

**INVISIBLE MINORITY: EXPERIENCE OF MIDDLE EASTERN AMERICAN  
WOMEN IN USING HEALTH CARE SERVICES**

A Dissertation

by

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## **ABSTRACT**

Issues related to the experiences of minority populations have received increasing attention during the last few decades. The research has been mostly focused on minority populations that are known to the U.S. general population including Hispanics, Asians, Native Americans, and African Americans. However, the Middle Eastern American population has received little attention. As the research on health disparities advances, there has been a growing attempt to reduce disparities that cause Middle Eastern populations to have chronic or life-threatening diseases. Some of these research studies have looked at the experiences of discrimination as a factor that would make a difference in the health of this population. While these studies are important, they usually engage a quantitative research method that is not fully equipped to evaluate the experiences of discrimination in a fuller sense. Addressing this gap in the literature, I conducted 30 in-depth interviews with Middle Eastern American women about their experiences with the U.S. health care system. Based on these interviews, there seem to be signs of anti-Middle Eastern racial framing among health care professionals that often caused significant problems for these respondents in their attempts to access the U.S. health care system.

## **DEDICATION**

To the precious fruit of my life, Tara Entesari.

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# CHAPTER I

## INTRODUCTION

*It's tough to name a group when most people aren't aware the group exists...that's why... I coined this phrase with our community: The Most Invisible of the Invisibles.*

—Kadi, 1994, p. xix

There is broad evidence that Americans are usually dissatisfied with the health care system, as they do not receive the care that they expect to receive (Haas et al. 2000). For minorities, one of the factors that led to this dissatisfaction is racial discrimination, and Middle Eastern Americans (MEA) are not an exception. Similar to many other minority groups, MEA have been victims of racial discrimination in different settings. Research, however, has failed to recognize this mistreatment as a concerning issue. The events of September 11, 2001, and the attention that this minority received, although negative, resulted in more scholars focusing on the possible experience of discrimination by MEA. Discrimination is defined as actions carried out by members of dominant groups that have a differential and harmful effect on members of subordinate groups. In most cases, discrimination involves members of powerful racial and ethnic groups against those with much less power and fewer resources (Feagin and Feagin 2003).

The major issue in research on MEA populations is the unknown number of them. The reason that there is no correct estimate of Middle Easterners is that the U.S. government does not categorize them as a defined minority group. This is the reason that



many social science scholars, as Kadi (1994) wrote, have thought of this minority as invisible. This lack of official recognition has resulted in failing to record many instances of discrimination toward Middle Easterners. As they have been historically seen as outsiders but categorized in the U.S. Census as white or others, MEA have to make their own individual decisions about their racial identity. The census has labeled Middle Eastern Americans as whites, which contrasts the racial identification of this group by an average American who views them as “nonwhite” (Marvasti and McKinney 2004). For instance, the term *Muslim American* is not a racially based category, as there are some whites that might practice Islam too. Feagin and Dirks (2004) conducted a survey asking white students to categorize Arab Americans. Only a small percentage answered that Arab Americans were “white.”

According to Tehranian (2009), some official U.S. institutions have purposely failed to have an exact number of this population in order to overlook the positive impact of this immigrant group. He argued in favor of creating a separate racial category for Middle Eastern individuals so the contribution of this population would be better understood. For instance, despite the fact that California is home to the largest immigrant Middle Eastern population anywhere in the world, there is no mention of them in any of official documents. Also, this lack of official recognition leads to a lack of knowledge about MEA culture and processes of acculturation. One of the respondents of this research study, who was a second-generation immigrant, revealed:

I strive for them to have a Middle Eastern box that I can mark off, or even another box so I can state that I’m Iranian or Persian. It’s very important to me.

Marginalization of this population has deterred them from reporting their racial identity. Many of Middle Eastern origin people may hesitate to report it and instead classify themselves as white. Robert Chang (1999) said this in respect to the term *Asian American*:

I hesitate to define “Asian American” because this term is malleable and is often used by the dominant group to confer and deny benefits...like its predecessor, “oriental” which was created in the West from the need to make racial categorizations in a racially divided, or at least, a racially diverse society...however, “Asian Americans” can serve as a unifying identity based on the common experiences of Asian Americans because of the inability of non-Asian Americans to distinguish between different Asian groups. (p. 1245)

Although officially labeling people from different countries as “Middle Eastern Americans” brings some disadvantages, it might be the only way that we can offer identity and recognition to this group. For that, we have to first admit that they exist as one official race category (Tehrani 2009).

