

Developing Cultural Competency in Laboratory Practice

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LEARNING OBJECTIVES:

1. Compare and contrast the different stages of culture competency development described by the National Center for Cultural Competence.
2. Describe the stages of cultural competency in the model based on the work of William Howell.
3. Given a description of a person's behavior, select the stage of cultural competency.
4. Differentiate between culture and demographic labels such as race, ethnicity, or nationality.
5. Discuss the impact that implicit bias can have on the quality of healthcare delivery.

ABSTRACT

Each of us holds preconceived assumptions about the things around us including the ideas, judgments, and values that have been developed from our personal experiences in life. Cultural identity is based on a set of beliefs and behaviors that guide a person's understanding of how things routinely work. But as we become a more global society we must understand that all cultures have a set of acceptable guidelines, some of which, may be very different from our own. Although many schools and companies require employees to attend seminars about developing cultural sensitivity, awareness, and competence, our implicit biases may interfere with the application of culturally competent behaviors in real life. The vast majority of health care practitioners are genuinely focused on the well-being of patients and the quality of medical practice. However, many are not aware of their implicit practices of bias that can cause as much harm as explicit prejudice. To find that we hold implicit or unexamined biases can be disturbing but at the same time it is a requisite first step to developing a culturally competent person. This article explores two models of cultural competence as well as a model for constructive communication in culturally diverse environments. Finally, examples of harmful and biased statements experienced by laboratory students and employees are also discussed with suggestions and guidance for constructive management and resolution.

ABBREVIATIONS: LGBT - Lesbian, Gay, Bisexual, Transexual, EEOC - Equal Employment Opportunity Commission, IDI[®] - Intercultural Development Inventory[®], NCCC - National Center of Cultural Competence

INDEX TERMS: Cultural competency, cultural blindness, inclusion, diversity, implicit bias, tolerance

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INTRODUCTION

Incident from 1970: Young woman enters Calculus classroom on the first day of class. Middle aged male professor publicly asks her to leave stating that women are not qualified to take his class.

Incident from 2007: Young woman (daughter of woman above) enters Calculus classroom on the first day of class with her male friend who is also in the course. Young male professor publicly asks her to leave because "girlfriends" are not allowed in his class."

What do each of these incidents tell you about the past and current state of our academic culture? What does this demonstrate about the implicit (perhaps explicit) bias each professor has about women and mathematics? What progress have we really made for gender equality in academia?

Each of us holds preconceived assumptions about the things around us; these are the ideas that have been developed from our personal experiences in life. Throughout a person's life one will encounter an ever-expanding number and type of people. As a child, a person is only exposed to their immediate and then their extended family. Typically, a person's family had the same basic appearance and the same cultural habits, but as a person follows their educational path they encounter more diverse groups and types of people.

It is human nature to sort and classify people by their outward appearance and characteristics. Infants recognize human faces and structures at birth, which may be an inborn social construct for human development. But similarly they also recognize quite early when faces do not align with a traditional format.¹ Infants may recognize other races as early as 3 months and their identification processing is developed by 9 months.^{2,3} This later processing development indicates that racial recognition is not inborn but is instead an environmentally developed social concept, it is learned.

As adults, we consciously or unconsciously label and categorize people as soon as we encounter them. Gender and race may be somewhat obvious to the casual observer; however, in today's society mixed-race people may not be so obvious by outward appearance nor is someone's gender identity or sexual orientation. You might also make some assumptions about a person's national origin or religion because of their language. But there are different ways of speaking English even among native speakers in the United States. You could also make assumptions about a patient's or coworker's ethnic nationality based on their name, but in many cases, you could be wrong. Age, certain disabilities, or socioeconomic status may not be obvious when you first meet someone. Not every 30, 45, or 60-year-old looks the same nor is everyone who wears torn jeans poor. Many handicaps are also not obvious by first appearances. Someone with a hearing loss or whose vision requires an accommodation may not be obvious

on first glance. Many people who use a handicapped placard for parking have a health issue but not an obvious physical impairment.

This essential idea is that appearances do not necessarily have a single interpretation or meaning. Recognizing differences in people may be a natural ability, but what it means, the interpretation of how we apply them, and our assumptions about these differences are learned abilities. As learned concepts, they can also be changed through constructive experiences and education.

Diversity and Culture

As we begin this discussion, it is important to define diversity, culture, and inclusivity. Diversity is the condition of having or being composed of differing elements. Diversity is made up of a variety of similar but different things. In context of these focus articles it is the inclusion of different types of people, as people of different races or cultures, in a group or within an organization.

