health and Human Services Department of the federal government: Assessing Health Care Disparities in the US: www.cdc.gov/nchs/)

SIX TARGETED AREAS

CANCER
CARDIOVASCULAR DISEASE
INFANT MORTALITY
DIABETES
HIV/AIDS
CHILD/ADULT IMMUNIZATIONS

DEFINING “CULTURAL COMPETENCY” FOR HEALTH CARE PROFESSIONALS

ELEMENTS OF CULTURAL COMPETENCE
HOW SHOULD WE TREAT RACE/ETHNICITY?
BIAS & DIVERSITY
MANAGED CARE & MINORITY PHYSICIANS
RACE/ETHNICITY AS A RISK FACTOR FOR POOR CARE
CULTURAL COMPETENCE & COMMUNICATION SKILLS

OVERHEAD: US CENSUS RESULTS

US population - breakdown by race in 2000 census
Race by states – Projections 2000-2010

INTERACTIVE ACTIVITY I:

World Statistics

Each individual answers questions on worksheet. Discuss answers

MYTHS & REALITIES

(From: “Managing Diversity in the Workplace”)

Myths - Developed to explain behaviors different from own culture

Myths - Sayings or stories used to bind thoughts of group & promote coordinated social action

Myths based on:

- Manipulative, hurtful lies
- Harmless little white lies
- Powerful truths
-

RACIAL GROUPS/UNDERREPRESENTED MINORITIES

AFRICAN AMERICANS

Myths about African Americans - stereotyped beliefs that result in prejudice and discrimination

Ethnic prejudice - still - primary challenge to African Americans moving up in US

Survey, taken 1992 (Thornton & Whitman) - following beliefs were still prevalent:

1. Are Blacks more violent than Whites? Yes, 63%

2. Are they less intelligent? Yes, 53%
3. Are they more likely to live off welfare? Yes, 78%
4. Do they blame everyone but themselves for their problems? Yes, 57%
5. Do they tend to be resentful troublemakers? Yes, 51%

FOLLOWING MYTHS STILL PREVAIL IN SOME PARTS OF COUNTRY:

Myths about African Americans

(From, "Managing Diversity in the Workplace")

1. African Americans - more violent than others
 - Cultural custom - African Americans' - preference for using direct confrontation to resolve conflict
 - Most Euro-, Asian and Latino Americans prefer more indirect methods

African American behavior - seen as hostile

 - Reality - certain behavior considered assertive and truthful by African Americans - often interpreted as anger or rage, which may erupt into violence

What feeds interpretation?:

 - Cultural differences about how to express concerns & emotions
 - "Violent" stereotype itself... see what we expect to see - ignore actions that don't fit stereotypes
2. African Americans - less intelligent than others
 - Euro-Americans assume - even highly intelligent African Americans – less competent
 - Reality - school grades and standardized test scores - more to do with socioeconomic status than any other factor, including ethnicity
3. African Americans - lazy and irresponsible
 - About same proportion African Americans hold jobs as Euro-Americans
 - African American men receive about 75% of pay of White men
4. African Americans - blame everyone else for problems
 - African Americans struggling to overcome 200 years of slavery & 100 years of legal segregation
 - Self-help programs - many feel government should help inner-city underclass break out from under history
 - Reality - progress made since civil rights laws of 1960's
About 1/3 of African Americans actually worse off and in extreme need of help
Those who made progress - done by "pulling themselves up by own bootstraps"
5. Many African Americans - resentful troublemakers
 - Myth - also connected to cultural differences in confronting issues and expressing concerns, history of attempting to break free from discrimination, inner city underclass crime
 - Reality - many in African American community believe in speaking assertively, being genuine, expressing feelings & confronting issues directly - valued, typical cultural patterns

ASIAN AMERICANS

(From, WEBSITE: <http://asianamericanhealth.nlm.nih.gov/>)

Common threads among all Asian American groups

- Asian Americans in US over 150 years - even before many European immigrant groups
“Different,” - often stereotyped as heathen, exotic, unassimilable

Chinese - first to arrive in significant numbers

- 1850's gold rush

What Happened:

- Chinese Exclusion Act of 1882- prohibiting entry of immigrants on basis of nationality
- Alien Land Acts - barring Asian Americans from owning land - because aliens ineligible for citizenship
- Miscegenation Laws - prohibiting marriage between people from different races
Influenced treatment of Japanese, Koreans, Filipinos, Asian Indians, & Southeast Asian refugees who came to US after Vietnam War

Most Asian American groups:

- Deal with similar myths and stereotypes
- Experience generational differences as new generations become Americanized
- Hold some common cultural values and behavior patterns
- Affected by some common political issues

Must learn differences among each Asian American group

Myths about Asian Americans

1. Asian Americans - retain foreign ways - difficult for them to fit in

Perpetuated by discriminatory laws and practices & Euro-Americans - see Asian Americans as:

Immigrants who represent small segment of population

People of color who bear distinct physical differences

People from culture & lifestyle just, “too different for comfort”

People who can never be completely absorbed into American society & politics

- Reality - 1/4 to 1/2 of members of most Asian American groups - born in US
- Bilingual Asian Americans who have recently learned English and still have heavy accents can be understood by those willing to listen for rhythm and pattern of their speech
- Asian cultures offer ancient wisdom to those open to different ways of viewing situations and incorporating different ideas

2. Asian Americans - unemotional

Euro-Americans complain - can't tell what Asian Americans - thinking or feeling

- Reality - Asian Americans experience same emotions
- Cultural values call for self-discipline in expressing emotions & indirectness in communicating
- When disagreeing - saying no or conveying unwelcome information - often do indirectly and subtly

3. Asian Americans learned how to make it in US society by working hard & being thrifty

Model minority” myth - true as far as it goes

- Makes Asian Americans more acceptable in business and society
- Ignores complexities and difficulties of (seen as willing to make major sacrifices for work & work for less, have no pressing social/political issues, causes resentment among other minorities)
- Reality - as a family unit, Asian Americans work harder and longer for less pay than Euro-Americans & get less help from society

4. Asian Americans can't master English grammar & pronunciation

Have communication problems

- Asian languages - extremely different from English
- Becoming fluent and proficient - long and arduous process for Asian American immigrants Most work diligently to improve communication skills
- Many Asian Americans believe - English should be only official US language
- Reality - most all Asian Americans born in US - fluent in English & may not be fluent in ancestral Asian language

LATINO AMERICANS

Government recognizes Hispanics as - distinct “racial” group for civil rights purposes

Difficulty with term - root word “Spain”

- Latino activists prefer - Latino
- Latino Americans include people from three large groups - Mexican American, Puerto Rican American and Cuban American & smaller groups from many countries

Most values & customs - woven from common Latino threads

Each country - own unique cultural influences, also

Most myths - false or distorted, partial truths

- Often come from misunderstandings about how certain cultural values and customs affect Latino Americans’ attitudes and actions

Myths about Latino Americans

(From, “Managing Diversity in the Workplace”)

1. Latino Americans are too passive, polite and lack conviction
 - Myth focuses on style, not substance
 - Values of harmony and positive interpersonal relationships - important to Latinos
 - Latino Americans do learn to adapt, Can be appropriately assertive
2. Latino Americans are too emotional and excitable
 - Latino Americans highly value emotions
 - Culture encourages - fully experience feelings, puts fewer restrictions on them than many other cultures
3. Latino American men - macho and women - easily intimidated
 - Latinos - generally viewed as passive and polite
 - Men -often stereotyped as being macho with their women and each other in bars or other similar situations
 - Machismo stereotype -Male - strong, in control, provides for family
- Female –submissive, lacking in power and influence
 - Reality - Latino cultures have own brand of patriarchy
 - Some studies show - male dominance in marital decision-making - not necessarily rule among Latino American couples
 - In Latino countries - both boys and girls socialized to admire this image
 - Latino husbands virtually always “wear the pants” in interactions with outside world and less likely to participate in household and child-care responsibilities
4. Latino Americans – don’t speak English very well, appear to be evasive in communication with others & have “manaña” attitude
 - Latino Americans - diverse group
 - Many in US for generations, Highly educated
 - Extremely loyal in relationships with family and friends

- Frequently indirect with strangers and outsiders - appears evasive
- Latino Americans - typically focus on present moment
 - Think and plan less for future because of uncertainty, Relates to sense of fate
 - Manāna refers to concept - future is indefinite, Rather than procrastination or laziness

NATIVE AMERICANS

(From, "Comprehensive Multicultural Education," 2003)

Who is an American Indian?

- Some full-blooded native people don't regard person with 1/4 native heritage as qualifying
- Others accept 1/128th
- Majority of native peoples accept person with at least 1/4 tribal heritage as member

Native American Lands

- 5%/94 million acres of US territory -currently held by Native Americans and Alaskan Natives
- Compared to 2 billion acres of land used by native people – 1492

Ten Primary Culture Areas Identified in North America,

- Arctic
The last Siberian wanderers to reach America
Aleuts and Inuits
- Sub Arctic
Nomadic hunters of taiga or northern forests
Carriers, Crees, Dogribs and Kutchins pursued big game (caribou & moose and small fur bearing animals)
- Northwest Coast
Premier woodworkers
Seafaring **Haidas, Kwakiutls and Tlingits** crafted totem poles, boats and elaborate dwellings from region's giant evergreens
- Plateau
Fishermen, foragers & hunters
Nez Perce, Spokane & Yakima Plateau tribes lived in underground, pit houses
In Columbia River country
- Plains
Horse & gun transformed **Arapaho, Cheyenne, Sioux** & other plains tribes from farmers to nomadic buffalo hunters
- Northeast
3 confederacies, **Powhattan, Iroquois & Miami**, occupied settlements on coast & in forested uplands and farmed, hunted & fished
- Southeast
Skilled farmers
Creeks, Chickasaws, Choctaws, Cherokees, Yamasees & Seminoles built villages in river valleys
- Southwest
Pueblo-dwelling Hopi & Zuni lived on rugged mesas
Hopi, Zuni and Pima fought **Apache and Navajo** hunter-raiders

- Great Basin
Bands of **Paiutes, Utes, Shoshones and Bannocks** roamed arid basin and snowy range making most of scarce, seasonal resources
- California
Hunter-gatherer tribal bands, speaking hundreds of different languages, lived in bountiful area smaller than today's state

Culture of Native Peoples of North America

- As dissimilar as peoples of Europe are in their culture, language & physical appearance
- European incursion into North America - hundreds of different Native American societies
- Over 200 different languages spoken
- Political, social and economic systems differed dramatically

Shared Cultural Perspective - world view - reflects basic spiritual values and reverence for earth

- European settlers - oblivious to history and culture of native peoples that developed over previous 20,000 years

Estimates of Native American population

- At time of European settlement - varies between 500,000 and 1,150,000, up to 10 million
- European diseases - especially smallpox, measles and syphilis wiped out large portions of Native American population during early years of contact

Ramifications of Politics and Settlement

- Indian Removal Act - passed 1830 - stipulated that Natives could be relocated only on condition of their consent
- Federal government forcibly removed native people living east of Mississippi to reservations in West
4,000 Cherokees died during the forced march out of the South on "trail of tears," to present day location in Oklahoma

Ethnocentrism large part in land conflict between European Americans & Native Americans

- Dawes Act- passed 1887 - provided each Native American family with 160 acres of reservation land
Titles held in trust by federal government for 25 years
- Native traditions- especially religions and education - suppressed
Native Americans - expected to become farmers, violating Native American cultural values
- Results of imposed value systems dramatically affected Native people - numbers shrunk dramatically - lost over 90 million acres of land to Whites

Native American Rights

- American Indians - declared citizens of US in 1924
- Since 1930's - native nations recognized as legally autonomous self-governing territories, separate from any state
- Indian Reorganization Act of 1934 - indicated return to early principle that native peoples have right to self-determination:
Reservation lands returned to tribal management
Community day schools replaced distant boarding schools
Traditional cultures, including religions encouraged