Besides identifying this minority group as a defined racial category, acknowledging their negative experiences of living in the United States is essential. According to Nazroo (2003), social and economic inequalities of minorities are supported by racism and cause fundamental inequalities in health. The racial discrimination experienced by MEAs at many different settings including airports, schools, workplaces, and during the job hiring process (Aroian 2012; Tehranian 2009; Widner and Chicoine 2011) has been examined. While discriminatory actions toward Muslims have been reported in employment (Carlsson and Rooth 2007; Fozdar 2011; Ghumman and Jackson 2010; Ghumman and Ryan 2013; King and Ahmad 2010; Scott and Franzmann 2007; Widner and Chicoine 2011) and education settings (Aroian 2012;

Shammas 2009), there is insufficient information available about discrimination of Muslims in the health care setting. Discrimination is not only a negative social experience but also causes emotional and physical distress for minorities (Johnston and Lordon 2011). The health care setting is one place where clients should feel safe and comfortable to be able to trust their health care providers and express their needs. For that reason, the health care system must be free of racial discrimination. Talcott Parson (1951) was the first social scientist to theorize the doctor and patient relationship. His functionalist approach defined analysis of the doctor and patient relationship for the next two decades. Parsons began with the assumption that illness was a form of dysfunctional deviance that required recovery. Illness prevented people from work and other responsibilities, and could be potentially a dysfunction to the social order if uncontrolled. Thus, a “sick role” should be created to make this transition easier for the patients. Parsons believed that the physician's role is to represent and communicate the norms of this “sick role” to the patient. Although he believed in emotional distance, which means neutral relationships in modern society, he argued in support of universality, which means that all patients should be treated equally. This universality obligates physicians to act in the interests of the patient rather than their own material interests, and to be guided by a universalism. Parsons has also been criticized for being overly optimistic about the success of physician to universalism and affective-neutrality. Physicians often react negatively to dying patients, patients they do not like, and patients they believe are complainers. Physicians also consider their personal and financial

interests in caring for their patients (Hafferty 1988). Part of this research is aimed to study the factors that lead to physicians not liking their patients.

The goal of this research was to examine the discrimination of MEA in the health care system and determine the factors that affect this experience. For instance, the influence of national origin, time of immigration (first vs. second generation), language skills, and religion on reporting of discrimination were reviewed. Also, the coping mechanisms used by most of MEA woman were determined.

This study, unlike other studies of Middle Eastern Americans, is not only focused on the Muslims. A common mistake that many Americans make is associating the Middle East with Islam and Arabs. However, as will be fully discussed, not all MEA are Arab or Muslim. Most studies that have focused on living experiences of this minority group only included participants who were Muslim or Arab. There are only a few studies that had representatives of different countries of the Middle East. Nevertheless, even those who are not Muslim or Arabs likely still experience discrimination in the U.S. society. For the purpose of this study, the term *Middle Eastern* is used as a racial category of this population.

### **Importance of Studying the Experiences of MEA in the U.S. Health Care System**

Compared to other racial minorities, there has been little research concerning MEA and their lives. Much of the available research on MEA is related to Arab Americans and their experiences after the attack of September 11, 2001 (e.g., Awad 2010; Cainkar 2011). The present study does not identify this population as white by arguing that what this population has experienced since its immigration to the United

States has never been the same as what a white person would have experienced. Furthermore, most non-Middle Eastern Americans do not currently see Middle Eastern Americans as “white.” This research used in-depth interviews with MEA females to learn about their experiences in using U.S. health care services. Racial minorities might report different factors as a reason for their dissatisfaction with health care services, and one of their most common negative experiences is racial discrimination. This racial discrimination is a product of the common white racial framing. The white racial frame is described as “an organized set of racialized ideas, stereotypes, emotions, and inclinations to discrimination” (Feagin 2006:25). Discriminatory actions toward a non-white race can be motivated consciously or unconsciously out of this racial frame. This racial frame usually becomes part of a white individual’s white consciousness during childhood and then can operate at an unconscious or conscious level for the rest of his or her life (Feagin 2006, 2010).

Much of the literature on the health of Middle Eastern people has only recently focused on the experiences of discrimination and its effects on the physical and emotional health of this minority. The literature has only briefly focused on the causes of discrimination against this population. The next section provides more details on the state of current literature.

### **Current State of Research on MEA and U.S. Health Care Services**

Previous research studies have mostly focused on the barriers that Muslim Americans face in using health care services. These studies identified barriers such as discrimination, language, and poverty. In addition, the cultural and religious issues that

could make Muslims uncomfortable during the use of health care services have been recognized (Hasnain et al. 2011; Inhorn and Serour 2011). Issues such as Muslim women feeling uncomfortable being alone in a room with a male physician or other providers, making direct eye contact with a male practitioner, answering direct questions, being asked to undress for clinical examinations, being touched by a male practitioner during clinical examinations, being asked to wear a revealing hospital gown, or to remove their headscarves (Hasnain et al. 2011; Inhorn and Serour 2011) have been examined.

Social marginalization of Arab Americans in mainstream U.S. society, particularly after September 11, 2001, has been identified as a major barrier to providing sufficient health care to this population (Inhorn, and Fakhri 2006). Some studies suggested that more acculturation is the solution to the problems that this population faces in the health care system (Abdulrahim and Baker 2009), or the idea of becoming more like “whites,” and less like “immigrants.” This marginalization is a result of the systemic racism, which suggests that racism is beyond random and individual acts of people but has its root in a white-controlled system that views whites as better and superior to other minorities (Feagin 2006). However, minorities do not always report discrimination. Schnittker and McLeod (2005) suggested that discrimination might be painful to report because the individual may feel the weakness to admit the discriminatory action of another individual (in this case, the health care provider).

