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ABSTRACT

Studies concerned with factors related to perceptions of the elderly have found that educational attainment is the only variable to show a consistently positive relationship with the way people view the aged. The goal of this curriculum model is to develop a training program that incorporates racial/ethnic content relevant to practitioners in health care. For purposes of the study, it is assumed that the majority of students currently enrolled in the health professions are non-minority students, and in addition to holding negative stereotypes of the elderly, they also hold stereotypical views of ethnic/racial minorities. Based on systems theory concepts, the model described in the appendix was developed by the Chicano Training Center (Houston, Texas) and includes three components: curriculum development, training, and development. A 15-item bibliography concludes the document. (NL)

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CROSS-CULTURAL ISSUES IN AGING: A CURRICULUM MODEL FOR INCORPORATING CONTENT ON RACIAL/ETHNIC ELDERLY MINORITIES

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CROSS-CULTURAL ISSUES IN AGING: A CURRICULUM MODEL FOR INCORPORATING CONTENT ON RACIAL/ETHNIC ELDERLY MINORITIES

Educating health care providers about patients/clients who possess traits, characteristics, values and belief systems that run counter to those of youth oriented mainstream Americans is a formidable challenge for the health care professions. In the field of aging educators have the added challenge of helping students overcome societal negative attitudes toward the elderly. There is evidence that care providers attitudes and knowledge about aging are factors that influence the quality of health care provided for the elderly. Several attitude studies sampling various health professions report negative attitudes, stereotypes and preferences for working with younger patients by medical students (Spence, Feigenbaum, Fitzgerald & Roth, 1969; Cichetti, Fletcher, Lernor & Coleman, 1973;Gale & Livesly, 1974). In a study of nursing students Buschmann, Burns, & Jones (1981) found quality of prior contact with the elderly was related to interest in geriatric nursing. Other studies report similar negative attitudes for dental students (Geboy, 1982) and other health professionals (Holtzman & Beck,1979).

In general, studies concerned with factors related to perceptions of the elderly have found that educational attainment

is the only variable to show a consistently positive relationship with the way people view the aged (Michielutte & Diseker, 1985).

PURPOSE

The purpose of this paper is to present a curriculum model that holds promise for addressing the educational needs of students in the health professions who are seeking to become more effective in their professional encounters with elderly patients who are members of racial and ethnic minority groups. The authors attempt to address what Bengtson (1979) indicates are the central questions in ethnogerontology. The hope is that this effort will add clarity to the field of ethnogerontology by addressing key issues that are widely and frequently misunderstood. The authors present a curriculum model for developing a training program that incorporates racial/ethnic minority content that is relevant to practitioners in health care. To illustrate the application of the model the authors present a hypothetical institutional case situation using a generic mission statement that would be applicable to a hypothetical health education program with a focus on geriatric education. A list of research topic cluster areas found in the field of ethnogerontology is presented to familiarize the reader with the current key research questions that can serve as guide posts for the curriculum developer in curriculum planning.

BACKGROUND

As a society the U. S. serves as a democratic model that is admired around the world because of its humanistic principals and

efforts to promote justice for all its citizens whose origins are varied and collectively represent multiple ethnic and racial groups. With the exception of Native Americans the United States is a nation of immigrants. The nation's racial/ethnic diversity, the authors argue, is a source of dynamic psychic energy that represents vast potential human resources. The English founders had a vision that in time ethnic group differences would disappear. It was assumed that societal institutions like schools and political entities would in time socialize inhabitants to the language, values, and ideas that were a part of the English pilgrims' home of origin life experience. Given the country's indigenous peoples and immigrant history of various national racial/ethnic backgrounds it is not surprising that the forces of group dynamics have found expression in periods of turmoil or conflict characterized by power struggles between and within groups. The perpetual societal question is to what extent should ethnic minority groups in American society be permitted or encouraged to preserve aspects of their culture of origin? Through societal institutions individuals are socialized to the norms of the prevailing social structure. The collective societal norms constitute the societal culture. A culture consists of behavioral patterns, explicit and implicit, that are acquired and transmitted by symbols. It represents the normative values, attitudes, beliefs, customs and achievements of the group. Societal subgroups who share a social and cultural heritage constitute an ethnic group. The terms ethnic and race are frequently erroneously used