Rights Not Restored

- Illegally seized lands not restored
- Many treaty agreements still ignored
- Reservations are colonies subjected to political and economic policies of Washington, DC

Most reservations located on barren land

NATIVE AMERICANS AND HEALTH STATUS

Compared to all other ethnic groups in US - Native American population suffers

Poorest health

Shortest life span

Greatest economic impoverishment

COMMUNICATION

CROSS-CULTURAL COMMUNICATION AND HEALTH CARE

Meaning:

Each individual has cultural background/Friends, neighbors, coworkers and patients each have cultural background

- Cross-cultural interactions occur when two cultures come into direct contact with each other

Unique relationship between patient and the physician

Makes it essential to find effective way to communicate across cultures

Cultural background influences patient's interpretation of:

Disease

Health

Health care

Manner in which they relate to health care providers

Cultural background influences physician's interpretation of patient's perspective into care provided

To provide health care, physicians must communicate with patients in number of ways

Patient presents with illness, three main avenues of communication required:

- Patient History: obtain specific information about previous illnesses, allergies, etc.
- Diagnose & treat illness: testing & prescription for care to eliminate &/or control illness
- Ascertain patient's understanding of treatment regimen & level of compliance & answer questions

Each process can be hindered through cultural differences

- Without effective communication, serious consequences can occur

EX: "The Spirit Catches You and You Fall Down" by Anne Fadiman

Book explores clash between small county hospital in California and refugee family from Laos over care & treatment of Lia Lee, Hmong child diagnosed with severe epilepsy

Lia's parents and doctors both wanted what was best for Lia - lack of understanding between

Hmong medical beliefs & western medical beliefs led to tragedy (MEDICAL

ETHNOCENTRICITY)

Barriers to effective communication in this situation:

CULTURE

LANGUAGE

RELIGION

AGE

HEALTH CARE SYSTEM that patient & family accustomed to in home country

Ethnocentricity

- Implies awareness of and concern with only one's own culture

- Works directly against communicating effectively with other cultures

WRAP UP: ????????

Final Questions and Discussion

HANDOUT:

CULTURE-SENSITIVE HEALTH CARE

From: www.diversityresources.com

CULTURE-SENSITIVE HEALTH CARE

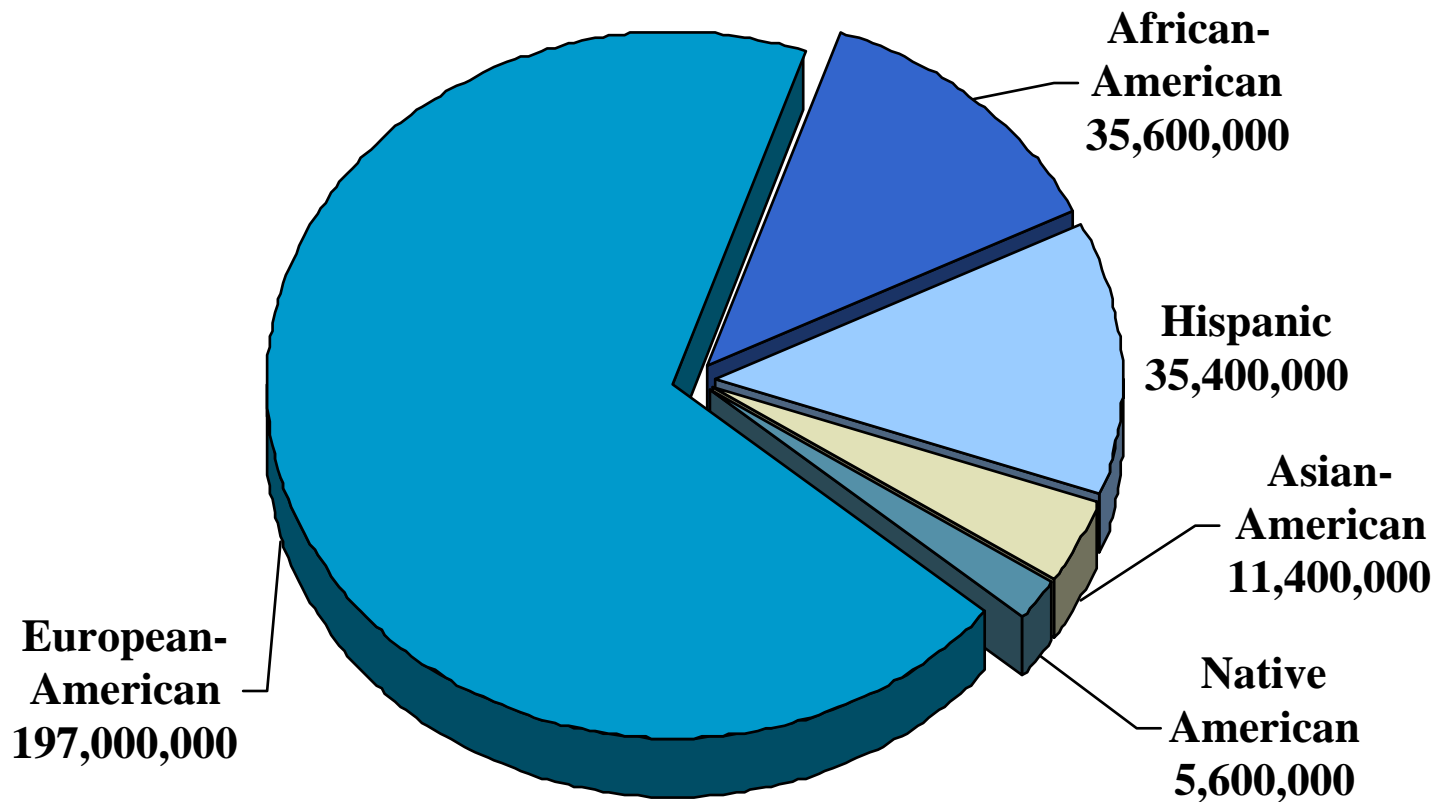
**TIPS FOR
HEALTH CARE PROFESSIONALS**

www.diversityresources.com

**INCLUDES MANY DIFFERENT
RACES/ETHNIC BACKGROUNDS**

US Population

2000 Census Estimates: 285,000,000



WORLD STATISTICS

If we could shrink the earth's population to a village of 100 people, with all of the existing human ratios remaining the same, what would it look like? **Fill in the blanks below** with your best guess as to the breakdown of that village.

OUT OF 100 PEOPLE, HOW MANY WOULD BE:

Asians _____

Europeans _____

From the Western Hemisphere _____

Africans _____

Female _____

Male _____

Non-white _____

White _____

Non-Christian _____

Christian _____

OUT OF 100 PEOPLE, HOW MANY WOULD:

Live in substandard housing _____

Be unable to read _____

Suffer from malnutrition _____

Be homosexual _____

Have a college education _____

Own a computer _____

50% of the world's wealth would be in the hands of how many people?

How many of the wealthiest would be citizens of the US?

When we consider our world from such a compressed perspective, the need for acceptance, understanding and education becomes glaringly apparent.

SOMETHING TO PONDER

- If you woke up this morning with more health than illness, you are more blessed than the 1 million people who will not survive the week.
- If you have never experienced the danger of battle, the loneliness of imprisonment, the agony of torture, or the pangs of starvation, you are ahead of 500 million people in the world.
- If you can attend a religious meeting without fear of harassment, arrest, torture or death, you are more blessed than 3 billion people in the world.
- If you have food in the refrigerator, clothes on your back, a roof over your head and a place to sleep, you are richer than 75% of this world.
- If you have money in the bank, in your wallet, or spare change in a dish somewhere, you are among the top 8% of the world's wealthy.
- If your parents are still alive and still married, you are very rare, even in the United States and Canada.
- If you can read this message, you are more blessed than over 2 billion people in the world who cannot read at all.

WORKSHOP III

GENDER & SEXUALITY

Sex

- Refers to biological differences between men & women

Gender

- Relates to normative expectations attached to each sex
- Gender focuses on characteristics of femininity and masculinity determined by culture

INTERACTIVITY I:

Masculinity and Femininity

- a. We all know what masculine and feminine are
Line yourselves up according to most feminine to most masculine in group
- b. What's an "All-American man?" What's an "All-American woman?"
What are the traits/qualities you like to see in men/women, traits and actions you feel comfortable with?
Using a flip chart, have group members give adjectives to describe
- c. Ask individuals who lined up as most masculine and most feminine if adjectives describe him/her

A. GENDER

SOCIETY CONTINUES TO HOLD DEEP-ROOTED ASSUMPTIONS ABOUT HOW MEN AND WOMEN SHOULD THINK, LOOK AND BEHAVE

SEXISM

- Belief in the inherent superiority of one sex over the other and thereby the right to dominance

SEX DISCRIMINATION

FAMILIES: Socialization patterns within family

- May limit potential of children when taught gender-differentiated behaviors:
GIRLS – taught to be more obedient, neat, passive & dependent
BOYS - taught to be more disobedient, aggressive, independent, exploring & creative
- Women often do not realize the extent to which they do not participate equally in society
- Men often do not realize privileges maleness bestows on them

Many discriminate on basis of gender without realizing it

- Raised in sexist society
Behavior is natural and acceptable
- Parents
Don't directly plan to harm daughters by teaching "feminine" roles
Don't realize such characteristics may prevent daughters from achieving societal benefits comparable with men

INTERACTIVE ACTIVITY II:

Stereotypes, Myths & Realities

Discuss stereotypes and write on board:

What traits are seen as those that are needed to be successful in a medical career?

What stereotypes about traits create barriers for women?

HEALTH CARE AND WOMEN

Important Statistics

As of 2000: (From, "Women's Health USA 2002" HRSA, US Government)

Women comprise more than 1/2 (51%) US population

- Women outnumber men in every age group over 25
- Women's life expectancy is 79.5
- Majority of those 85 and over are women

U.S. Census 1990-2000

Diversity – among females 1990-2000

- % Hispanic women grew 8.6% to 11.6%.
- % Asian/Pacific Islanders women grew 2.8% to 3.9%.
- Other racial/ethnic group's % of women changed only slightly or remained unchanged

2000 Census also shows:

- Many advances (1990-2000) in women's educational attainment and employment
- Men still achieve higher levels of education than women
Bureau of Labor Stats - 56% of white, black & Hispanic women age 16 & older employed
- Women still earn only 75 cents/\$1.00 men earn

EMPLOYMENT & HEALTH INSURANCE

Employment Key Factor in Obtaining Health Insurance

In 2000:

- 87% of women had health insurance coverage
13% lacked any coverage.
- Although women more likely than men to have health coverage, approximately 1/4 of women 18-24 no coverage in 2000

MULTIPLE ROLES

Many women perform multiple roles

- Caregiver to elderly relatives
- Caregiver to young children

Affects health & economic stability

1998 survey of women's health:

- 9% women caring for a sick or disabled relative
- 43% of these women providing more than 20 hrs of care/week
- Caregivers more likely than non-caregivers to be in POOR HEALTH

PREVENTIVE HEALTH CARE

- Promote good health throughout woman's life
- Women more likely than men to seek preventive care
1996 - 1/4 of women's ambulatory care visits were for preventive services Mammograms
Pap smears

Immunizations

Dental care

- Important preventive services can detect diseases in early stages

INFLUENCE OF MEDICAL CARE ON WOMEN'S HEALTH STATUS LIMITED:

- Women less likely to engage in light or moderate leisure physical activity than men
- Women less likely to consume regular servings of fruit and vegetable
- Percent of women who smoke (behavior which leads to many chronic illnesses) remained steady last several years at 20% of adult females
- Adolescent girls smoking more than adolescent boys (14.1% to 12.8%)
- Women report higher number of chronic conditions & have higher rates of disability than men
- In SELF REPORTS & HEALTH STATUS, more men than women report health as "excellent" or "very good"
- Among women, Hispanic & Black women more likely than white women to report health as "fair" or "poor"