## **Research**

Shaped by systemic racism, the health care system has been a white-dominated institution that has a long history of racism against people of color (Bhopal and Donaldson 1998). The brutal practices of white health care providers against African Americans, provided in the literature review, demonstrate the extent of whites' domination. MEA, as a minority who have particularly faced a great deal of discrimination after September 11, 2001, have reported cases of racial discriminations in different settings including schools and work environments. Addressing the problem of discrimination in health care settings requires a perspective that would evaluate the discrimination not only at the individual level but also through the system in which discrimination is being reinforced. Focusing too much on the culture of the patients instead of considering the dominant white culture in the health care system was the research focus for this study. Acknowledging that there are things that minorities need to learn, as new ways of life, and directing our attention to the white-dominated culture that does not welcome differences might be a more reliable approach (Taylor 2003).

This study examined the experiences of racial discrimination of MEA through the theory of systemic racism (developed by Joe Feagin and his colleagues), which includes the role of whites in creating a frame, called "white racial frame," through which most whites and even minorities see other minorities via negative narratives, images, and stereotypes (Feagin 2010). In this study, I analyzed the narratives of the respondents using the framework of the white racial frame, which is one key aspect of the larger reality of systemic racism. Identifying the mistreatment of Middle Easterners

in health care settings as an indication of racial discrimination directs us to finding solutions. Additionally, I used a second framework, the Transcultural Caring Model, to better understand the participants' experiences. This model, based on the theme of cultural competence, offers a solution to eliminating the act of racial discrimination.

The following research questions guided this study:

- What are some negative experiences that MEA women report in the U.S. health care system?
- What type of discrimination do they report most and why?
- What factors lead to higher reports of discrimination?
- How has being an immigrant played a role in their report of discrimination?
- MEA from which country of origin are more likely to report discrimination?

### **Outline of Remaining Chapters**

Chapter II of this project outlines my theoretical framework for analysis, focusing on Feagin's (2010) theory of systemic racism. This chapter also covers the concept of cultural competence offered by public health literature and some frameworks for working with minority populations offered by nursing literature. The literature review in Chapter III provides readers with a background of research on MEA populations, health disparities, and discrimination. Along with the current issues, the current literature is explained. Chapter IV describes my research methods and interview processes. Chapter V includes the data on participants' experiences of discrimination with different health care providers. Next, Chapter VI examines factors that influence discrimination by health care providers, while Chapter VII reveals participant data



related to coping strategies. Other settings in which respondents have experienced discrimination are discussed in Chapter VIII. Finally, Chapter IX offers a conclusion of this discussion, followed by the references and appendix.

## **CHAPTER II**

### **THEORETICAL FRAMEWORK**

In this section, different theories related to this research study will be examined. Before focusing on the main theory for this research study, it is worth mentioning that most social science racial theorizing only accents concepts such as prejudice, stereotyping, and discrimination on an individual level. These theorists fail to identify the framework that most whites operate out of. According to systemic racism, stereotypes are only one element of the white racial frame, and the white racial frame is only one element of systemic racism. This research study used the theory of systemic racism and specifically the white racial frame to explain the discrimination of whites against Middle Eastern Americans.

#### **Systemic Racism**

One of the debates in racial relations theory these days is systemic racism theory and its insistence on new concepts such as white racial frame. The systemic racism theory, developed by Joe Feagin and his colleagues, presents racism as a foundation in many major U.S. institutions. Feagin (2006:2) said, “It is a material, social, and ideological reality that is well-embedded in major U.S. institutions.” The main theme of systemic racism theory is white-on-black oppression, which is the major difference between this theory and other race-related theories (Feagin 2006). Unlike other theories that focus on analyzing minority groups and their socio-demographic issues, systemic racism takes a new approach and analyzes the oppression of whites over blacks and its

consequences. Other theories have directed their attention more toward the effects of racism, while systemic racism studies the causes of racism by explaining the systemic oppression of whites throughout history. Systemic racism is “about creation, development, and maintenance of white privilege, economic wealth, and sociopolitical power” (Feagin 2001:210). Systemic racism has many different dimensions, including the unjust distribution of wealth, status, and privilege between whites and blacks, the white racial frame, the cost of racism, the role of white elites, the resistance to racism, the alienation of racial relations, the racial hierarchy, and the rationalization of racial oppression (Feagin 2000, 2006). Most of these concepts will be explained throughout the following discussion.

### **Resistance to Discrimination**

Systemic racism explains that racial minorities have different ways of resisting racial oppression. One tool for this resistance is through the counter-frame against the white racial frame. For instance, blacks—from slavery to the present—have practiced hidden and unhidden resistance to racial oppression. Some examples of this resistance are protests that happened during slavery or before Civil War. In response to the negative effect of the white racial frame, blacks used the black counter-frame to fight back. Similar to the white racial frame, the counter-frame also includes images and ideas, but they are based on requesting freedom and justice (Feagin 2010). In the case of non-Americans and immigrants, this resistance can be a different experience. Some of these immigrants may fight back using the “home-culture frame” by wearing a headscarf or speaking their home language (Feagin 2010). Some immigrants from the Middle East

choose not to fight back against the white racial frame. Instead, they become more Americanized and less isolated from mainstream American society (Marvasti and McKinney 2004). This is probably a solution that an assimilation theorist would suggest by arguing for structural assimilation. In Gordon's (1964) view, structural assimilation means that gaining entrance into the institutions of the host country is the ultimate solution to the racial conflicts of immigrants. Clearly, assimilation theory, in contrast to systemic racism, suggests that immigrants should assimilate to the dominant white culture to survive while systemic racism finds the problem of racial discrimination to be the racial oppression of whites over other racial groups. It also assumes that those racial groups will eventually be allowed to assimilate.