interchangeably. Race involves genetic factors that distinguish various subgroups of the human species. Cultures are usually open systems that are subject to change as the group comes in contact with other group ideas. In modern day societies the schools are assigned a primary role in transmitting the societal culture. In multicultural societies like the U.S. the task of assimilating individuals from minority cultures to the dominant societal culture is a complex ongoing process. Minority leaders frequently oppose policies that erode individual groups' cultural heritage. Adopting majority societal group norms for the minority group person represents both socioeconomic rewards and multiple sources of personal conflict. The conflict takes on various forms like peer pressure and feelings of guilt over giving up part of one's self. This is particularly difficult for minority youth. Most persons tend to perceive change as negative rather than growth producing. Change is frequently perceived as a loss. Change in the context of adopting group majority norms may be interpreted as challenging personal beliefs or values associated with treasured family customs. Change may result in cohort peer group alienation. Thus, the minority youth person who grows to be old in the midst of dual cultures may still experience self doubts about the value of giving up her/his identification with his/her culture of origin. The majority group in the context of this paper refers to those persons who for the most part share racial characteristics and societal values that were functional in Anglo Saxon institutions. The majority culture includes various other national origin

subgroups who are considered part of the white majority and who frequently hold varying values that effect their interactions within the majority group and with members of minority groups.

Historically, in the U. S. members of racial/ethnic minority groups who looked different, whose skin color was darker, who spoke with an accent or who were non-English speakers were treated as outsiders or foreigners. Even Native Americans were treated as foreigners. This climate, in part, served as a stimulus for ethnic and racial groups to form parallel institutions (e.g. NCOAI National Congress on American Indians, NAACP National Association for the Advancement of Colored People, LULAC League of United Latin American Citizens, GI Forum). These organizations served as sources of minority group support by sponsoring activities that affirmed the particular group's uniqueness and cultural heritage. This organizational separateness, served to offset the negative effects of conflicting encounters with the majority group. On the negative side it had the effect of reinforcing both majority and minority groups' ethnic differences that became psychological barriers or inhibitors for the process of acculturation.

Problems in Cross-Cultural Patient Care

In the 1990s an influx of new ethnic immigrants from Asia, Central and South America has increased the number of minority potential patients who are Limited English Proficient and whose health care customs present special challenges for both health care professionals and novice students of health care. These ethnic minority individuals, like earlier ethnic or racial minority

groups, share characteristics that set them apart like physical attributes, personal values and views of health care that are foreign to the non-minority health care student and some minority students too. Ethnic and racial minority students of health care who may also come from middle or lower class backgrounds may share their non-minority student cohorts prejudices towards the poor and elderly who may be of the same or other racial minority groups. Frequently, minority students who have overcome economic and racial oppression have emotional scars that predispose them to identify with both the positive and negative majority values which frequently includes negative references to the student's respective reference group. When these negative references become internalized they may present interpersonal barriers for the health care minority student who may experience painful flashbacks when collecting patient data. This phenomenon is not a universal experience and may be less problematic in short term patient-care encounters. Supervisors must be sensitive to clues that indicate a need for closer supervision or referral for professional counseling.

For purpose of this paper the term "minority" is used to designate ethnic or racial groups that are named in the federal statues pertaining to protection of civil rights. The challenge for educators today is to help students of higher education reframe their concept of differentness so that a negative value is not automatically associated with the idea of being different. It is the quality of being different that makes each person special and

unique. The recent changes in Eastern Europe may well result in a new wave of immigrants and a need for increased expertise sharing which involves multilevel and interdisciplinary interactions that will require language facility and sensitivity to cultural differences across disciplines. The growing science of communications technology is rapidly forcing world leaders to recognize that in this day and time citizens hold membership in the world community.