HEALTHCARE DISPARITIES BASED ON RACE & GENDER SIX PRIORITY AREAS

(From the HHS Race and Health Initiative – (www.cdc.gov/nchs/))

Priority Areas:

1. Infant Mortality

- More women seeking prenatal care in first trimester
- Both infant and maternal mortality rates decreasing
- Gap continues to grow between Black and White women
Black women four times higher risk for pregnancy related deaths than white women

2. Breast and Cervical Cancer Screening and Management

- More women diagnosed each year with breast cancer than any other type of cancer

3. Cardiovascular Diseases

- For most major causes of death – heart disease, cancer and stroke – women die at lower rates than men
- Heart disease remains #1 killer of women
- Black women have highest lung cancer death rates and white women have the highest breast cancer death rates

4. Diabetes, Asthma & Osteoporosis

- Women disproportionately affected by these diseases
- Prevalence of diabetes increases with age and higher among overweight women
- 9.1% of women compared to 5.1% of men suffer from asthma
- Osteoporosis especially common in women 65 and older

5. HIV/AIDS & Domestic Violence

- December- 2000 -total of 130,104 cases of AIDS reported in adolescent and adult women in US
- Disease most prevalent among women 25-44 years of age and Black Women
- National Survey on violence (1995-96) reports
More than half of women reported being physically assaulted in their lifetime
Native American (Indian & Alaskan) women more likely to report being raped, physically assaulted or stalked than women of other races and ethnicities

6. Child and Adult immunizations

- More effort being placed into making sure children given childhood immunizations to prevent recurrence of diseases like polio

INTERACTIVE ACTIVITY III:

Gender Bias Discussion

- Have you ever felt as though you have suffered from gender bias?
- Share with the group your own stories about how you believe your gender has affected your opportunities and life decisions
- What do the stories you've shared tell about how entrenched cultural stereotypes about gender are?
- What gendered behaviors do you think are developed through stereotyping and what might be innate to each sex?

DISPARITIES BY RACE

- Women of Asian, African and Hispanic descent wait more than twice as long as white women between having abnormal screening mammogram and receiving follow-up testing to diagnose breast cancer (Chang et al. 1996)
- African American women with fibroids more likely than white women to have them surgically removed with procedure that preserves uterus (Agency for Healthcare Research & Quality 2001a)
- Vietnamese women 5X more likely than white women to have cervical cancer
- Women (& blacks) presenting to physician with chest pain 2X as likely as white men NOT to be referred for cardiac catheterization (New England Journal of Medicine, 1999)
- 75% of HIV/AIDS cases reported in women & children occur among minority groups
- African American & Hispanic American HIV patients only half as likely as non-Hispanic whites to participate in clinical trials of new medicines designed to slow HIV progress (Safford et al. 2002)

WOMEN AND MEDICAL RESEARCH

(From 1982 study, "The Physician's Health Survey" by researcher Charles Hermakens)

- Small regular doses of aspirin could reduce likelihood of first heart attack by as much as 30%
Important finding from standpoint of preventive medicine
However, all 22,071 subjects men
- Did findings apply to women?
- Gender-exclusive character of study led many advocates for women to look at other studies
Found - Women not being adequately represented as subjects in medical research
Results - More studies now DO include women

B. SEXUALITY

GAY, LESBIAN & BISEXUAL

- Little actual knowledge about homosexuality
- KNOW many myths about it
- Develop irrational fear of homosexuality
Manifests in disgust, anxiety, anger, violence

INTERACTIVE ACTIVITY I:

SELF-EVALUATION OF NON-BIASED BEHAVIOR

Discuss each statement, their responses & why

TERMINOLOGY RELATED TO HOMOSEXUALITY

American Psychological Association's (APA) Committee on Lesbian and Gay Concerns

- Adopted (1991) following guidelines for terminology recommended to psychologists
Gay male and lesbian, rather than homosexual
Gay persons when referring to lesbians and gay men as group
Antigay prejudice instead of homophobia
Bisexual when referring to persons attracted to both same-sex and opposite-sex partners

MYTHS ABOUT GAY, LESBIAN AND BI-SEXUAL PERSONS

(From, "Managing Diversity in the Workplace")

- 1. Gay men want to be women, Lesbians want to be men**
 - Gay persons emotionally and sexually attracted to members of same sex
 - Homosexuals sometimes confused with transgender persons
Born in wrong body
Are "really" people of opposite sex born biologically incorrect
Homosexuals & transgenders NOT same
- 2. Bisexuals can't make up their minds between being gay or straight and people become bisexuals to "increase their chances"**
 - Bisexuality, homosexuality & heterosexuality - degrees on continuum of human sexuality
 - No rule of nature that anyone is either homosexual OR heterosexual
 - Bisexuality normal, legitimate expression of human sexuality
Emotional/sexual attraction to members of both sexes
 - Bisexuals capable of having long term, committed relationships with person of either gender
- 3. Homosexuals molest children**

US Department of Public Health study

 - 95% of child molestations perpetrated by heterosexuals against female children
 - Majority of molestations of boys by men perpetrated by self-proclaimed heterosexuals
 - Child molester's problem is that he/she molests children, not his/her sexuality
- 4. Gay persons obsessed with sex and can't have stable, long-lasting relationships**
 - Sex is only ONE of facets of gay, lesbian or bisexual person's life

- Gay persons spend no more time thinking about or participating in sex than average heterosexual
- 5. All a gay person needs to be cured is a good sexual experience with opposite sex (AKA... "The Good Lay Theory") or homosexuals have not tried opposite sex or can't get lover of opposite sex**
- Commonly used in reference to lesbians
 - One researcher (Wolff) found that 55% of lesbians in study had engaged in sexual encounters with men
 - Many homosexuals who have had relationships/sex with opposite sex have been emotionally unfulfilled or disinterested
 - Trying to force relationships with opposite sex has often led to emotionally devastating results
- 6. Homosexuals/Bisexuals recruit others to their lifestyle**
- Based on idea that since gays and lesbians "can't reproduce own kind" - must recruit others
 - ALL gays product of heterosexual relationships (or at least sex)
- 7. People who associate with gays are probably gay themselves**
- Stigma by Association
Can create barriers to gays' establishing support networks and mentor relationships
Can block competent researchers from addressing gay issues because of tendency of public to assume heterosexuals not interested in these topics
 - Gays who have not publicly declared sexual orientation frequently fear disclosure and avoid association with other gays, leading to loneliness
- 8. Gay sex is immoral and gay persons are promiscuous**
- A religious/philosophical belief - cannot be RATIONALLY proved or disproved
 - Constitutional rights concerning separation of church and state provide some protection in legal system against discrimination based on such personal beliefs
 - A percentage of entire population engages in promiscuous sex, at least during certain phase of life, regardless of sexual orientation
 - Many homosexual couples have long-term relationships, or commit their lives to one another

GAY SEX AND AIDS

- Related to belief that gay sex is immoral - belief that AIDS is God's punishment for gay persons
- Ignorance about disease led to myth that people who come into contact with gay persons expose themselves to AIDS
- Worldwide
Most reported cases of AIDS among heterosexuals
Lowest rate of AIDS transmission among lesbians
Rate of transmission among homosexuals decreasing as community becomes more aware of severity of disease & takes more responsibility for sexual activity
Spread among heterosexuals rising

ANTIGAY PREJUDICE

- Gays experience unique brand of prejudice based on myths discussed

WHY? DO PEOPLE FEEL ANTIGAY PREJUDICE?

- Antigay prejudice more dominant in certain regions and among certain socioeconomic groups
- Ranges from mild disapproval to violent hate crimes (GAY BASHING)
- Varying reasons. Attitudes towards gayness can be influenced by:
 - Adherence to traditional sex roles
 - Fear of contact with gay persons
 - Past interactions with gay persons, whether or not they were rewarding
- Personal benefits from expressing attitude
 - Affirming self-identity
 - Increasing self-esteem
 - Maintaining sense of belonging to group with antigay beliefs
- **EX:** "I feel like a real man when comparing myself to that gay man."
- People who want to boost own egos by putting down gays likely to get social approval
- Gay persons easy targets in most communities

THE ARM'S LENGTH SYNDROME

Heterosexuals who report they don't know a gay person

- More likely than others to have negative attitudes toward gayness

Gay persons also less likely to reveal they are gay to such prejudiced persons

- Perpetuates lack of knowledge of anyone gay, creating "arm's length syndrome"

Information source for isolated individual is hearsay and the media

- Gay persons rarely seen in films or on TV unless playing stereotyped role, having problems or dying
- Limited information may perpetuate negative attitudes
- More eagerly person endorses traditional sex roles - more negative he/she tends to be toward gay persons
- Heterosexuals who are not prejudiced toward gays more open to interacting with them and gain more experiential knowledge of them

WHO? ARE THE PREJUDICED?

- People with antigay attitudes tend to have following characteristics:
 - Male, Older, Less well educated, Reside in rural areas, the Midwest or the South, Members of a conservative religious denomination, Strongly religious
- Men - More prejudiced than women
 - May stem from cultural belief that masculine men - heterosexual
 - Feel pressure to affirm masculinity by rejecting Anything not culturally defined as masculine - being gay
 - That which is perceived as negating importance of men, such as lesbianism
- Women
 - Rarely feel that rejecting homosexuals has anything to do with own gender identity

WHAT? DOES ANTIGAY PREJUDICE DO TO PEOPLE?

- Impact on gay persons lives when excluded, ridiculed or assaulted
Ranges from difficulty adapting to deep psychological damage
- Almost all children learn to disapprove of gayness
Because of antigay stereotypes and attitudes in our culture
- Many institutional policies stigmatize and discriminate against gay persons
- Gays experience considerable violence
Research shows general pattern of treating gay persons differently, more harshly than nongays
- Gay persons infected with HIV treated more harshly than heterosexuals infected with HIV
People less willing to interact with gay persons with AIDS than with heterosexuals with AIDS

IS ANTIGAY PREJUDICE DECREASING?

National opinion surveys

- Suggest that people's attitudes toward civil rights for gay persons - often independent of moral judgment about homosexuality
- Even though gay lifestyle is unacceptable to many Americans, most agree that gay persons should have equal employment opportunities and free speech rights

RECENT EXAMPLE OF ANTIGAY PREJUDICE AT NATIONAL LEVEL

Comments of Senator Rick Santorum

SUPREME COURT

Decision to strike down sodomy laws in thirteen states that still had laws on books

Step in direction of tolerance and inclusion

Many states already repealed sodomy laws making sex with same sex partner no longer criminal act

FROM "MENTALLY ILL CRIMINAL" TO "SOLID CITIZEN"

Beliefs about gay persons over past 20 years evolved from:

"They are mentally ill sexual deviants whose lifestyle is depraved and illegal" to

"They have a right to express their sexual orientation and most are solid citizens"

Following are some dates and milestones in recent gay history:

1952: APA classifies gayness as a mental illness rather than a choice to be sexually perverted and depraved

1969: Stonewall riots and first Gay Power meeting in New York

1970: Gay pride parade in New York attracts 10,000 gay persons

1973: APA announces that homosexuality is no longer considered a mental illness

1974: First openly lesbian state representative elected: Elaine Noble, MA

1977: Anita Bryant, former Miss America, begins national campaign against gay rights on behalf of religious conservatives

1977 First openly gay person elected to city government: Harvey Milk, San Francisco supervisor

1978: California voters defeat a statewide proposal to remove gay teachers from schools

1981: Kaposi's sarcoma, a rare cancer, is diagnosed in 41 gay men; tennis star Martina Navratilova comes out

1982: Gay Olympics, later called Gay Games, begin (and by 1994 was one of the largest sporting and cultural events in the world)

1986: The US Supreme Court upholds Georgia's anti-gay-sex law

1992: President Clinton signs executive orders forbidding firing of gay persons as "security risks" and banning discharge of people from the military solely for being gay