### **White Racial Frame**

The white racial frame is one of the major dimensions of systemic racism theory. Many of the concepts covered in systemic racism theory are also included in the white racial frame. By using this concept, Feagin (2010) attempted to explain why many whites have a white racist understanding of racial issues in the United States. He argued that even many of the scholars who have developed race-related theories have viewed racial matters from this dominant white racial frame. The white racial frame is defined as "an organized set of racialized ideas, stereotypes, emotions, and inclinations to discrimination" (Feagin 2006:25). These discriminatory actions toward a non-white race can be expressed consciously or unconsciously. It usually becomes part of an individual's white consciousness during childhood and then stays in the unconscious level for the rest of his or her life. For instance, many white Americans associate a black

face with negative traits (Feagin 2006). Feagin emphasized the importance of the white racial frame in the long oppression of whites over people of color. This frame is more dominant and extended than any other frame (Feagin 2010). The frame has in its center the pro-white sub-frame. The pro-white frame is the normal way of life that whites operate out of every hour of every day and of which they expect everyone else to do the same. Anything that is not “normal” for whites as far as accents, clothing, attitudes, names, and so forth would result in a negative reaction by whites. When they react and discriminate against people of color, they are acting based on their white racial frame, which is a reaction against some abnormal situation. Also, the discrimination is based on their sub-frame of “anti-others,” depending on the racial identity of the person of color.

The frame has been centrally built based on white-on-black oppression. This means that from the beginning, when European Americans first created this frame, white people have seen themselves as the superior racial group and blacks the inferior. The focus of this frame is on blacks. Feagin argues that the reason for this central focus goes back to the history of African Americans. After 246 years of slavery and nearly 100 years of Jim Crow oppression, they have been under white’s oppression for a longer period of time than any other minority groups (except for Native Americans). Native Americans have not been a central part of the frame since they have not been economically considered a central part of the white dominant economy (Feagin 2010).

As mentioned previously, the white racial frame has many different important parts, including racial stereotypes, racial narratives and interpretations, racial images and language accents, racialized emotions, and inclinations to discriminatory actions (Feagin

2010). For instance, fear is one of the racialized emotions that whites practice out of the white racial frame. Fear is the reason behind whites' racism toward blacks. Feagin

(2000:78) labeled fear as:

central to the ideology and attitudes woven through the system of anti-black oppression...significantly of the three large scale systems of social oppression—racism, sexism, classism—only racism involves the dominant group having a deep and often obsessively emotional fear of the subordinate groups.

Feagin (2001:78) called this an “emotionally intense racism.” For instance, whites have a fear of black sexuality, while in reality there is no medical evidence that proves that there is a difference in sexual desire between blacks and other races. Not only do whites believe in this false stereotype, they also base the argument “we must never put any restrictions on the sex life of blacks because that is what keeps them too exhausted to protest against anything else” on it (Feagin 2006:178). This racialized emotion originates from the early white notion that blacks are dangerous savages.

The same pattern is practiced on other minority groups, including Latinos and Asians. Fear of Latinos has been seen among white Americans. Whites' labeling of Latinos as illegal aliens helps create fear toward this minority group. The idea that Mexican undocumented immigrants are criminals is another way of creating fear that originates from the white racial frame. Since the 1970s, Mexican immigrants have been seen as invaders of the United States (Chavez 2008). Also, Chinese Americans and later Japanese Americans were labeled as dangerous and dirty, both of which create fear toward this population (Chou and Feagin 2008). Native Americans have also been seen as a threat to whites' safety and have been identified as hostile people who want to take the lives of white Americans (Hall and Fenelon 2009). It is interesting to note that racial

minorities also use the white racial frame against other minorities. During an interview of a Mexican man by Zulema Valdez, the Mexican man called the black neighborhood a dangerous and high crime area (Cobas, Duany, and Feagin 2009).

Central to the frame are narratives that relate the concepts of framing to American history. These narratives focus on the achievements of white Americans in order to prove the superiority of their position in racial hierarchy. For instance, there are many stories that focus on how European Americans became successful by hard work even though they did not have many resources when immigrating to the United States. Stories abound that address how these white Europeans had to fight the “savage” Native Americans to be able to be able to use their lands (Feagin 2010:13). In cases such as those, the narrative also justifies the violence that white Americans used against Native Americans by bringing in the issue of success and achievement, as if fighting and violating the rights of Native Americans is the most natural thing to do in order to have access to lands for making more money.