THE EDUCATORS CHALLENGE

Educators need to anticipate that at some level present day students, like practicing care providers have inherited ideas from their early upbringing that includes stereotypical negative references for persons or customs that are different. Early parental prohibitions like avoiding strangers may well have been a functional protective mechanisms in childhood to emphasize the danger of going with strangers. This form of childhood socialization seems to be universally true. These internalized stranger prohibitions can well be the ingredients that explain why some adults continue to fear strangers and may explain how this fear is generalized to include fear of groups and customs that are different. This can present a real challenge for the prospective care provider who has to interact with "strange patients". It is easy to understand why some health care students might prefer treating a patient who shares similar characteristics, speaks the same language and conforms to the student's world view. Pluralism is a component of a democratic society. It is human differences

that make each person special and unique. It is frustrating and ego deflating both for the care provider and the patient when language and cultural differences present barriers to interpersonal communication. Members of minority groups, particularly recent immigrants and those with low education and limited resources, the poor, are perhaps, and appropriately so, extra sensitive to verbal or nonverbal noncaring messages that are communicated, perhaps, unintentionally. The idea that minority group status in combination with other stratifying characteristics, like aging, could lead to double or multiple- jeopardy is often regarded as the central concept of ethnogerontology (Jackson, 1985). To facilitate understanding of the critical issues in ethnogerontology, the authors present a brief review of the central concepts that are found in the literature to describe this area of investigation.

Terminology

Ethnogerontology is the study of the causes, processes, and consequences of race, national origin, and culture on individual and population aging (Ibid., p. 265). For the sake of discussion the authors propose that some students in the health care professions in addition to holding negative stereotypes of the elderly also may also hold negative stereotypical views of ethnic/racial minority persons. If this were true, the student as a care provider would have a double handicap. This kind of phenomenon for the patient recipient is described by Crandall (1980) as double jeopardy. This has application for describing victimization of individuals or groups who possess two or more

traits that are societally undesirable which subjects them to prejudice and discrimination. Rationale for the federal government declaring Asian-Americans, Afro-Americans, Hispanics, and American Indians as protected classes is in part due to documented evidence that members of these racial/ethnic groups have historically experienced differential and unequal treatment which resulted in victimization of members of these groups. Thus, a question that needs to be addressed in curriculum planning is whether or how much of the curriculum focus should be on increasing student self-awareness in dealing with ethnic-cultural differences and how much to focus on developing knowledge and skills that will help the student become more effective in his/her treatment of minority patients?

The field of minority aging, or ethnogerontolgy has been criticized for its lack of conceptual clarity regarding central concepts such as "minority" and "ethnicity." The term "minority" in the context of civil rights legislation has an expanded meaning. Webster (1979) defines minority as the lesser part of a smaller number or a racial, religious, national, or political group smaller than and differing from larger, controlling group of which it is a part (p. 1146). In the context of civil rights legislation the Webster numerical relationship does not apply. For example women in the United States are numerically a majority in relationship to number of men. In civil rights legislation women are designated a minority because of historical differential and unequal treatment. The question then becomes who is not considered a minority? In

social science literature the societal majority group in American society are persons of northern European heritage that are referred to as White Anglo Saxon and Protestant (WASP). Of course, this is not accurate because many Americans of Europeans parents do not share an Anglo Saxon and Protestant heritage.

Berry (1958, p.52) chides sociologists who have substituted the term "minority" for race and classes of societal groups like women or the elderly who have experienced exclusion from full participation in society. The profession of social work has adopted this expanded use of the term "minority. Social work educators use the term "minority" to include both protected societal classes and gay and lesbian individuals. Presently the latter group is not a legislated protected class. To meet accreditation standards schools of social work must present evidence that the curriculum addresses content on oppressed groups, and that the program policies reflect inclusive rather than exclusive criteria in its admissions and personnel hiring.