Culture is different than Race, Ethnicity, or Nationality although these factors may overlap. Culture is the environment in which a person was raised and where that person currently lives. It is a set of beliefs and behaviors that guide a person's values and understanding of how things are supposed to work. Culture can be described as our way of living every day.⁴ It includes a set of values, beliefs, standards, language, thinking patterns, behavioral norms, communications styles, and our traditions. Culture can also include foods and how they are prepared. Defined in this way, culture is a learned process. Most of us have learned our home environment culture by the time we are 3-years-old. We expect our parents and other family members to behave in the regular patterns that we have experienced over time. Young children are often very upset when their habits and routines are changed because they are used to their culture or expectations of what is "usual and customary." As we grow older we realize that there are other cultures besides our own.

What may not be outwardly obvious are the different cultures we enter and leave each day. We have the culture of our home life but it may be a very different culture than our school or work life. Each school or place of business is likely to have a variety of "cultures." Some cultural differences are subtle while other differences can

be quite dramatic. A person's cultural background can determine how they interact with these transitions based on how different they may be from their personal perspective of what is usual, expected, or customary. There is also a culture, or expected customs, in a health care setting for employees. But, anyone who has worked in more than one laboratory setting knows that the traditions can be quite different from one laboratory to the next.

Every human being holds preconceptions about "different" cultures and different people. It is probably part of our evolution and human development history that allowed us to survive – by being aware and cautious of new things and different people. But as we become a more global society we must strive for cultural competence in everyday life.

Cultural Competence

According to the National Center of Cultural Competence (NCCC), cultural competence is a set of behaviors, practices, attitudes and policies that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations.⁵ Cultural competence does not mean learning all characteristics of all people nor does it require you to like everything about everyone, but it does require mutual respect and valuing of individuals. It is also important to realize that cultural competence is not something that can be achieved and finished; it is a process that is applied in each specific case. Cultural competence is developed over time and never stops developing, because each person you meet throughout life is a new opportunity to practice and polish your skills. To be able to acquire cultural competence you must begin with the awareness of need. Only if you are aware that you must develop this skill will you be able to achieve your goal. After awareness is the increase in personal knowledge and the enhancement or practice of skills.

In order to become aware of cultural competence, you must evaluate or assess your current competency level so that you can focus your education on attaining the next level and continue to improve. There are several models for assessing your level of culture competency (see Evaluation of Cultural Competency, below), but the key element of performing a self-assessment is to examine your true competency level compared to where you

believe you are.^{6,7}

The cultural competence continuum developed by Cross et. al. from Georgetown University and the NCCC, described six levels of personal growth from Cultural Destructiveness to Cultural Proficiency.^{5,8} At the bottom end of the spectrum is Cultural Destructiveness. At this level, rights and privileges are only provided for people in the dominant group and people in the non-dominant groups are intentionally excluded. This level is what most would call overt racism. This is where implicit or unconscious bias may lead to practices which are culturally destructive. At the middle of the development spectrum is the term Cultural Blindness. At this level people tend to "treat everyone the same;" however, this approach only meets the needs of people in the dominant cultural group. This level ignores the differences which truly exist between people.

At the level of Cultural Pre-competence people explore cultural issues and learn about them. At this level people are committed to developing their overall competence because they understand the benefits of being culturally competent. This level is where organizations may be as they assess the needs of their organization, their clientele, and their employees. As an organization evolves, individuals gradually move toward Cultural Competence; they recognize and value cultural differences within their group. Individuals at this level seek advice from diverse individuals when setting policies and when evaluating outcomes. An organization intentionally hires culturally unbiased employees who also value diversity as a means to strengthen the organization.

The top level is Cultural Proficiency. At this level individuals or organizations work actively to implement changes and to improve services based upon cultural needs of their community, including work, school, and patients. Individuals at this level may include their best practices in research and teaching style to achieve cultural competency.

Another model of cultural competency, based on work by William Howell, labels the lowest level of culture competency as Unconscious Incompetence.⁹ This level is similar to the Cultural Blindness level in the previous model in which one is unaware that there are real differences in how people view the world, but it could

also be related to Cultural Destructiveness because people at this level view their way of doing things as the right way and they may not really understand how harmful this can be to others. At the next level of Conscious Incompetence, a person begins to realize that there are differences among others and that person is unsure if they understand others. Conscious competence is similar to the Pre-Competence level in the model above in which one is aware of the differences between their beliefs and those of others around them and although it is difficult, one wants to make a conscious effort to improve. One is consciously aware of how their behaviors and statements can impact others. In the final stage of this model a person reaches Unconscious Competence where appropriate interactions with others are routine and no longer need to be forced. Cultural sensitivity is part of who they are.