Because of backlash, the military policy is modified to "don't ask---don't tell" which in effect requires gays to not reveal sexual identity in order to stay in military

1993: Gay persons hold the third and largest civil rights march in Washington, DC

BEFORE 1952

- Gays viewed as sexual perverts, morally depraved engaged in immoral, criminal sexual activities
- Most professionals viewed gayness as immoral, criminal behavior until American Psychological Association classified it as mental illness
- Prior to 70's almost no one admitted openly to being gay
- 1972 APA removal of gayness as a mental illness changed that
- Many now believe gay persons have right to privacy regarding their sexual orientation and should have the same rights and protection under the law as other citizens
- Some still hold pre-1950's beliefs

PROFILE

As group:

- Gay persons highly educated
- In spite of work place discrimination, many in responsible, well-paid occupations
- Extensive, well-respected survey of Americans study (Michael et al., Sex in America: A Definitive Survey, 1995) aged 17-60 indicates:
 - 2.15 % of all persons are gay
 - 1.5 % of women are gay
 - 2.8 % of men are gay
- Gays found in virtually every demographic group
- Gay community encompasses wide range of diversity that cuts across all cultural ethnic, economic, economic, social, age and other lines, according to this

NATURE OR NURTURE

Nature theory indicates:

- Gayness caused primarily by genes and hormones
- Gays found in every society even though no known society socializes children into homosexual roles or has ever set up gay role models
- Accepted by most scientific researchers - there is genetic and hormonal determination before birth

Nurture theorists - two different beliefs:

- Traditional belief – being gay caused by environmental influences & personal choice
- More modern belief - it is some combination of both nurture and nature

HANDOUT:

PRIVILEGES OF BEING HETEROSEXUAL

CHANGING PREJUDICE AND DISCRIMINATION

- Anti-gay prejudice stems primarily from lack of information about gay persons and gay community
- Educating all people about sexual orientation and homosexuality likely to diminish anti-gay prejudice
- Accurate information about homosexuality especially important to young people struggling with own sexual identity

SOLUTION SIMPLE:

- Accept gayness as normal expression of human sexuality for some people
- When gays are as valued as anyone else, people won't need to worry about being gay
- Your attitude will come through and allow gay person to feel at ease discussing personal-life events and health issues

•

NEW HIPPA REGULATIONS:

- Gays need to be made aware that partner needs to be included
GOOD FILM: "If these Walls Could Talk" A film about two women...One woman gets ill & family won't allow partner to see her

HANDOUT:

HETEROSEXUAL QUESTIONNAIRE

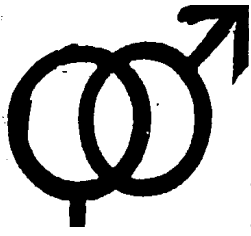
WRAP UP: ????????

Final Discussion and Questions

HANDOUT:

WHITE PRIVILEGE AND MALE PRIVILEGE

By: Peggy McIntosh



Heterosexual Questionnaire

1. What caused your heterosexuality?
2. When and how did you first decide you were heterosexual?
3. Is it possible your heterosexuality is just a phase you may outgrow?
4. Is it possible your heterosexuality stems from a neurotic fear of others of the same gender?
5. If you have never slept with a person of the same gender, how do you know you would not prefer that?
6. If heterosexuality is normal, why are a disproportionate number of mental health patients heterosexual?
7. To whom have you disclosed your heterosexuality?
8. Why do heterosexuals feel compelled to seduce others into their sexual orientation?
9. The great majority of child molesters are heterosexual. Do you really consider it safe to expose children to heterosexual teachers and service providers?
10. How can you enjoy a fully satisfying sexual experience or deep emotional rapport with a person of the opposite gender; when the obvious physical, biological and temperamental differences are so vast? How can a man understand what sexually pleases a woman, and vice versa?
11. Why do heterosexuals place so much emphasis on sex?
12. Marriage receives a great deal of societal support, yet the divorce rate continues to increase. Why are there so few stable relationships among heterosexuals?
13. Considering the menace of overpopulation, how could the human race survive if everyone were heterosexual like you?
14. A disproportionate number of criminals, welfare recipients and other irresponsible or antisocial types are heterosexual. Why would anyone want to hire a heterosexual for a responsible position?
15. Do heterosexuals hate and/or distrust others of their own gender? Is that what makes them heterosexual?
16. Why do you insist on making a public spectacle of your heterosexuality? Can't you just be what you are and keep it quiet?

PRIVILEGES OF BEING HETEROSEXUAL

The following are examples of aspects of interpersonal relationships that people in heterosexual relationships often take for granted. Imagine the trauma endured by lesbians, gay men and bisexuals who are not allowed the same rights.

- The right to kiss or show affection in public
- The right to talk about your relationship/significant other
- The right not to question your normalcy
- The right to show sorrow when a relationship ends
- The right to live comfortably in a home, neighborhood or community without enduring the fear of rejection from people who live around you
- The right to be open about apartment/house hunting with your significant other
- The right to marry
- The right to dress without worrying about what it represents
- The right not to have to hide friends and same-sex activities
- The right to have a heterosexual reference base by family, friends and others in the community, so you never have to feel excluded
- The right to open support from family and friends
- The right to have your partner appear in family photographs
- The right to have friends not avoid being seen with you for fear of being labeled by others
- The right not to resent media for heterosexual reference base, or to feel excluded by media
- The right not to explain your sexual orientation
- The right to be accepted, not just tolerated

Adapted from: Sharing Silent Journeys of Faith. Catholic Pastoral Committee on Sexual Minorities (1989)

Self-Evaluation of Non-Biased Behavior Addressing Lesbian and Gay Issues

To complete the self-assessment:

- Rate yourself for each item along the continuum: Never, Sometimes, Always
- Review your ratings, and then pick several of those you have rated “Sometimes” or “Never” and develop specific goals for increasing your fairness. For example, if you never include role models that are GLBTQ; research some examples and include them. Your local library may be able to help you identify both past and current role models. Set a specific time limit for yourself to accomplish your goals.

1. Attitude: I take the idea of equity for GLBTQ seriously. For example, I do not put down gays and lesbians, or joke about their abilities, backgrounds, traits or sexual behavior.

Never	Sometimes	Always
____/_____	____/_____	____/_____
2. Language: I use non-biased language. For example, I do not refer to homosexuals as “faggots”, “dykes”, “queers”, “homos”, etc.

Never	Sometimes	Always
____/_____	____/_____	____/_____
3. Generalizations: I avoid generalizations that reinforce stereotyping. For example: “gay men are not masculine” or “lesbians don’t like men.”

Never	Sometimes	Always
____/_____	____/_____	____/_____
4. Role Models: I include examples of GLBTQ men and women from diverse backgrounds involved in a wide range of jobs and activities.

Never	Sometimes	Always
____/_____	____/_____	____/_____
5. Facts: I communicate accurate and factual knowledge about GLBTQ men and women and the issues they face.

Never	Sometimes	Always
____/_____	____/_____	____/_____
6. Teaching about diversity: I supplement inadequate treatment to GLBTQ in literature, movies, curricula, textbooks, etc. by adding information or by discussing their inaccurate portrayal in my office.

Never	Sometimes	Always
____/_____	____/_____	____/_____
7. Personal Comfort: I am comfortable discussing GLBTQ issues when they are brought up in my office.

Never	Sometimes	Always
____/_____	____/_____	____/_____
8. Discipline: I stop all pejorative name calling towards GLBTQ immediately and forcefully in my practice and in the office.

Never	Sometimes	Always
____/_____	____/_____	____/_____
9. Communicating with peers: I bring to their attention homophobic comments or jokes made by other colleagues.

Never	Sometimes	Always
____/_____	____/_____	____/_____

Please note that this list is not meant to “rate” you, but rather to help you identify unconscious biased behaviors you may have in dealing with patients and colleagues. It can help you focus on any actions or expectations that create a hidden agenda of bias in your practice. It is important to view this exercise as a means to assist in your personal growth and awareness about lesbian, gay, bisexual and transgender issues.

WORKSHOP IV

RELIGIOUS DIFFERENCES, VALUES & HEALTHCARE

RATIONALE FOR LEARNING ABOUT RELIGIOUS BELIEFS AND VALUES

- Can lead to better understanding and respect for individuals of differing beliefs
- Developing understanding of values and beliefs of more frequently practiced religions in area can make more effective practitioner

(World view can be described as a set of assumptions, values and beliefs that are related logically to one another. This set of assumptions affects the way people perceive and experience the world, including the way they experience sickness){Jones, W. J. "World views and Asian medical systems." UCLA Press, 1976.}

RELIGIOUS AFFILIATION IN US

- 190 million people claim religious group affiliation
- Religion important aspect of many people's lives
- Influences way many people think, perceive, behave

INTERACTIVE ACTIVITY I:

- Belief Systems & Health

Ask:

Why do people get sick/well?

Each individual write down reasons

Discuss in 2's/3's

Report to group/write on board

RELIGION & SOCIETY

Immigration And Migration Patterns Throughout History

- Ethnic and religious groups settled in different parts of country
- Religious doctrine influences what a family expects in all areas of society, including health care
- Physicians face frequent challenges in area where religious perspectives and medical expectations differ

Separation of church and state

- Integral part of U.S. heritage
- Two usually support each other
- Secular ideas of "American Dream" pervade many religions in US
- Many religions reflect dominant values in society

Many western religions emphasize individual control over life

Many religions believe their religion uniquely true and legitimate and all other religions false

INDIVIDUAL RELIGIOUS IDENTITY

Most Americans born into parents' religion - later join same body

- In US individuals free to change religion or choose no religion

Person's ethnicity, class, gender

- Influence behavior and values

Religion may be primary microculture with which many individuals identify (Ex: Irish Catholic, Russian Jew, etc.).

RELIGION & HEALTH CARE:

Values and lifestyles

- Affected by religious beliefs

RELIGION'S INFLUENCES ON MANY ASPECTS OF LIFE

- Patterns Of Sex Roles
- Marriage
- Divorce
- Birth Rates
- Child Training
- Sexual Activity
- Alcohol Consumption
- Smoking and Dietary Habits
- Things That Affect Individual's Health – Both Physical & Mental

CHART: U.S. MEMBERSHIP IN RELIGIOUS GROUPS

Most Americans In One Of Four Major Faiths

- Catholic, Protestant, Jewish, Muslim

Catholic, Protestant, Jewish Religions

- Historical religious groups share same Old Testament heritage
- Do not attest to diversity of beliefs and interpretations of Bible

Some Denominational Differences Have Origin In Ethnic Differences

RELIGIOUS PLURALISM

Fostered accommodation of American religious movements toward mainstream acceptability and respectability by society

Smaller groups that maintain distinctiveness - historically victims of harassment by members of many mainstream religious groups (Ex: Christian Scientists and Jehovah's Witnesses)

Conflict among three major faiths intense during different historical periods

HANDOUT:

A BRIEF COMPARISON OF THE 5 MAJOR RELIGIONS

Includes Judaism, Christianity, Islam, Hinduism and Buddhism

RELIGION AND GENDER

Role Of Women

- Clearly defined and limited in many conservative religious bodies

Fundamentalist churches/denominations

- Not willing to ordain women ministers

Women in New Testament

- Lydia, Phoebe, Priscilla, Deborah - Leadership roles in formative days of Christianity
- Other biblical passages used to delimit participation of women in leadership roles

Biblical verses

- Admonish women to submit to husbands
- Indicate husband is head of wife

Adam and Eve

- Some biblical interpreters - God gave dominion of Adam over Eve (therefore men over women)
- Others - God gave both Adam and Eve dominion over living things

Islam & other religions

- Limit participation of females
- Put leadership only in men's hands

Religion & Society

- Used to define parameters of religious participation
- Used to prescribe male and female roles outside religious context where women have less prominent status
- Carries over into general family life & other aspects of society

RELIGION & RACE & ETHNICITY

Religious beliefs

- Profound impact on race and ethnic diversity issues
- Mingling of religion with ethnicity common in groups with history of social competition and conflict with others

Examples of Religion With Ethnic Cast

- EX: Italian fiesta for patron saint
Jewish bar/bat mitzvah
Irish wake

Religious freedom in U S

- Retaining customs and religions
- Major reason why original 13 colonies came to exist

Christianity and Slavery

- Believers seek to "establish the Kingdom of God on earth."
- Fashion values and behaviors on Biblical scripture
- Biblical scripture misinterpreted or interpreted to justify aberrant behavior

Anti-Semitism

- Historical roots in Bible
- References to Bible often used to justify behavior

Modern Civil Rights movement

- Centered in Southern African American Churches

HANDOUT:

RACIAL/ETHNIC DIFFERENCES IN RELIGIOUS VALUES & BELIEFS

Information about different races belief systems

INTERACTIVE ACTIVITY II:

What happens after we die?