In planning curriculum content key terms like ethnic, race or minority need to be operationally defined to guide the curriculum planner in identifying breadth and depth of content that needs to be identified in the selection of learning materials and activities. Wirth's (1945) conceptualizes a "minority" as "a group of people who, because of physical or cultural characteristics, are singled out from others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination". The needs of

the program can be determined by assessing with some form of pretest at enrollment time the student's attitudes and knowledge of cultural factors related to health care with the target minority population. A needs assessment of the service population can be determined by examining the current and projective demographic characteristics of the service population. This will help the curriculum planner determine whether the emphasis should be on helping students with their negative stereotypes of the target population or with increasing their knowledge of cultural belief systems that need to be considered in providing health services to an elderly minority population.

In the context of addressing the health care needs of minority elderly Wirth's (1945) concept of a minority population provides a useful operational definition that a curriculum developer can use in identifying the areas of content that might be included in a curriculum that addresses racial/ethnic cultural considerations of health care practice.

The term "ethnicity" in the social science literature is frequently used interchangeably with the terms "minority" and "race." For the purpose of this paper the authors use the three terms with qualifications. The terms racial/ethnic are used to underscore and distinguish it from gender or other societal groups who also meet the criteria "minority" class in the context of victimization and societal oppression. Shermerhorn (1970) views a minority group as a collective within a larger society. An ethnic group, he says, has "real or putative common ancestry, memories of

a shared historical past, and a cultural focus on one or more symbolic elements defined as the epitome of their peoplehood (p. 12). Guttmann (1979, p. 248) defines ethnicity as "the cultural bond of a given social group." In the case of American Blacks social scientists are not sure whether Afro-Americans constitute an ethnic group. Berry (1958 p.55) argues that Afro Americans are a racial group that do not have a distinctive culture of their own thus they cannot be considered an "ethnic" group. The need for scientific precision in classifying peoples sometimes gives way to social and political practicality (Street, 1977 p. 32).

The whole question of ethnicity is an important question for curriculum developers to address. In a pluralistic society like the U.S. with a history of indigenous tribes and immigrant history every person could well argue that his or her ethnic heritage should have a place in the training curriculum. The major question becomes what groups should be represented in the curriculum? One example question is whether the curriculum should include content on American Jewish culture? Jews have a history of oppression not only in the U.S. but throughout the world. The authors recognize that questions concerning boundaries of content are important. Given crowded curriculum space the curriculum planner must set some limits. The authors have for this reason limited the focus of this paper to the four ethnic/racial groups that are designated in the civil rights legislation. The curriculum planner needs to anticipate challenges from colleagues and students who may not be convinced that the proposed content merits priority in the crowded

curriculum. Ethnogerontology is a relative new field that is still trying t identify its boundaries. Central questions which Bengtson (1979) says need tc be addressed by ethnogerontolgy are:

1. What is ethnicity?
2. Does ethnicity matter as a dimension of social organization and behavior within contemporary American society?
3. What difference - if any - does ethnicity make in mitigating patterns or problems of growing old?
4. What are the possible implementations that can be made in policy, practice, and research, given answers to first three questions?

These are critical questions for the field that can serve as guidelines for organizing the content areas that have been suggested. The confusion found in the social science literature which is evident in lack of clarity with use of terms and specificity of key issues is a function of the state of art in this field. The educator's challenge is to engage in research that addresses the questions raised and to incorporate in her/his teaching content that addresses both normative cultural diversity and the effects of minority status (oppression) on members of minority groups.

Curriculum Model

The proposed model that is described (see appendix) was develcped in the mid 1970s by the Chicano Training Center (Souflee, 1974). The model includes three components which are interrelated

processes that occur in three phases. These are identified as (1) curriculum development (2) training and (3) evaluation. The model is based on systems theory principals which presuppose an ongoing process of inputs, conversion and outputs at each stage of development. The activities of each phase are interdependent, changes in one phase require modifications in the other parts of the model. Each component of the model is subject to ongoing feedback for purposes of integration and refinement.