Collective memories and collective forgetting are another aspect of the frame. Social relations play an important role in understanding society, and this understanding is gained primarily from parents, media, and friends. By passing on beliefs in racist images and stereotypes from parents to their children, the white racial frame is reproduced. Media also plays an important role in the reproduction of the white racial frame (Feagin 2010). Hill (2008) explained the use of racist comments in media by collecting numerous examples from different sources of media, including the Internet, newspapers, and blogs. Collective forgetting, on the other hand, is forgetting some of the

un-human and racist incidents that have happened throughout history. This may mean weakening the memory of the long-time oppression of blacks by whites, weakening the memory of how Mexican Americans were brought into this country, weakening the memory of what happened to Native Americans upon the arrival of whites, or weakening the memory of the violence against Japanese Americans that happened during World War II. It is certain that whites could not continue their domination without collective memories and collective forgetting. Collective memories remind whites that white racial frames elements are normal part of their lives and collective forgetting assists them in forgetting the history of white oppression. According to Hill (2008:175), “White racism lives in the minds of American whites in a curiously misapprehended shape. Most of them understand it as a peripheral part of America’s past that does not require much attention.” Furthermore, whites usually deny that racism ever existed; also, the whitewashed history made by white Americans makes it impossible for anyone to think otherwise (Hill 2008). Whitewashed history is only one of the examples that have been created by collective forgetting. Whites rarely think about the devastating destruction of racism. They fail to acknowledge this harm during their social interactions. They only see the harm to a particular social group and in a limited amount of time, without understanding the significance of it to the entire community of minorities. Whites usually attempt to avoid discussions about the costs or existence of racism (Feagin 2010).

Racial stereotypes are a major component of the white racial frame and, as a result, of systemic racism theory. In racial formation theory, there is barely any focus on



racial stereotypes or racialized emotions, images, narratives, etc., by racial formation theorists, whereas in systemic racism theory a focus on these elements abounds. The term *racial reaction* was once used by Winant (2002) to explain the violence that whites used both in Europe and in the United States against other people. Omni and Winant (1994:59) explained, “One of the first things we notice about people when we meet them is their race...we expect people to act out their apparent racial identities.” Omni and Winant further stated that analysis of such stereotypes reveals the link between social structure and race. However, they failed to define stereotypes or explain how they are formed. Their main concern—which is certainly valid—was to link racial relations with social processes and structures, but their analysis lacked details about some of the concepts that they introduce, including details about their concepts concerning racial stereotypes. Critical race theory (CRT) explains stereotypes by discussing the filters that sustain white hegemony. It argues that racial stereotyping gives the dominant group the power to shape norms and define other groups (Brooks 2009). This definition is close to what systemic racism describes in discussing the white racial frame. However, the white racial frame is more detailed and has many different components while CRT only covers a few of them, including the stereotypes.

### **Racial Hierarchy**

Another concept emphasized and explained by systemic racism theory is racial hierarchy. The theory explains that whites place different Americans of color on a white-to-black status continuum. The continuum represents the social acceptance of a particular minority group in the eyes of whites. Imagine that the white race is positioned

on the far left-hand side of the continuum, and the black race on the far right-hand side of it. Any other minority group would fall in between, depending on how close they get to the status of whites. Sometimes, some racial minorities make great progress toward the white racial spectrum and are labeled “near whites.” White elites are decision makers who decide where each racial group should be placed on this racial spectrum or hierarchy (Feagin 2010). Due to this racial hierarchy, there is a difference between the political and economic interests of whites and blacks (Feagin 2006). Regarding this racial hierarchy and how whites racialize each minority group, Brodtkin (1998) argued that the status of Americans of color on the racial hierarchy depends on economy. Brodtkin further noted that during the period that Jews and other immigrants of Europe formed the core industrial working class they became darkened—moved more toward blacks—which shows that there is a link between having a degrading job and non-white racial status. Applying this explanation to another example, one can see that Asian Americans became the model minority and moved up the ladder of racial hierarchy when they were seen as successful and educated (Chou and Feagin 2008). There might be a link between the type of jobs that minority people have and their status on racial hierarchy; however, several examples of professional and high-educated blacks may prove otherwise because they are still seen at the bottom of racial hierarchy by most whites.

### **White-on-Black Oppression**

Du Bois (1999:18) said, “I ask but what on earth is whiteness that one should so desire it? Then always somehow, some way, silently but clearly, I am given to

understand that whiteness is the ownership of the earth forever and ever.” Du Bois was probably one of the first ones who analyzed the emergence of the idea of whiteness (Feagin 2000). As explained earlier, white-on-black oppression is the major theme of systemic racism theory. However, race theories have different perceptions toward whites and their role in racial relations. Systemic racism is unique because it focuses on the effect of white oppression on the lives of minority people. This oppression extends beyond the matter of economy. It destroyed the culture and heritage of blacks. No other groups were forced to lose so much of their home country’s ties (Feagin 2000). In their argument about racial formation theory, Omi and Winant (1994:2) explained that race has been and “will always be at the center of the American experience.” In his book *The World Is a Ghetto*, Winant (2001) argued that race is an important social fact. Race has been “systemically overlooked” (Omi and Winant 1994:138) as an important factor in understanding American society. The racial formation theory emphasizes that race is a social and political construction and operates at the micro and macro levels. Racial formation has been defined as a socio-historical process in which racial categories are created, inhabited, destroyed, and transformed (Omi and Winant 1994). Although racial formation theory argues that race has been a key determinant of mass movements, state policy, and even foreign policy, it does not give that much detail on why race has been a determinant and how whites have affected this process. It seems as if racial formation theory explains the object without giving details and explanation about the subject. Who has created this situation? Who has made race to be the determinant of state and foreign policies? In other words, who were the decision makers? The theory focuses on the

construction of racial identities through historical and social processes, but it fails to recognize how the domination of whites over resources and political institutions of power has created this racialization. While it is true that the theory fails to provide information on the role of whites in creating the racial identities, it is still a creative work in explaining the power of race and the role of government and politics in racial relations. The racial formation theory focuses on the existence of racism rather than on the domination of one group over another.