Discuss in small groups

Report to group/Record on board

HANDOUT:

GREETINGS FOR HOLIDAYS

Information To Increase Sensitivity To Patients' Beliefs & Values

INTERACTIVE ACTIVITY III:

CASE STUDIES INVOLVING HEALTH CARE AND RELIGION

WRAP UP ????????

Final Discussion and Questions

HANDOUT:

SPIRITUALITY - BACON AND EARTH

By Nova Panebianco

Medical School Student

2000

Bacon and Earth

He smells like bacon and earth. Formaldehyde too, but I expected that. I didn't expect the 70 year-old dead man on the steel gurney to have his own unique, and now unforgettable, smell. All of the bodies have their own signature smell and the teaching assistants, whose hands become contaminated with human grease, carry the smells of each cadaver to mine. The sick mingling of smells, my first sight of the gray-blue body, the slick greasiness of my fingers covered in human fat revealed to me that anatomy would traumatize all of my senses.

Doesn't death purge the individual? I thought this the first day. Is the smell of my cadaver his last effort to maintain an identity? Our lab dissector reads like a cookbook.

It is "government issue" for all cadavers, which feeds the fallacy that once you are dead you are just a generic bunch of flesh. As I have come to know the cadavers, I have learned that every one of them had unique attributes. Internally, some have aberrant arteries, missing organs, and strangely colored tissues. Externally, the scars of life persist in death, as do little things like an IUD in the 300-pound lady two gurneys down, and chipped pink nail polish on the hands of an old woman.

I have grown to find dissection strangely pleasing. After a few sessions with our body, I began to like the process of removing layers, exposing veins, arteries, organs; things which I will never have the chance to see again in such detail. As long as I don't look more than an inch in any direction outside of the area I'm working, I can ignore the truly gruesome nature of dissection. I found naming our cadaver much more disturbing than cutting into him. My lab partners chose the name "Herbie", and by naming him I could no longer forget that he was once alive. Out of respect for the gift this man has given to us, I agree he deserves a name; however it was easier for me to not give him an identity or personify him.

It is human to build defenses against traumatic events, so that the significance of reality doesn't become too much to bear. I have built such defenses, but in the gaps, when my guard is down, I have caught myself thinking about Herbage's life, and death. After weeks of dissection we found no obvious signs of death, and his body was not wasted like many of the other students' cadavers. I've imagined the scene of his death; dramatic, chaotic, and unexpected. In his stomach we found a last meal of kidney beans. If he had known this was going to be his last meal, would he have chosen kidney beans? He was about the same age and size as my grandfather when he died. I wonder if a child cried for him when he died. I wonder who carries memories of his life, and what they would think if they knew how intimately I now know him. It's amazing what I think about as I strip skin off a dead man.

My mother, who is an artist, feels that art is anything that makes you look at the world in a new way. If this is true, then my experience with Herbie was been one of art. I don't look at people the same way as I used to. For example, after the second week of lab, I went to a yard sale with my parents. I saw an old man there, and in a flash I envisioned his body dead on a gurney. I knew exactly what he would look like, with his stringy muscles protruding under his translucent ashy skin. I wondered if his body would have cancer, and what his unique smell would be. If this experience is art, or trauma, I don't know.

The effects of this experience continue to haunt me outside the lab, and my waking dreams have become more complex as I learn more. While watching television the other day, instead of seeing Julia Robert's beautiful face, for a brief moment I saw the muscles, nerves, vessels, and skin of her face contorting into its expressions. I now regularly find myself fixating on the components of a face while pretending to be in rapt conversation. What would they think if they knew? I'm not the only one who is experiencing this. While watching a movie with medical school friends the other night **I** found myself fixated on the substantial platysma muscle in Ben Spiller's neck. As **I** was thinking about the muscle my housemate said, "nice platysma". I'm glad I'm not alone in my trauma. I'm glad I'm not the only one seeing dead people in beautiful living ones.

During orientation Dr. Stem, our anatomy professor, said something to the effect that this would be the most bizarre and beautiful experience of our lives. There is truth in this paradox. I find my cadaver indescribably beautiful. The complexity of the system, the marriage of form and function, and the intricate detail of the organs are awesome. The body, to me, represents millions of years of evolution, of selection for perfection, and I hardly feel worthy of the right to excavate this man. **I** will never forget the way Herbage's heart looked. The organ was glossy, red with purple veins and yellow fat marbling its sides. The inside was textured in some places, and perfectly smooth in others. In my hands it rested like a freaky still life waiting for the artist to translate its beauty onto canvas. We have dissected the body piece by piece; however it is clear that the total is greater than the sum of the parts. The complexity of the organs and vessels and nerves individually are no match for that of the whole system

This "rite-of-passage" has matured me, and separated me from my peers. How could **I** explain to my friends what it sounded like as we cracked our cadaver's pelvis, and why finding beauty in my cadaver makes doing these horrible acts possible? Like a soldier back from the war, **I** have images in my mind that can never be spoken, and **I** cannot explain the sensation of cutting flesh just like a man cannot truly convey what it is like to pull the trigger of a gun. In this separation there is satisfaction, and **I** have, amazingly, grown to like my waking dreams of facial muscles and dead people because it reminds me of how much I've learned. These ghosts are my teachers.

Anatomy has inspired the child in me that forever asks, "Why", and **I** now enter lab with an excitement for the day's discoveries. I almost don't want the course to end because my hands will miss it. The experience of both the gruesome act of dissection, and the sublime beauty of the body exposed will stay with me as a doctor, and like the memory of a first love, Herbie will forever be my frame of reference. I imagine I will always associate the smell of bacon and earth to the traumas and the beauty of this class, to the uniqueness of the human condition, and to the awareness that **I** will never be the same.

(@ 2000 Nova Panebianco, All Rights Reserved)

CASE STUDY

RESPONDING TO THE RELIGIOUS & FAITH NEEDS OF INDIVIDUALS DURING THE PERIOD OF DEATH & DYING

You are a physician caring for Mrs. Bolinski. She has advanced cancer and your health care team will suggest to the patient/family to stop active treatment except for pain relief with morphine. You need to talk to her about this decision, but she does not speak English and her daughter and son have asked to be present at all medical discussions.

You know that her children are going to have great difficulty telling their mother that she is dying. Her husband died of cancer a year ago and her children did not even want her to be told of her diagnosis. However, the health care team does feel that it is important for Mrs. Bolinski to know that she is dying so that she can prepare herself for death.

QUESTION

1. What should the physician do with Mrs. Bolinski's children's request that she not be told that she is dying?

It is now a few days later and Mrs. Bolinski is near death in her hospital bed. Both of her children are present.

QUESTIONS

1. What needs to happen to prepare Mrs. Bolinski for her nearing death?
2. How should health care professionals be involved with Mrs. Bolinski at this time?

Mrs. Bolinski died this morning.

QUESTION

1. What are the immediate religious responses/practices upon death?

You would like to express your sympathy to the family over the period of mourning.

QUESTION

1. How can health professionals who have cared for Mrs. Bolinski express their sympathy best?

A Brief Comparison of the Major Religions

Religion:	<u>Judaism</u>	<u>Christianity</u>	<u>Islam</u>	<u>Hinduism</u>	<u>Buddhism</u>
Supreme Being(s):	Yaweh	God the Father, Jesus, Holy Spirit	Allah	Many: Vishnu, Krishna, Siva, Ganesh. etc	No single god, Within self
Founder:	Abraham	Jesus Christ	Mohammed	None	Siddhartha Gautama
Age of Religion:	5,765 yrs	2,000 yrs	1,400 yrs	3,000- 4,000 yrs	2,500 yrs
Population in US:	6,000,000		6,000,000	700,000	
Holidays or Holy Days	Yom Kippur, Rosh Hashana. Hanukkah, Passover	Lent, Easter, Christmas. Saints' feast days	Ramadan, 'Id al-Fitr, 'Id al-Adha	Deepawali or Diwali, Holi, Nutan Varsh	Bodhi Day, Buddha's Birthday
Tenets:	10 Commandments Golden Rule	10 Commandments Golden Rule	5 Pillars of Islam	Karma Ahimsa (non-violence)	Four Noble Truths. Eightfold Path
Holy Book:	Bible. Old Testament Torah, Talmud	Bible, Old and New Testament	Quran or Koran	Vedas, Upanishads, Ramayana. Mahabharata	
Spiritual Leader:	Rabbi	Minister, priest	Imam	Priest. Guru	Monk
Place of Worship	Temple	Church	Mosque	Temple	Temple
Words/Concepts:	Kosher. Chosen people Waiting for Messiah	Original sin, Resurrection, Trinity	Halal, Haji, Fasting	Reincarnation, Nirvana. Yoga. Discipline of Mind and body	Reincarnation, Desire brings Suffering. Enlightenment, Meditation, mantra

RACIAL/ETHNIC DIFFERENCES IN RELIGIOUS VALUES AND BELIEFS

AFRICAN AMERICANS

CHURCH

- Major role in advocating social change throughout the 20th Century
- Still plays central role in many aspects of life
- Major efforts to help the underclass break out of shackles keeping them in poverty
- Offers array of self-help programs

KWANZA–SPIRITUALITY

- A way of life
- Honors African heritage for purpose of encouraging greater sense of unity, identity and purpose among African Americans
- Seven (7) Kwanza Principles focus on:
 - UNITY
 - SELF-DETERMINATION
 - COLLECTIVE WORK: RESPONSIBILITY
 - COOPERATIVE ECONOMICS
 - PURPOSE
 - CREATIVITY
 - FAITH
- Many symbols and terms come from African tradition, but holiday is creation of African Americans begun in 1966
- Kwanza annual celebration takes place around the Christian Christmas holidays

ASIAN AMERICANS

- Protocol, rank and status-important parts of all Asian cultures, ranging from Hindu caste system to Confucian system
- Everyone expected to honor certain binding obligations to immediate family and relatives
- Society structured to minimize deviations from these obligations
- Women subordinate to men, sons to fathers, younger to older brothers, wives to husbands/Elders especially respected across religions and cultures. Belief in hierarchy includes:
 - Valuing sense of order, propriety and appropriate behavior between persons of varying status
 - Basing status on occupational position, education, wealth and family background

FILIPINO AMERICANS

- 85% are Roman Catholic
- 40% have a Christian Malay heritage

SOUTHEAST ASIAN AMERICANS

- Most strongly believe in evil spirits
- Most unique HMONG hill tribe of Northern Laos.
- Trust shamans

- Distrustful of western medicine
- Most Southeast Asians – Buddhism primary religion
 - Can be expressed more as traditional philosophy of values and social relations rather than attendance at services or professions of beliefs

JAPANESE AMERICANS

- Surveys in Japanese American cultural groups indicate
 - Most Japanese American young people believe in traditional Japanese cultural values-typical Asian cultural values

KOREAN AMERICANS

- Major religion Buddhism
- Strong underlying ethic of Confucianism and Shamanism
- Confucianism has affected cultural values and practices (evidenced in Asian American general information)
- Concept important to understanding Korean American is KIBUN – literally “inner feelings” with closest English translation, “mood”
 - When Kibun good-person functions smoothly, easily, feels great
 - When Kibun bad-person upset, feels awful, depressed