Evaluation of Cultural Competency

To address the critical need to improve cultural competency many large universities and corporations have begun to use interactive evaluation processes for faculty and staff. Some health care professional education programs have also used these surveys to help teach students about cultural competency prior to entering the practice field. One such evaluation process is the Intercultural Development Inventory® (IDI®).^{10,11} The IDI uses a series of situations presented in an online survey format of 50 questions. This model has similar levels of competency from Denial and Polarization to Acceptance and Adaptation. What is different about this product is that the final reports provide information about the perceived level of competence and the actual level of competence. It also provides descriptions and explanations for the differences or gaps in competency levels.

Examples of Implicit Biases and Microaggressions in the Real World

As discussed above, the vast majority of us do not practice overt prejudices in our healthcare careers. We are genuinely focused on the well-being of our patients and the quality of our laboratory practice. However, we may not be aware of our implicit practices of bias, which can potentially cause as much harm as overt prejudice. As well-educated and moral people, most of us consciously consider ourselves to be unbiased people. To find that we hold implicit biases can be disturbing but at the same time a requisite first step to developing a culturally

competent person.

Implicit biases are the subconscious practices that guide our interactions with others.⁴ They are stereotypes and assumptions we have about people based on their outward appearances or labels and from our individual experiences. With the abundance of Internet news, fake news, and social media trending topics, the experiences we believe we have do not have to be first hand and may in fact be unreal or false. Implicit bias also involves judging and valuing based on these assumptions and that is where we encounter problems. Microaggressions are the statements we make or the actions we take that place a judgment on a targeted group of people and, in essence, devalue who they are.¹²

Examples of microaggression include the display of only White students or only females on an employment web site or school brochures. This may imply to individuals of color or males that they are not welcome in a facility. Likewise, expecting an applicant to make direct eye contact with you throughout the interview, whether for job or acceptance into a school may be based on your biased definition of normal. For many cultures, direct eye contact is considered disrespectful and yet most interview evaluations will mark a candidate down for this. Making assumptions about what is appropriate from the perspective of your cultural lens is the basis of marginalization. Those who are not targeted by these assumptions, because they follow the majority cultural practices, are “privileged.” That is, they are not targeted by our assumptions in everyday life. Recognition that these assumptions exist is again the first step toward change.

Below are some of the real microaggression encounters experienced by students, faculty, and staff during the past year. Try placing yourself on the targeted end of these situations or substituting a characteristic that does not evoke bias to see the inappropriateness of the statement.

- **You speak English very well for an Indian (Native American).** This implies that minorities are not expected to speak English as well as non-minorities, even when they were born here. If you substituted a hair color in the statement above can you now see the absurdity of it?
- **Upon hearing that the Asian student has a part-**

time job while in school a preceptor says - Do you work in a nail shop or your parents' restaurant? Although the question was asked in a curious tone the student was outraged and responded in a hostile tone, "No my father is a lawyer and my mother a circuit court judge." The site initially reported the student for poor affective domain, but soon realized the preceptor's error.

- **They didn't mean anything by that statement; they're not really a racist (colleague to colleague in the lab).** This devalues the impact that hateful statements can have on others. Although you may be trying to help them feel better, this in fact has the opposite effect. You are devaluing the target person's feelings and telling them this type of treatment is acceptable.
- **A pre-med advisor asks a female student if she is planning on getting married and having children while in medical school as the advisor (also female) is considering whether to write a letter of recommendation.** This implies that the student should reconsider applying or reconsider starting a family. Either way the prejudiced assumptions can damage her potential. Please note that this is female to female.
- **I would have never guessed that you were a scientist.** This was said to a woman faculty member of color by a University administrator.
- **Laboratory supervisor of color is mistaken for a service worker by the new pathologist.** This implies that people of color must be in a professional setting because they are in service roles and are not expected as professional colleagues.
- **What nationality are you?** This was said to a laboratory technician who is of Middle Eastern decent and wears a hijab, but whose family has been American citizens for 4 generations.
- **A male laboratorian when hearing that a woman laboratorian has gone home because she is not feeling well states aloud in the break room, "it must be that time of the month."**

- **You people don't like ranch dressing like we do – so I didn't get any for you.** Said to an African American student by a White student in the same cohort.
- **A lab manager made a joke that was overtly racist but then turned to the Latino and said, "I'm just teasing don't beat me up, or call your posse."** This scenario and these comments epitomize microaggressions.

When individuals are subjected to these kinds of statements on a daily basis there can be eventual loss of self-esteem and self-efficacy. Over time individuals may also begin to internalize the loss of value believing that they will never be equal because of these workplace or academic environmental pressures. They lose respect for the people who display these microaggressions and we eventually may lose them from our facility or even our field. As professionals in a diverse society we must strive for culture competency in our work lives and in our personal lives. The world is changing – we need to keep up.