CRT is a theory that explains the relationship between race, racism, and power (Delgado and Stefancic, 2001). Compared with other theories, it is probably the closest to systemic racism in recognizing the role of whites in racial relations of this country. CRT analyzes whites from the perspective of power relations. Whites exercise power through different filters that privilege insiders (whites) and subordinate outsiders (blacks; Brooks 2009). CRT argues that disparity resources in black society are sustained by white hegemony. Because whites have power, they can control the resources and blacks cannot (Delgado and Stefancic 2001). The theory also explains the concept of interest convergence through a white filter. Interest convergence states that because racism advances the interests of both white elites and working class people, large segments of society have little incentive to fight it (Delgado and Stefancic 2001). Although some people may dislike the use of the term white power structure—for ignoring the non-white centers of power—it should be remembered that American pluralism becomes a monolithic structure on issue of race. When faced with demands from black people, whites react in a united group to protect interests they perceive to be

theirs (Ture and Hamilton 1992). In the book *Still the Big News*, by Blauner (2001), racial oppression has been linked to the issue of racial relations. Regarding white-on-black oppression, Blauner (2001:25) stated, “All forms of social oppression, whatever their motivation, confer certain privileges on the individuals and groups that oppress or are able to benefit from the reluctant inequalities.”

Thinking about the benefits that whites received out of slavery may give an impression that the domination of whites over blacks is caused by whites being in the majority demographically. However, Chua’s (2002:14) work on the theory of minority domination showed that whites do not need to be in the majority in every part of the world to subordinate resources and take advantage of economic situations: “Whites are a market dominant minority in South Africa, and in a sense in Brazil, Ecuador...Guatemala and much of Latin America.” A white-on-black oppression clearly is evident in these regions in spite of the white minority and demonstrates that the theory of systemic racism can be seen even when whites are the minority group.

Domination of whites over blacks and other groups of color, over several centuries, is the major factor that leads to the unjust distribution of wealth among different racial groups. In analyzing the unjust distribution of wealth, it is essential to identify what causes this unjust distribution. According to systemic racism, whites have been in charge of the economic resources in this country for a long time. Blacks have been used as a labor force for white Americans, and this has created an enormous amount of benefits for whites. Blacks had been slaves in this country beginning in 1619 until slavery became unconstitutional in 1865. According to Feagin (2006), by 1860,

nearly one-fifth of the entire national wealth in the United States was the investment represented by enslaved African Americans, about \$3 billion. Du Bois (1999:69)

described the use of black people for slavery in his book *Darkwater*:

We believe that at the bottom of organized human life there are necessary duties and services which no real human beings ought to be compelled to do. We push below this mudsill the derelicts and half-men, whom we hate and despise, and seek to build above it—Democracy.

Obviously, by “half-men” he means black slaves. Ture and Hamilton (1992:24) explained, “When the countries of Europe undertook to develop the New World, they were interested primarily in the exploitation of America’s natural resources. Labor was obviously necessary and the cheaper the better.” As a result of Indians and poor Europeans being out of the picture for labor, blacks proved to be the white economic salvation (Ture and Hamilton 1992). Even after the end of slavery, blacks had an unbearable economic situation. Farm labor dominated the economy of the south and, according to the U.S. Census in 1940, 40 percent of this population was black. Despite large numbers of black farm workers, black owners operated only 8 percent of southern farms. Having black maids was universal; even some white families with income under \$1,000 per year would still want black maids to work for them. Working almost 70 hours a week gave black women an income of barely \$5 per week (Katznelson 2006). Essentially, legal segregation prevented blacks from creating resources and wealth necessary to compete with white Americans (Feagin 2000). Even today, whites enjoy special privilege in areas of education, income, neighborhood, occupation, and lifestyle while racial minorities are excluded. For example, currently white families have at least eight times more wealth than blacks, and blacks have only 59 percent of white income,

even after 20 generations (Feagin 2006). According to Blauner (2001), the most visible inequality, however, can be seen in the labor market and the structure of occupations.

### **The Process of Racism**

Numerous CRT scholars argue that historically, the problem with issues of race and non-black minorities is that the white idea of race is usually related to the experience of African Americans. It is true that the history of discrimination against blacks is not comparable to other minorities, but based on differential racialization theories, each disfavored group in the United States has been racialized in its own way, depending on the advantages of the majority (i.e., dominant whites). Also, they argue that binary thinking, only accenting black and white races, gives more power to the dominant whites. By pretending that some of the non-black minority groups are white, like MEA, whites are increasing their power and taking credit for their accomplishments. In the past, those who could pass as whites could benefit from good schooling and resources, making minorities want to be seen as whites.