ASIAN INDIAN AMERICANS

- Northern Indian region of Punjab: mostly SIKHS
 - Combines aspects of Hindu and Muslim religions
 - Highly visible religious customs for males include wearing long turban, dagger, iron bracelet, never cut hair
- Predominant religion in India-Hinduism
- All religions strongly influence values and customs of people
- Hindu marriages
 - Women expected to show absolute dedication, submission, obedience to husband
 - Traditional status in household low until male child produced
- Other traits:
 - Belief that there “are no accidents” - all things interrelated in cosmic order
 - Indian women not spoken to by men who are strangers
 - Not appropriate for strange men to help women out of car, up steps, etc.
 - People don’t address others outside extended family by first name – Mr. Bill, Teacher, Dr.
People expected to be on time
- Asian Indian Americans-much in common with other Asian Americans but culture is most distinct because of Hindu influence
- Many Buddhists, also
- Strong Muslim influence, especially Pakistan and Bangladesh
 - Affects values of immigrants from these countries

LATINO AMERICANS

- Most important value
 - Focus on family, inter-group loyalty-family and in-group persons

- Latino Americans express desire to pass on to children cultural and religious traditions
- Have distinct world view – how they see reality
- Basic to what Latino countries have in common is influence of Spanish culture
 - Includes aristocratic hierarchy based on powerful patron who protects subjects
 - Subjects in turn serve him and owe him loyalty
- Latino spiritual beliefs closely tied to Catholic Church
 - Belief in fate
 - Unique attitude toward relationship between life/death (destiny and thin veil/less distinction), physical world, spirit world
 - Belief that dead are just beyond veil of physical reality
 - Nothing to fear from spirits of relative or friends
- Celebrate afterlife and death symbols
 - Ghosts, skeletons, skulls
- Holidays
 - In relationship with death and the dead
 - Observe “Day of the Dead”-early November
 - Part of three day holiday – Halloween first with other Americans
 - All Saints Day next day-observe religious rites
 - Following day-Day of the Dead-Most important of three days
 - Rituals include setting up altars in churches, homes and shop windows; all-day picnic in cemetery, candlelit procession in costume and all-night vigil in cemetery
 - Belief that spirits of dead friends and family present at these events and spirits move in and out of physical world all the time
- Roman Catholic Church
 - One of Latin America’s major cultural institutions
 - Has played major role in shaping cultures of all Latin nations
 - Priests more involved in family lives of members than leaders in other denominations
 - 80% of Latino Americans Catholic
- Dependence on fate/little control of own destiny stems from ancient American Indian mysticism combined with Latino interpretation on Roman Catholic teachings
 - Belief that outside forces govern lives since life follows preordained course
 - Human action determined by will of God
 - Those holding belief willing to resign themselves to “inevitable,” bow to fate and take what comes their way (Belief contrasts sharply to typical Euro-American belief that “God helps those who help themselves,” or that people create their own reality)

MEXICAN AMERICANS

- Religion is unique blend of Catholicism and ancient beliefs handed down by Mayans and Aztecs
- God is deeply personal, caring for each person through specific Saints
- Home altars decorated with santitos, images of saints dear to each family
- Mexican Catholics believe the Virgin Mary protects them

PUERTO RICAN AMERICANS
Primarily Catholic

QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

WORKSHOP V

AGEISM, CLASSISM & DISABILITIES

A. AGEISM

Aged often discriminated against

INTERACTIVE ACTIVITY I:

At What age will you become old?

Describe an "Old Person"

What are some things you think an old person would say?

Have group brainstorm and write answers on board

Discuss

AGEISM

Described as "aversion, hatred and prejudice toward the aged and their manifestation in the form of discrimination on the basis of age"

- Aged stereotypes:
 - Senile
 - Rigid in thought and manner
 - Garrulous
 - Old-fashioned in morality and skills

AGE GROUPS

As people mature in age - move through different age groups

Bring with them other aspects of culture

- Ethnicity
- Socio-economic status
- Gender

Various cultures interface with one another and blend unique qualities - adds to pluralism of American Society

STATISTICS

- 1900: 1 in 25 Americans over age 65
3.1 million in US
- 2000: 1 in 8 or 12.65% of population over 65
34,848,000
- 2030 (projections):
20.2%
70,000,000
- People 85 or older - one of fastest growing segments of society –
1.6% today
5% by 2050
- 100 Years or older – 65,000 estimated in 2000 (US Census)

AGE DISCRIMINATION

Resembles Other Oppressed Minority Groups

- As numbers increase

Segments of society perceive elderly as “drain on resources”

Providing Adequate Support For Elderly - Challenge In Future:

- Social security
- Healthcare for chronically ill
- Medicare/Medicaid
- Personal assistance for elderly with disabilities

Three Basic Misconceptions Regarding Older Persons:

1. Most elderly sick or infirm
Reality – only 20% of persons over 65 in this category
Only 10% unable to engage in normal activity
2. Most elderly senile
Reality – fewer than 10% of aged have incapacitating mental illness or senility
3. Most elderly people cannot be productive
Reality – as a group, elderly are as productive as younger people

Elderly discriminated against in many areas affecting well being and lifestyles

- Employers – hiring and retention
- Young People – avoid elderly due to prejudices
- Medical personnel – admit they prefer NOT TO TREAT ELDERLY

POVERTY

Serious problem with aged

- 2000 US Census - Poverty threshold
Single individual 65 or older - \$7,900
Couple (head of household over 65), \$10,075
- With this criteria
97% of elderly in 2000 - living in poverty

Figures almost double if “near poor” included

- (Includes individuals whose incomes no greater than 150% of official poverty level)

Significant differences with racial and ethnic backgrounds factored in:

- African Americans and Latinos
More than 1/2 depend on SS as sole income
SS benefits - lower than whites because of lower income levels when working

INFLUENCES OF SOCIOECONOMIC STATUS

Socioeconomic status and income affect

- Longevity
- Health status
- Housing
- Marital status

Middle and high-income elderly typically have

- Social security
- Pension plans
- Savings
- Medical plans

Low-income individuals

- Have limited or no pensions/savings
- May have to work well beyond normal retirement to survive

Elderly persons with higher incomes have advantages associated with greater financial resources

- During earlier years - able to maintain better living conditions and better health care
- Translates into better health in later years
- Financial resources allow maintenance of
Higher living and health care standards
Extended, quality leisure activities like travel

Individuals from high socioeconomic backgrounds view old age more favorably than low-income counterparts

MYTHS AND REALITIES ABOUT THE ELDERLY

(From, "Managing Diversity in the Workplace")

#1 People quit learning when they get old

- Most rapid rate of learning occurs at very young ages, but capacity to learn remains high throughout life
- Intellectual performance remains strong throughout life for healthy people
- From 30 onward slight slowdown in reaction time, but older persons compensate with increased speed on certain complex repetitive tasks
- Vocabulary choice gets better with age
- Brain continues to develop throughout life
Pathways for nerve impulses that create thought, feeling and memory – keep growing/spreading
- 92% of persons older than 65 actually show NO SIGNIFICANT MENTAL DETERIORATION
Only 8% have symptoms of partial memory loss, slowing reaction time

RESEARCH INDICATIONS

- Age brings some positive changes in certain mental abilities
Type of intelligence involving experience, meaning, knowledge, professional expertise & wisdom
Continues to increase though speed in completing IQ tests may decline
Older individuals bring lifetime of experience to learning situations
Better at problem solving, good mediators
- If remain healthy and continue physical and mental activity, DO NOT DETERIORATE in either basic mental competence or intelligence, even in 80's

#2 Older people more rigid and dogmatic

- Evidence indicates dogmatic behavior unrelated to age
- Older persons - become more caring, accepting and mellow
- Handle crises better and see humor in life's problems better than younger people
- Nurturing And Accepting
- Appreciative of Respect
- Creative

#3 Older people less productive

- Age related decline occurs in

Speed And Accuracy Of Movement

Perception

Hearing

Vision

Certain Types Of Problem Solving Skills

- Declines affect performance only in things requiring extremely high levels of sensory or cognitive skills
- Age stereotypes
Frail and fragile
- Changes in lifestyles, dietary habits, exercise patterns and better medical interventions
- Some individuals who view aged as non-productive may adopt “ageist” attitude

#4 Older people’s value tied to looks

- Emphasis in US society on physical beauty
Society obsessed with youth and fearful of old age
Old age negatively stereotyped
- Women’s value tied more to looks than men’s
Society regards elder women as relatively unattractive and useless
- Men considered in prime – fifties and sixties
Combination of ageism and sexism turns older women into invisible citizens
In pre-patriarchal societies
Older women considered founts of wisdom and wrinkles badges of honor
- Old age negatively stereotyped by media
Causes old age to become something to dread and feel threatened by

#5 You’re only as old as you feel

- Scientists discovering that aging partly in mind
- Best ways to slow mental aging process:
Maintain positive attitude
Remain mentally and physically active

#6 Use it or lose it.

- Key to staying healthy and alert, as we grow older
- Aging decline - reversed with changes in diet, exercise, lifestyle and environment
- Learn to view aging as continued human development
- Staying connected to family, community and work place - key to aging and longevity

HOW OLD IS OLD?

Census Bureau

65

Business

Older than 40 – when protection from discrimination kicks in

Bureau Labor Statistics (BLS)

55

Gerontologists use TWO AGE CATEGORIES

Young-Old – currently 65-75, soon to be 75 to 85

Old-Old – now older than 75, soon older than 85

HOW MANY ARE OLD?

2000 census bureau:

- Almost 35 million people over 65 in US

Projected by 2015:

- Will increase to 54 million, 17% of population, or 1 or 6 people

ETHNIC DIFFERENCES IN AGE

How old you live to be - affected by ethnic heritage

Percentages of people in 1990 older than 65

- Euro-Americans 13%
- Asian-Americans 8%
- Latino-Americans 8%
- African-Americans 6%
- Native Americans 6%

Who lives longest?

- Euro-American Women Average Age 80 at death

Who dies youngest?

- African-American Men Average Age 45 at death

Women – Older and Poorer

- 2/3 of people over 65 women, because they live longer
- Older women more likely to live alone, twice as likely to live in poverty
- Because women live longer and may need to work
In 1998 – 255,000 women - 70's, 80's and even 90's working
80% increase from 1985

HOW TO MOVE BEYOND AGEISM

Older you get - more devaluation and discrimination likely to face

Americans view old age very **NEGATIVELY** - equate it with

- Loss of: Abilities, Vitality, Attractiveness
- With: Illness, Nursing Homes, Death

Many younger people avoid older people and depressing thoughts presence create

To move beyond ageism:

- Must learn to deal with **NEW FACTS OF LIFE**
- **ADOPT LIFE-AFFIRMING BELIEFS**

Entering era when old age will be full one-third of life for most people

- Youth First 30 years of life
- Middle Age Second 30 years of life
- Old Age Third 30 years of life

Many people retain great vitality throughout third age

- Must re-examine stereotypes of AGE
- Must value older persons
- Must allow and expect that elderly will continue to grow and develop

HANDOUT:

ELDER ABUSE

B. CLASSISM

Class: Defined in terms of income, wealth, status and/or power

Classism: Defined as

- Institutional, cultural and individual set of practices and beliefs that assign differential value to people according to their socio-economic class
- Economic system that creates excessive inequality and causes basic human needs to go unmet

Example: A hospital

Differences: Uniforms, modes of transportation, parking areas, eating areas, etc.

INTERACTIVE ACTIVITY I:

Classism Quiz

How much do you know about class in the US?