Cultural Competency Case Studies

One model for developing constructive conversations in a multicultural environment uses the word R.E.S.P.E.C.T. as an acronym (Figure 1).¹³ This cross-cultural communication model provides some key concepts and phrases to consider and apply when speaking with patients, their family members, or colleagues in the workplace. As you read through the scenarios realize that these were taken from actual incidents encountered in the clinical or educational setting. Describe how concepts from the Welch R.E.S.P.E.C.T. model could be applied in each scenario?

Scenario 1

54-year-old Hmong male is recently admitted to the hospital with preliminary diagnosis of severe hypertension (high blood pressure) and risk of stroke. You've come to draw a blood sample and you introduce yourself and explain why you are in his room. He responds, "I can't give you more blood! They took some of my blood last week at the doctor's office and now I am feeling worse. You can't have any more blood!" He seems genuinely frightened of having blood drawn and begins to scream at you.

The R.E.S.P.E.C.T Model of Cross-Cultural Communication¹³

- **Rapport**
 - Connect on a social level
 - Seek the patient's (coworker's, student's, etc.) point of view
 - Consciously attempt to suspend judgment
 - Recognize and avoid making assumptions
- **Empathy**
 - Remember that the patient has come to you for help
 - Seek out and understand the patient's rationale for his or her behaviors or illness
 - Verbally acknowledge and legitimize the patient's feelings
- **Support**
 - Ask about and try to understand barriers to care and compliance
 - Help the patient overcome barriers
 - Involve family members if appropriate
 - Reassure the patient you are and will be available to help
- **Partnership**
 - Be flexible with regard to issues of control
 - Negotiate roles when necessary
 - Stress that you will be working together to address medical problems
- **Explanations**
 - Check often for understanding
 - Use verbal clarification techniques
- **Cultural Competence**
 - Respect the patient and his or her culture and beliefs
 - Understand that the patient's view of you may be identified by ethnic or cultural stereotypes
 - Be aware of your own biases and preconceptions
 - Know your limitations in addressing medical issues across cultures
 - Understand your personal style and recognize when it may not be working with a given patient
- **Trust**
 - Self-disclosure may be an issue for some patients who are not accustomed to Western medical approaches
 - Take the necessary time and consciously work to establish trust

Figure 1. The R.E.S.P.E.C.T. model.

For this scenario think about the cultural disconnect between the patient and the healthcare provider. What is occurring here? Thinking about the development of cultural competence how this situation offers an opportunity for personal growth? Put yourself in the role of the patient and then put yourself in the role of the healthcare provider.

Although you may feel the patient is acting irrationally,

it is important that you respect his fears. Adult patients are legally in charge of their own bodies and can decide whether they want any medical treatment or intervention in spite of the doctor's orders. You therefore cannot force him to have his blood sample drawn. Respecting his refusal, you should follow your facility's policy to notify the physician and/or nursing staff.

The incident does provide an opportunity for you to learn more about cultural beliefs related to health and causes of disease. Many non-American cultures view the human body as a whole and each part of the body has an integral role in health. Each portion of the body is essential and removing blood could be viewed as upsetting the balance within the body. The key element in many Asian beliefs is "Qi" or energy, which many believe is found in blood. Knowing this may help you understand why he was so afraid and may help you empathize. Applying the R.E.S.P.E.C.T. model, you could begin by suspending judgment (rapport), reassure the patient that you are there to help (support), be flexible (partnership), and respect his beliefs (cultural competence).

Scenario 2

You are the laboratory manager in a large metropolitan hospital. Your evening shift supervisor (a 32-year-old White female) comes to you about a new MLS employee (a 25-year-old Resident Alien Visa status male). The new employee will not follow the shift supervisor's instructions without first checking with a 50-year-old White male laboratory assistant, who is also on evening shift.

What would explain the reason for this continuing behavior by the MLS employee? What communication strategy could help correct this situation? As the laboratory manager it's important to talk with the shift supervisor to get specific details. Meet with the new employee to find out why they check with the laboratory assistant before implementing instructions from the shift supervisor. Inquiring first may provide a rationale unrelated to gender or race. It may be that they do not know the hierarchy within the laboratory; not everyone wears their position title on their badge. Using the R.E.S.P.E.C.T. model it is important to not make assumptions (rapport), seek out their rationale (empathy), ask about and try to understand the barriers to compliance (support), and build trust. Let them know

your expectations for compliance without judgment. It would also be important to talk with your shift supervisor and the laboratory assistant to clarify your expectations for them.