Factors Influencing Curriculum Choices

The factors that shape the curriculum process are the institution's funding source, its program policies, and its implicit or explicit philosophical and epistemological frame of reference. The use of external funding normally dictates some parameters of focus. The program policies may present certain constraints. In a medical school the emphasis is on knowledge of medical science as opposed to acquiring interpersonal skills in patient care. In most educational programs there is always tension or conflict over what really merits space in the school's educational program. Faculty in health care programs frequently hold varying philosophical and epistemological frames of reference.

The outcome of the curriculum development process is the curriculum. The curriculum is fed into the training process, where it is further shaped by the needs of the learners, the program's training capabilities (the training environment, format, limitations) and the functions of the trainee's institution. When this is completed the curriculum is implemented into actual

training activities. These activities are fed into an evaluation process for assessment in terms of curriculum content and implementation coherence and effectiveness. The assessment is subsequently fed into the curriculum development process for refinement and modification.

Hypothetical Curriculum Development

To describe this process we formulated this hypothetical case situation that addresses what we assume to be the educational needs of a program like the Oklahoma Geriatric Education Center. We both admit we know little about the center so please overlook our ignorance if it shows. For the OGEC, the process would look something like this:

1. Curriculum Development Process

   Input: Funding source (Administration on Aging)

   Output: A curriculum emphasis on training of health care providers in geriatrics

   Input: Program policies (Mission of OGEC)

   Output: A curriculum emphasis on holistic care for geriatric care to train health care providers that are sensitive to bio-psycho-social and cultural aspects of patient care.

2. Training Process

   Input: Needs of Learners

   Output: A training emphasis on the development in the learner of humanistic values, theoretical knowledge and practice skills that guide the practice of

health care for minority elderly that is sensitive to sociocultural differences.

Input: Program Capabilities

Output: Training formats that can be incorporated into the existing curriculum; Identification of faculty that can address the program needs.

Input: Institutional Functions

Output: A training emphasis on content areas which address the functions of the learning institution.

3. Evaluation Process

Input: Program Objectives

Output: An evaluation that assesses training activities in relation to program objectives.

Input: Participant Reaction

Output: An evaluation of participants' subjective reactions to the training experience in terms of subject matter, coherence and content delivery.

Input: Educational Objectives

Output: An evaluation that addresses the attainment of specified educational objectives.

Content Areas

In selecting areas of content for the curriculum the curriculum developer can be guided by the research areas that are found in the ethnogerontolgy literature. Jackson (1985) identifies the following five areas:

1. Aging images and attitudes, e.g. subjective perceptions on importance of religion, life satisfaction, morale, etc.
2. Aging activities, e.g. reading, employment, babysitting, voting, volunteer work, etc.
3. Aging problems, e.g. income, health, housing, etc.
4. Supportive networks with a focus on kinship & friendship circles;
5. Need, access, and use of aging programs , e.g. Medicaid, nursing homes, food stamps, and subsidized housing.

Conclusion

We were asked to speak to cross-cultural issues in aging and to offer a curriculum model for incorporating racial-ethnic content. We commend the Oklahoma Geriatric Education Center, Summer Geriatric Institute planning committee for their interest in this subject matter. In doing the research for this paper we found little in the geriatric education literature that spoke to the questions of educating health providers for practice with racial/ethnic minority patients. We attempted to familiarize you with the language of the field, the key questions and areas of research. We presented a curriculum model that we hope can be useful in developing your respective programs.