Allport (1979) argued that social support of one's views validates those views and protects individuals from being doubtful about their discrimination. In the case of MEA, the political situation and major terrorist attacks such as 9/11 provide a person who discriminates against this group with enough social support. The media would support the discrimination, as would those who are concerned about the safety of their families, and many of political figures would also agree. The acts of discrimination and even of false accusations against MEA, like what happens at airports on many occasions, are justified and seem normal.

Previous research shows that MEA women who cover their hair or wear traditional clothing are more likely to experience discrimination from whites and other Americans of color. This discrimination has two aspects. First, it is a product of systemic racism that encourages negativity toward non-whites and their groups and sends negative images and stereotypes through the white racial frame (Feagin 2010). Second, people either show (due to their religious beliefs in this case) their group's membership, like Muslim women, or they hide it, and no sign of their membership is visible. Where visibility exists, it is always thought to be linked to deeper differences between the minority and majority (Allport 1979). This means that the covering of Muslim women may send a message to the American people that she is very different from them, when in reality she might not be.

In analyzing which group suffers more discrimination than the others, the theory of intersectionality has been used and described in detail in related chapters. Intersectionality means the examination of race, sex, class, national origin, and sexual orientation, and how their combination and interlocking plays in different settings. These categories can each be a separate disadvantage factor. However, when an individual occupies more than one of these categories, it creates a condition for more oppression (Delgado and Stefancic 2001). The theory of intersectionality argues the disadvantages of those who are placed in more than one of these categories, such as black Non-American Muslim woman.

MEA are one of the minority groups that have caused a minimum of "trouble" for whites in the United States. Besides the false association of this group with the



terrorist attack of 9/11, the rest of the experiences of this population's immigration have been smooth. According to Cobas et al. (2009), the white image of the "good" immigrant is of the one who comes by legal means, works hard, and becomes as close to white as possible. Research shows that MEA have done all of this. They usually come in to the United States legally and belong to a higher socioeconomic status when compared to the average American (Marvasti and McKinney 2004) , and due to their lack of recognition by the census and the negativity shown toward stating their ethnic identity, many of them like to be seen as "white" even when they are not (Tehrani 2009). Cobas et al. (2009) further stated that most whites see the best solution for immigrants to become "good" immigrants is one-way assimilation. The next section explains the process of assimilation.

### **Assimilation to White Culture**

While some speak of the beginning of an era of post-racial U.S. society, there is still a high expectation by whites for American minorities to assimilate to the white dominant culture of the society. This expectation is visible among political institutions, the education system, and the general public. This can be explained based on the theory of assimilation, proposed first by Robert Park and later advanced by sociologists such as Milton Gordon. While the American society supports the idea of multiculturalism, assimilation puts a pressure on minorities to engage in a process that they may not desire. According to Louise Wirth (as cited in Blauner 2001), one of Park's students, minorities may have different goals than simple assimilation. Gordon (1964) also explained the idea of a melting pot, which he defines as the intermarriage of ethnicities.

However, when large waves of immigrants from other European countries attempted to keep their cultural heritage, Native Americans were sent into reservations, and blacks remained outside of mainstream society; the idea of a melting pot did not seem realistic, and instead Anglo-conformity dominated the society. Recent times have seen more people who believe that the values of groups such as Native Americans or Latinos are not as important as the dominant values of the society, meaning the values of whites (Blauner 2001). Assimilation theorists such as Gordon see assimilation as a way for addressing the problem of racial relations in American society. They believe that by one-way Anglo-conformity assimilation, Americans can move to that post-racial society where race is not a main concern any more. It is certain that two different ideas of assimilation and post-racial society do not come together. If one defines post-racial society, as a place where minorities do not feel negative about their race or face discrimination, then there should be no need for them to assimilate to the white-dominated culture. In an ideal case, the process of assimilation should be two-way, where white Americans would also learn from the cultural practices of minorities. In cases of food or music, there are some patterns of whites' assimilation to the immigrant culture (Feagin 2010). To explain this type of assimilation, the concept of interest convergence proposed by CRT, which argues that the interest of minorities in achieving equality will only be accommodated when it converges with the interests of whites (Delgado and Stefancic 2001), can be used. The assimilation of whites in cases of food and music might be due to their need for change in diet or music.

Gordon (1964) argued that the way humans identify each other in terms of ethnicity is a label that is attached to a person when he or she arrives in this world. The way assimilation theory defines racial identity is different from many structural theories (such as systemic, racial formation, and CRT) wherein race is defined as a social construct and not a biological characteristic. However, based on the racial hierarchy defined by Feagin (2006), immigrants who desire more assimilation may attempt to identify themselves as white or closer to the position of whites on the racial spectrum.