Scenario 3

A student knows they have a lab exam on Monday, but they've had a lot of personal family issues come up in the last few days and need more time to study. As the oldest male child in a first-generation, multicultural family, they've had to take on the family leadership responsibilities; their family expects it. They inform the instructor by email that they won't be able to take the exam because of a family situation this past week. They are shocked when their instructor tells them this is not an allowable absence according to university policy and they must take the exam on schedule.

For this scenario think about the cultural disconnect between the student and the instructor. What is occurring here? Thinking about the development of cultural competence, how does this situation offer an opportunity for personal growth? Put yourself in the role of the student and then put yourself in the role of the instructor. How can you explain to the student what is expected here and why? How can you explain to the instructor that the student honestly thought this was legitimately appropriate? As with many immigrant or multicultural families, older children often have to take on adult responsibilities when a parent dies, becomes ill or is unable to work. Instead of hastily denying the student's request, the instructor might take a few moments to connect on a social level with the student (rapport) without judgment, and try to understand the student's rationale (empathy), etc. University policies are meant to be followed, but the instructor does have leeway within their course. The instructor could perhaps allow the student to take the exam at a different time on this occasion, but then discuss their expectations for the future. Opening a dialogue with the student and working to understand the pressures and expectations from their family may go a long way toward mutual understanding.

Scenario 4

You are a bench tech in a critical access hospital. One of your fellow employees leaves the lab every day at 1:00 pm to pray. They return after 30 minutes, which is their allotted time for lunch. You feel that this puts an extra burden on you because one of the local clinics always

delivers their morning samples at 12:30 pm. You begin to berate this fellow employee behind his back and express your belief that they are receiving favoritism from management. You are shocked when you receive an affective domain counseling session from your supervisor.

You can perhaps see why the bench tech believes they are being treated unfairly, but are they? What does Human Resource law say about accommodations for religious practices? If this employee is taking their lunch time and it has been approved by the supervisor then this is not favoritism at all. What they do on their break or lunch period is up to them as long as they return on time as scheduled. How would you counsel the unhappy employee so that you can help them understand that this is not unfair treatment? Federal law prohibits discrimination or biased treatment (denial or favoritism) based on religion. If the employee who is taking their lunch break to pray is obeying the time restraints of your laboratory, they are well within their rights. After all, the bench tech who is complaining has no restrictions on their lunch break activities. However, the workload issue may be a valid concern. Helping the bench tech understand that their disparaging comments are unacceptable, while also listening carefully to their concerns is a delicate line to walk. Ultimatums are not productive and understanding may take time. Allowing the bench tech to voice their concerns and responding constructively to them may be all that's needed.

Scenario 5

You are the education coordinator at a University-based MLT program. One of your students reports repeated "racist" incidents at their clinical site. They are genuinely concerned that their grading will be negatively biased and asked to be moved to a different site. Your student is African American while you and all of the clinical preceptors are White. Although the student did not suffer any negative grading from the clinical site, they can document the following statements and more from the laboratory supervisor.

I assume you got into college because of Affirmative Action like all other Black people. If Black people want me to respect them, they have to stop begging for hand-outs and get off welfare. I'm tired of paying for all of these babies.

For this scenario, think about the cultural disconnect between the student and the lab supervisor. What is occurring here? Thinking about the development of cultural competence how does this situation offer an opportunity for professional growth? How can you explain to the student what is needed here? How can you explain to the laboratory supervisor that this was inappropriate? How will you manage this clinical site in the future given your responsibilities as an accredited program?

Because the student did not endure any grading harm, you may be tempted to ignore this situation. However, ignoring this actually endorses the behavior as acceptable. Because the student has brought this forward and can document the incidents, this becomes a formal complaint and must be managed. Using the R.E.S.P.E.C.T. model, talk with your student to assure them of your support (support and empathy). Discuss the incident with your clinical site management team and follow your academic institution's requirements for recording this with your office of Equal Opportunity. Consider that this environment may also impact the affiliation agreement contract for a providing a safe learning environment. Discuss the potential of providing workshops on cultural competency for both academic and clinical employees.

Summary

In the above scenarios, at least one statement from the cross-cultural contamination model of R.E.S.P.E.C.T. is not being followed. If we strive to suspend judgment, seek out and understand rationale for behaviors, and respect the patient and his or her beliefs, we will move toward cultural competence and inclusion. The same constructive practices should apply in the workplace or in a place of education. Learning more about our own biases and working to achieve Cultural Proficiency or Unconscious Competence can go a long way toward improving diversity and acceptance in the workplace, in universities, and in society.

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