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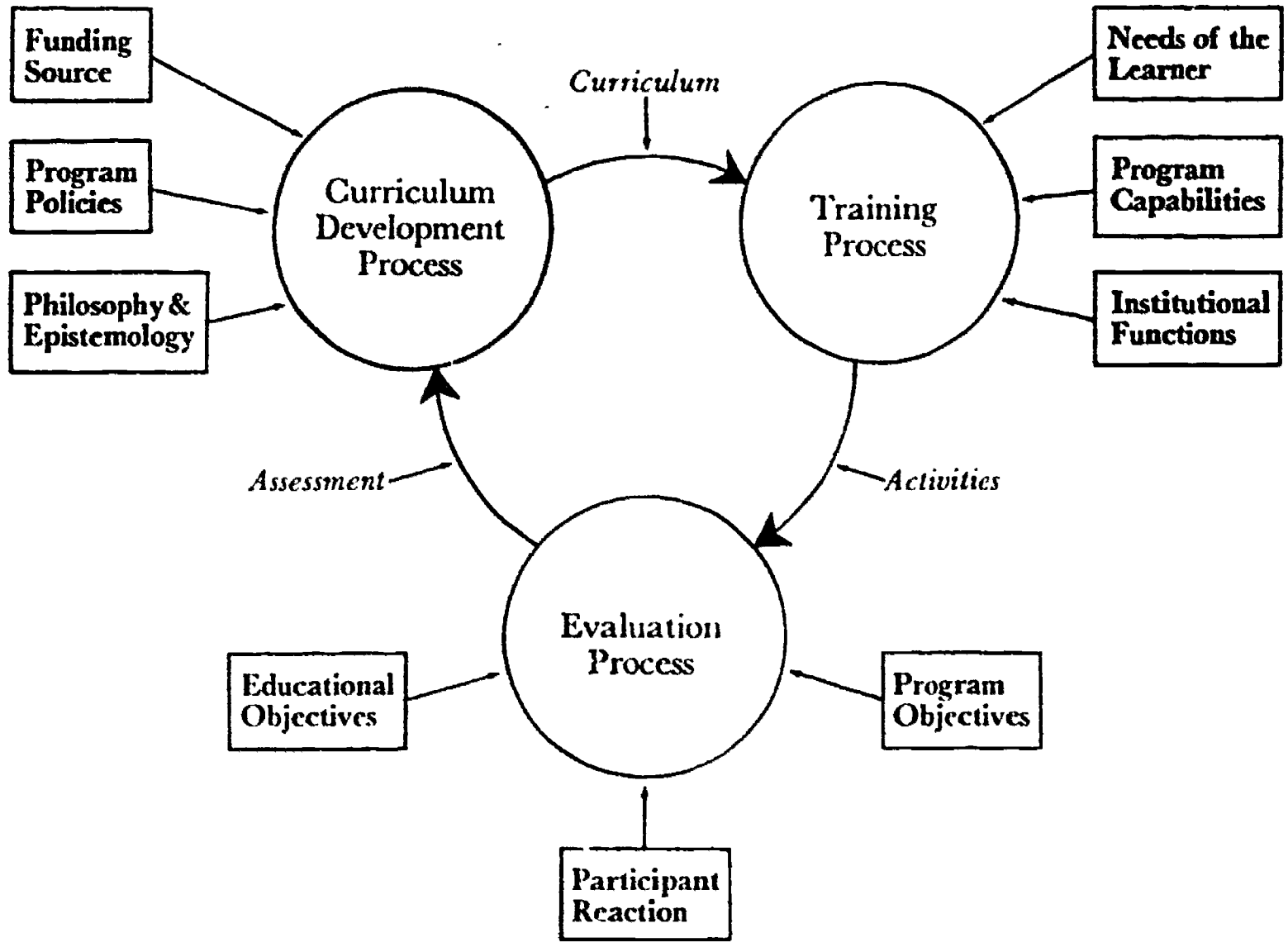
APPENDIX



The Curriculum Building Model was developed by the Chicano Training Center (1974), Houston, Texas as part of an NIH training grant number MH 13640, Federico Souflee, Jr.ACSW, Director.