DESCRIPTIONS OF CLASSES USED TO DESCRIBE PEOPLE AND FAMILIES

THE UNDERCLASS

Label for portion of population who suffers most from lack of stable income or other economic resources

- Includes long-term poor

Poverty creates problems for children

- Live with a single parent, most frequently mother
- With father absent, children often lack adequate male role models
- Mother bears entire burden of discipline and financial support
- Single mothers living in poverty must often work outside home to provide
- Mothers from other classes may not need to work outside home
Can choose day care for children - environment reinforces family values

POVERTY IN US

1998 19% of children lived in poverty

- For first time since 1980, rates dropped below 20% (Annie E. Casey Foundation, 2000)
- Many suffer from inadequate housing, nutrition, medical care, homes with inadequate heating/cooling

Affects sleep and physical well-being

2000, Annie E. Casey Foundation Report-Washington, DC

Center of power in US - leader in poverty and at-risk areas for children

- Low-birth weight children
- Infant deaths per live births
- Child deaths per 100,000 children, ages 1-4
- Teen births by accident, homicide or suicide, ages 15-19
- Children living with parents without full-time, year-round employment
- Families with children under age 18, headed by a single parent
- 16-19 year olds who are not in school and are not working

Number Of Homeless Persons And Families Increased In past 10 Years

- National Law Center on Homelessness and Poverty (1999) indicates more than 700,000 people per night housed in homeless shelters
- Urban Institute (2000) estimates 3.5 million people homeless at least once in any given year
- As many as 12 million adults in US experienced homelessness at least once during lifetime (National Coalition for Homeless, 1999)

People - Homeless For Several Reasons

- Poverty
- Lack of affordable housing
- Domestic violence

Shinn and Weitzman (1996 study) Indicated

- One third of people in homeless shelters children
- Homeless children not as healthy as other children
- Many haven't received immunizations expected in childhood

CLASS DESIGNATIONS IN US

THE WORKING CLASS

Factor most important in description of working class is subordination of a member to control of production

- Group does manual work for which income varies widely
- Don't give orders-take orders from others

THE MIDDLE CLASS

Past myth of middle-class Americans

- Married couple with two or three children
- Suburban house with a double garage
- TV
- Latest household gadgets
- Father primary breadwinner

Today

- Americans move in and out of variety of family types over course of lives
- Families headed by divorced parent, couples not married raising children, two-income families, same sex couples, families with no adult in the labor force, blended families and empty-nest families
- Families with annual incomes between \$30,000 and \$80,000 classified as middle class

INTERACTIVE ACTIVITY II:

What are Your Perceptions of others?

- What images do you conjure up when you think of the underclass, the working class and the middle class?
- Which characteristics are positive and which are negative?
- Why are your perceptions value laden?
- What must you watch for in your own perceptions to ensure that you do not discriminate against patients from one of these groups?

THE UPPER MIDDLE CLASS

Professionals, managers and administrators-elite of middle class

- Upward mobility
- Incomes allow them to lead lives different from those of middle class individuals
- Group has benefited most from nation's economic growth
- More accurately reflects middle-class myth than any other group

Educational credentials more important than other groups

- Incomes and opportunities to accumulate wealth high
- Individuals often participate in civic and voluntary organizations
- Active participants in political process and major recipients of public benefits

Individuals' occupations play central role in lives

- Determine who friends, business and professional associates are
- Have more autonomy in careers
- Allowed great amount of self-direction
- View affluence, advantages and comforts as universal, rather than unique Group believes in American Dream of success because they've achieved it

THE UPPER CLASS

Necessary characteristics for entering upper class and for being accepted by members of group

- High income and wealth

Upper class comprised of two groups

- Individuals and families who control great, inherited wealth
- Top-level administrators and professionals, where a prestige position, rather than great wealth, allows them to enter or maintain status at this level

Disparities between income and wealth of members of class and members of other classes

1970 CEO's earned 79 times as much as the average worker

1990 CEO's pay was 85 times average workers'

1999 CEO's pay reached 475 times average workers'

Wealth and income ensure power

- Extremely small portion of population that holds vastly disproportionate share of wealth benefits disproportionately when resources distributed, including health care

INTERACTION OF CLASS WITH RACE & ETHNICITY, GENDER AND AGE

POVERTY

Most often:

- Condition of young, persons of color, women, full-time workers in lowest paying jobs and illiterate

Government set poverty level in 1997

- \$8,183 - single individual
- \$16,400 - four-person family

According to the US Census Bureau - 1999

- 35.6 million people (13.3% of our population) living in poverty

Low-income people include members of following groups:

<u>Group</u>	<u>Number</u>	<u>Percentage</u>
White	24.4 mill	11% of all whites
Black	9.1 mill	26.5% of all blacks
Latino	8.3 mill	27.1% of all Latinos

Older than 65	3.4 mill	10.5% of all 65+
Younger than 18	14.1 mill	19.9% of all >18
Female-headed households	13.5 mill	35.1% of all such families

CEILING FOR POVERTY LEVEL

- Indicates income level necessary to maintain adequate, not necessarily comfortable, living
- Families with incomes just above level - difficult to pay for essential food, housing, clothing, health care
- From groups included in low-income category, many individuals most vulnerable for health care problems in US

INTERACTIVE ACTIVITY III:

- Name 3 unearned Disadvantages of being brought up in the system you were brought up in based on class
- Name 3 unearned Advantages of being brought up in the system you were brought up in that you have gained based on class
Share some with the group

C. DISABILITIES

53 million Americans have disabilities (US Census Bureau 2000)

- Fall under Americans with Disabilities Act (ADA) definition:
“A physical or mental impairment that substantially limits one or more of the major life activities.”

INTERACTIVE ACTIVITY I:

Origin of the term, “Handicapped”

Where does the term “handicapped” come from?

DISABILITY STATISTICS

Persons with disabilities make up largest minority group

- 53 million
- 9.7 million cannot work
- 7.2 million limited in type of work can do

Number of people with severe disabilities increased

- 1 in 10 people – 2000
- From 1 in 8 people - 1997

Maintain higher rate of unemployment than any other minority group

- 68%

Many people with disabilities who are unemployed claim they WANT to work

- 82%

Persons with disabilities who have 12 or more years of work experience

- Make 70% of salaries of non-disabled coworkers

MYTHS & REALITIES ABOUT PEOPLE WITH DISABILITIES

(From, “Managing Diversity in the Workplace”)

1. Persons with severe disabilities

- Childlike/Dependent
- In need of charity or pity

Many persons with severe disabilities

- Have great deal to contribute/able to work and manage own lives

Related myth - disability is constantly frustrating tragedy

- Individuals with disabilities see disability as inconvenience provided disability dealt with as inconvenience

Persons with disabilities - unable to lead normal lives

- Live relatively normal lives and want to
- Many impaired in only one functional area and compensate for impairment in many ways
- Able to do most things well, some things better than others and participate actively in society

Persons with disabilities - better educated than before ADA instituted in 1990

2. Persons with disabilities can only do menial/entry-level jobs & most don't want to work

- Most want to work & see work as major route to self-fulfillment
- Many adults with disabilities indicate dissatisfaction with life

Related to desire to work and live normal life

RULES OF BEHAVIOR WHEN DEALING WITH PERSONS WITH DISABILITIES

1. Avoid terms and phrases that infer how person feels about his/her disability
2. Avoid terms or phrases that define someone by their disability rather than describe one's condition or situation
3. Do not use terms that make judgments about the person's disability or condition
4. Do not use outdated or derogatory terms in relation to a person's disability

HANDOUT:

DISABILITY LANGUAGE

WHY PERSONS WITH DISABILITIES EXCLUDED

People tend to shun or devalue people who are different

Devaluation

- Defined as: Regarding someone as inferior, not useful, possibly burdensome
- Follows close behind outright oppression - psychologically damaging consequences
- Most common attitude facing persons with disabilities
- Influenced by surrounding culture
- Most societies so subtle - devaluative practices unrecognized for many years

Unfamiliarity and Discomfort with persons with disabilities

- Little or no experience with someone with disability
- Unfamiliarity disconcerting

People frequently confused and uncertain about how to act and what to do

- Avoid making eye contact or speak to person with individual with disability instead of individual

Unfamiliarity Consequences

- Can cause people to focus on equipment individual with physical handicap uses (braces, wheelchair, etc.), rather than focusing on individual

- Person with disability gets little or no attention and becomes “nonperson”

INTERACTIVE ACTIVITY II:

What if you become impaired?

List some barriers you would face in a typical day if you lost your ability to walk, vision or hearing.

Complete worksheet

EVOLUTION: FROM VICTIM TO ACTIVIST

Cultural attitudes and policies toward people with disabilities changed dramatically in 20th century

Persons with disabilities indicate that most serious barriers to living reasonable lives not necessarily own physical or psychological disabilities - often:

- Others stereotypes and attitudes
- Buildings
- Vehicles
- Walkways
- Steps
- Restrooms

HISTORICAL CHANGES:

(From, “Managing Diversity in the Workplace”)

Before 1850	Traditional moral attitude: take care of disabled
1850's	Provide special schools for trainable
1880's	Institutionalize disabled in large centers
1880's to 1920's	Involuntary confinement and sterilization
1930's	Rehabilitation for some
	Sight impaired advocates fight for participation in society
	FD Roosevelt, who uses wheelchair, elected President
1940's	WW II opens doors for disabled workers – manpower shortages
	March of Dimes, Cerebral Palsy associations formed
1950's	Focus on rehabilitating & adapting to environment
1960's	Disabled-rights advocates organize to change environment
	Urban Mass Transportation Act, Architectural Barriers Act
	“encourage” access
1970's	Federal law requires access & accommodation from some employers and organizations; some states pass similar laws
	Independent Living approved by Congress and some states
1980's	Air Carriers Access Act
1990's	Federal ADA requires access & accommodation from most employers and public buildings
2000's	Persons with disabilities continue to fight for handicap “useable” facilities, not just handicap “accessible” as provided for in ADA

WHAT IS IT LIKE TO BE A PERSON WITH A DISABILITY?

Experiences as person with disability depends on following factors:

- Type of disability: severity, stability
- Inner resources People adjust more easily if have wide range of interests

- Being male or female elicits different reaction.
- Personality variables
- Environment
- Financial assets
- Mobility-impaired people - Main issue - Accessibility
- Visually impaired - Main issue - Safety
- Hearing impaired - Main issue - Services local community and volunteer organizations make available
 - TV & telephone service, transportation, etc.,

WRAP UP ????????

Final Discussion and Questions

HANDOUT:

DISABILITY ETIQUETTE

Classism Quiz

How much do you know about class in the U.S.?

Life at the Bottom

1. How many people in the U.S. had no health care coverage in 1994?
(a) 8 million (b) 22 million (c) 37 million
2. The best public schools in the U.S. spend over \$15,500 per pupil and have class sizes of about 15. What is the average per-pupil spending and class size of the worst schools?
(a) About \$7,000 and over 40 students per class
(b) Under \$3,000 and over 60 students per class
(c) About \$6,000 and over 100 students per class
3. What are the two biggest factors that predict whether an American has an abandoned toxic waste dump affecting his/her local air and water?
(a) Proximity to heavy industry; occupation
(b) Race; income
(c) Rural/urban location; Northern/Southern U.S.
4. In the Netherlands in 1987, over 60% of poor people were lifted out of poverty by government programs. In Britain, the percent was about 45%; Canada, 20%; France, 52%. What percentage of poor people in the U.S. were lifted out of poverty by government programs in 1987?
(a) 18% (b) Half of 1% (c) 7%
5. The majority of people who became homeless in the 1980x were single mothers with children. Why was this true?
(a) More teenagers had babies than before
(b) Average rents rose 20% and welfare benefits for single-parent families dropped an average of 23% during the decade
(c) New rules at low-income housing excluded unmarried mothers.

Politics and Wealth

6. Who was the wealthiest person in North America in 1776?
7. The average successful candidate for U.S. Senate in 1992 spend how much of his or her own money on the Senate campaign?
(a)\$40,000 (b) \$212,000 (c) \$660,000
8. The "Tax Reform" bill of 1986, which was supposed to eliminate tax loopholes, cut the tax bill for Americans with incomes between \$10,000 and \$20,000 by 6%, or an average of \$69 per year. How did it change the tax bill for millionaires?
(a) Increase of 3% (b) Decrease of 27% (c) Decrease of 12%
9. In 1992, the richest 1% of American families paid an average of 7.6% of their income in state and local taxes. The middle 10% paid 10%. What percent of their income did the poorest 20% of American families pay in state and local taxes?
(a) 3% (b) 18.2% (c) 13.8% (c) 8.8%

Disability Etiquette

1. When talking with a person with a disability, speak directly to that person rather than through a companion or sign language interpreter.
2. When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting.)
3. When meeting a person who is visually impaired, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.
4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
5. Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others. (Never patronize people who use wheelchairs by patting them on the head or shoulder.)
6. Leaning on or hanging on to a person's wheelchair is similar to leaning on hanging on to a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.
7. Listen attentively when you're talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than COJTecking or speaking for the person. If necessary , ask short questions that require short answers, a nod or shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow the person to respond. The response will clue you in and guide your understanding.
8. When speaking with a person who uses a wheelchair or a person who uses crutches, place yourselfat eye level in front of the person to facilitate the conversation.
9. To get the attention of a person who is deaf, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly, and expressively to determine if the person can read your lips. Not all people who are deaf can read lips. For those who do lip-read, be sensitive to their needs by placing yourself so that you face the light source and keep hands, cigarettes and food away from your mouth when speaking.
10. Relax. Don't be embarrassed if you happen to use accepted, common expressions such as "See you later," or "Did you hear about that?" that seems to relate to a person's disability. Don't be afraid to ask questions when you're unsure of what to do.

Adapted from the W A State Deaparbnt of Social Health Services Website <http://www1.dshs.wa.gov/dvr/emRloyers/etiquette.htm>

Disability Language

When writing or speaking about people with disabilities it is important to put the person first. Some people favor terms like 'blind or deaf, while others prefer visually impaired' and 'hearing impaired'. Catchall phrases such as 'the blind', 'the deaf or 'the disabled, do not reflect the individuality, equality or dignity of people with disabilities. The following are some recommendations for use when describing, speaking or writing about people with disabilities:

Term no longer in use: The disabled

Term Now Used: people with disabilities or disabled people

Term no longer in use: Wheelchair-bound

Term Now Used: person who uses a wheelchair

Term no longer in use: confined to a wheelchair

Term Now Used: wheelchair user

Term no longer in use: Cripple, spastic, victim

Term Now Used: disabled person, person with a disability

Term no longer in use: The handicapped

Term Now Used: disabled person, person with a disability

Term no longer in use: Mental handicap

Term Now Used: learning disability

Term no longer in use: Mentally handicapped

Term Now Used: learning disabled

Term no longer in use: Normal

Term Now Used: non-disabled or able-bodied

Term no longer in use: Schizo, mad

Term Now Used: person with a mental health disability

Term no longer in use: Suffers from (e.g. asthma)

Term Now Used: has (e.g. asthma)

Adapted from the National Disability Authority Website:

<http://www.nda.ie.CntMgmt.nsf/Category/2294F7824465D7C580256C7B005A49876OpenDocument.>

ELDER ABUSE

(From www.elderabusecenter.org)

Federal definitions of elder abuse, neglect and exploitation appeared in the 1987 Amendments to the Older Americans Act. The definitions were provided only as guidelines for identifying problems and NOT for enforcement purposes. State laws currently define elder abuse and definitions vary greatly from one state to another.

Major Categories:

1. Domestic elder abuse

Generally refers to several forms of maltreatment of an older person by someone who has a special relationship with the elder (spouse, sibling, child, friend or caregiver in the older person's own or the caregiver's home)

2. Institutional elder abuse

Generally refers to any of the forms of abuse mentioned in domestic abuse, but occurring in residential facilities for older persons (nursing homes, foster homes, group homes, board and care facilities). Perpetrators of institutional abuse are individuals who have a legal or contractual obligation to provide elder victims with care and protection

3. Self-neglect or self-abuse

Generally refers to the behaviors of an elderly person that threatens his/her own safety.

Types of Abuse:

PHYSICAL ABUSE: Use of physical force that results in bodily injury, physical pain or impairment. May include striking, hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching & burning...Inappropriate use of drugs and physical restraints, force-feeding & physical punishment of any kind.

Signs & Symptoms of physical abuse:

- Bruises, black eyes, welts, lacerations & rope marks
- Bone fractures, skull fractures
- Open wounds, cuts, punctures, untreated injuries in various stages of healing
- Sprains, dislocations, internal injuries/bleeding
- Broken eyeglasses/frames, physical signs of being subjected to punishment, signs of being restrained
- Lab findings of medication overdose or under utilization of prescribed drugs
- Elder's report of being hit, slapped, kicked or mistreated
- Elder's sudden change in behavior
- Caregiver's refusal to allow visitors to see an elder alone

SEXUAL ABUSE: Non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent. Includes, but not limited to unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity and sexually explicit photographing.

Signs & Symptoms of sexual abuse:

- Bruises around the breasts or genital area
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained or bloody underclothing

- Elder's report of being sexually assaulted or raped

EMOTIONAL OR PSYCHOLOGICAL ABUSE: Defined as the infliction of anguish, pain or distress through verbal or nonverbal acts. Includes verbal assaults, insults, threats, intimidation, humiliation and harassment. Treating an older person like an infant, isolating an elderly person from his/her family, friends or regular activities, giving an older person the "silent treatment," and enforced social isolation are examples of emotional/psychological abuse.

Signs & Symptoms of Psychological abuse:

- Being emotionally upset or agitated
- Being extremely withdrawn and non communicative or non responsive
- Unusual behavior usually attributed to dementia...sucking, biting, and rocking
- Elder's report of being verbally or emotionally mistreated

NEGLECT: Defined as the refusal to fulfill any part of a person's obligations or duties to an elder. May also include failure of a person who has fiduciary responsibilities to provide care for an elder...pay for necessary home care services...or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety and other essentials included in an implied or agreed-upon responsibility to an elder.

Signs & Symptoms of Neglect:

- Dehydration, malnutrition, untreated bedsores and poor personal Hygiene
- Unattended or untreated health problems
- Hazardous or unsafe living condition/arrangements...improper wiring, no heat or no running water
- Unsanitary and unclean living conditions...dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing
- Elder's report of being neglected

ABANDONMENT: The desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Signs & Symptoms of Abandonment:

- Desertion of an elder at a hospital, nursing facility or other similar institution
- Desertion of an elder at a shopping center or other public location
- Elder's own report of being abandoned

FINANCIAL OR MATERIAL EXPLOITATION: The illegal or improper use of an elder's funds, property or assets. Includes cashing an elderly person's checks without authorization or permission, forging an older person's signature, misusing or stealing an older person's money or possessions, coercing or deceiving an older person into signing any document...contracts or will, and improper use of conservatorship, guardianship or power of attorney.

Signs & Symptoms of Financial or Material exploitation:

- Sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the elder
- The inclusion of additional names on an elder's bank signature card
- Unauthorized withdrawal of the elder's funds using the elder's ATM card

- Abrupt changes in a will or other financial documents
- Unexplained disappearance of funds or valuable possessions
- Substandard care being provided or bills unpaid despite availability of adequate funds
- Discovery of an elder's signature being forged for financial transactions or for the titles of his/her possessions
- Sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions
- Unexplained transfer of assets to a family member or someone outside the family
- Provision of services that are not necessary
- Elder's report of financial exploitation

SELF-NEGLECT: Characterized as the behavior of an elderly person that threatens his/her own health or safety. Generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated) and safety precautions. Definition of self-neglect EXCLUDES a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice.

Signs & Symptoms of Self-neglect

- Dehydration, malnutrition, untreated or improperly attended medical conditions and poor personal hygiene
- Hazardous or unsafe living conditions/arrangements...improper wiring, no indoor plumbing, no heat, no running water
- Unsanitary or unclean living quarters...animal/insect infestation, no functioning toilet, fecal/urine smell
- Inappropriate and/or inadequate clothing, lack of the necessary medical aids...eyeglasses, hearing aids
- Grossly inadequate housing or homelessness

What are Risk Factors for Elder Abuse?

Extremely Complex Issue

Generally a combination of psychological, social and economic factors, along with the mental and physical conditions of the victim and the perpetrator, contribute to the occurrence of elder mal-treatment.

Some causes

- Domestic violence grown old...spouses who have traditionally tried to exert power & control over the other through emotional abuse, physical violence & threats, isolation, etc.
- Personal problems of abusers...particularly in case of adult children who are dependent on their victims for financial assistance, housing, etc.
- Living with others and isolation...abusers who live with the elder have more opportunity to abuse, yet may be isolated from the larger community themselves or seek to isolate the elders from others so abuse is not discovered.
- Caregiver stress...theory that well-intentioned caregivers are so overwhelmed by the burden of caring for dependent elders that they end up "losing it" and harming the elder
- Personal characteristics of the elder...theory that dementia, disruptive behaviors, problematic personality traits & significant needs raise an elder's risk of being abused.

- Cycle of violence...theory that domestic violence is a learned behavior transmitted from one generation to another.

Who are the Abusers?

More than two-thirds of elder abuse is carried out by family members, typically serving in a caregiver role.

Crime?

- Dependent on statute of a given state
- Most physical, sexual and financial/material abuses are crimes in all states
- Certain emotional abuse and neglect cases are subject to criminal prosecution.

HELP Regarding Elder Abuse

- State & Local Agencies help victims & families involved in elder abuse
- APS (Adult Protective Services)...located within the human services area (usually the county department of social services)
- State unit on aging, law enforcement agency, medical examiner coroner's office, hospitals & medical clinics, public health agency, area agency on aging, mental health agency, long-term care ombudsman's office & facility licensing/certification agency.
- In most jurisdictions, APS, Area Agency on Aging or the county Dept. of Social Services is designated as the agency to receive & investigate allegations of elder abuse and neglect. If abuse or neglect is found, they make arrangements for services to protect the victim.

HOTLINE PHONE NUMBERS

Law Enforcement...local police, sheriff and prosecuting attorney

In states where elder abuse is a crime...may be required to report suspected elder abuse

Long-term Care Ombudsman's Program...since passage of the 1975 Older Americans Act, every state has a program to investigate nursing home complaints.

Information & Referral...All areas Agency on Aging operates an I & R line to refer people to services for people 60 and over.

National & State Information...Long-distance caregivers can call a nationwide toll-free Eldercare Locator Number...1-800-677-1116 to locate services in the community in which the elder lives.

Medical Fraud Control Units...States' Attorney General's offices are required by Federal law to investigate & prosecute Medicaid provider fraud and patient abuse or neglect in health care programs that participate in Medicaid, including home health care services.

THE ORIGIN OF “HANDICAPPED” WORKSHEET

SECTION A:

- _____A. Golf, where poorer players are given an advantage to allow them to compete.
- _____B. Horse racing, where faster horses must carry heavy weights.
- _____C. Beggars, who held their caps in their hands.
- _____D. None of the above.

SECTION B:

- _____A. Blind as a bat.
- _____B. A lame excuse.
- _____C. Not playing with a full deck.
- _____D. Funny as a rubber crutch.
- _____E. The blind leading the blind.
- _____F. A cripple (as in baseball).
- _____G. Stone deaf.
- _____H. Lame duck president.
- _____I. What a spazz!

WHAT IF YOU BECOME IMPAIRED?

List some barriers you would face in a typical day if you lost your ability to walk, vision or hearing.

ACTIVITY

MOBILITY IMPAIRED

VISUALLY IMPAIRED

HEARING IMPAIRED

- Getting up in the morning
- Getting to work/school
- Doing work, communicating
- Having lunch
- Using the restroom

- Other activities