In general, immigrants prefer to be identified by their nationality rather than by their race. The national identity is self-defined while the racial identity is self-imposed and other-defined. In the case of Cuban Americans, their identity was defined by their race instead of their nationality upon their arrival in the United States. In that case, white Cubans prefer being identified by their race because it may help them to be categorized as white Americans. They separate themselves from the country of their origin and black Cubans to become part of the white-dominated society (Cobas et al. 2009). This can be seen as an attempt by Cuban Americans for assimilation into the white culture. A survey that compared the experience of black American women with Cuban American women showed that—probably as a result of being identified as white rather than Cuban by white Americans—Cuban American women felt that white Americans saw them as white while black women felt that they were economically and socially excluded by whites (Feagin and Feagin 2003). Middle Eastern Americans also attempt to assimilate to the white culture by changing their names to American names. They may even lie about the country of their origin to escape the stigma that is associated with their

nationality (Marvasti and McKinney 2009). Latino immigrants display their intention for assimilation by waving U.S. flags and saying the pledge of alliance. However, engagement in these practices has not made them part of the mainstream society since many of them are not accepted as legal immigrants and are seen as a threat to the security of Americans (Chavez 2008). Asian Americans try to survive by achieving a near white position on the racial hierarchy. In one example, an Asian American girl attends white-dominated parties and gatherings as much as possible in order to assimilate into the culture (Chou and Feagin 2008). Sometimes, even after all the attempts that minorities make for assimilation—for the purpose of being included in this white-dominated society—whites still categorize them as other race. A non-white person who has been raised in a white community may still not be accepted as white. According to Hall and Fenelon (2009), Indians who have been raised in white communities have almost never been accepted as whites, whereas often non-Indians raised as Indians have often been accepted as Indian. This is also the case for second-generation Asians who still have the physical characteristics associated with Asian immigrants but have no or few ties to the culture of their parents; this generation is also treated as being different and still “Asian” by white Americans (Chou and Feagin 2008:131). This shows that in some cases, no matter how much non-white people practice the cultural norms of white Americans, as suggested by assimilation theory, they will still not achieve what they have been hoping to earn.

Another point related to this assimilation process that demonstrates how much race is still a problem in this country is the insistence of whites on showing that

minorities want to assimilate to the white culture. King and Springwood (2001:93) described that Eurocentric perspective as creating this value system in which whites believe that “even Indian children want to be a cowboy.” This insistence might be due to the fear that they have developed toward minorities through the use of the white racial frame. Whites may think that the more the minorities become assimilated to the mainstream culture, the less likely they may be to represent a threat to the lives of white Americans.

### **Issues with Cultural Competence Framework**

To address the issues of discrimination and inequalities in the health care system, some research studies have proposed the use of a cultural competence framework. Because of the realization that culture plays a role in nursing education, scholars focused on developing a framework that would address conflicts that arise from differences between nurses and their patients. Madeline Leininger (1985:4) defined cultural competence as:

A formal area of study and practice that focused on comparative holistic culture, care, health, and illness patterns of people, with respect to differences and similarities in their cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse culture.

Cultural competence is both a process and an output, and results from the synthesis of knowledge and skills that we acquire during our personal and professional lives.

Professor Irena Papadopoulos is a pioneer in the field of transcultural nursing and one of the leading experts in the subject.

According to Andrews et al. (2010), the cultural competence model proposed by Papadopoulos focused on the concept of culture. The goals of the model are promoting the development of culturally competent nurses and health care professionals and helping staff develop the knowledge, skills, and attitude necessary to plan and deliver services. The right attitude values diversity, challenges discrimination, and promotes equality. The key concepts of this model are cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. This model can be applied to nursing education, medical education, and other paramedical professions. The part of this training about immigrants is related to the experience of at least first-generation Middle East Americans. The following bullet points better define the position of a cultural competence framework as it applies to immigrants and immigration:

- People immigrate for a variety of reasons (religious, political freedom, etc.), and a better life for themselves and their children.
- Some refugees and political activists may fit better in the host country.
- There is emotional stress involved in living within another culture and country.
- The person will experience doubt, insecurity, and a need to compromise and make adjustments, and pressure to change.
- The host country benefits from having the immigrants, so it is a two-way relationship.

Another important element of this framework concerns the role of female immigrants:

- Migration may create marginalization of female immigrants by them being “set apart” in the host country.
- Women may be isolated from social networks, community resources, and health services. Special attention is needed because the environment is new, intimidating, and strange to them (Andrew et al. 2010).

This shows the extreme isolation of first-generation MEA women who might be in contact with a very limited number of people until they become sick and has to pay a visit to health care services. Health care services can be one of their first exposures to the host country, and for that reason, a satisfying experience can make a significant difference in the way that she will interpret every other thing.

Cultural competence claims challenge the racial discrimination in health care settings. However, although the cultural competence theory covers some elements that would help in the process of teaching cultural awareness and cultural sensitivity toward minority patients, it lacks a significant element that this chapter has been discussing up to this point. That element is finding a way to actually resolve the issue of racial discrimination instead of only challenging the concept. As the data of this study will show in upcoming chapters, one of the foremost issues for minority patients is the experience of discrimination. Cultural competence is able to address the issue of understanding culture but fails to examine critically the white source of the problem and does not cover the anti-racism training in its framework. The systemic racism theory suggests the process of deframing and reframing for anti-racism education. Deframing and reframing include deframing the major elements of the white racial frame, including

positive images, narratives, and stereotypes, about white people (pro-white sub-frame), and negative ones related to minorities, including Middle Eastern Americans (the anti-MEA sub-frame). After deframing those concepts, the reframing process is implemented, in which non-racist elements are replaced by the negative old ones. According to Feagin (2010:198), “Deframing involves consciously taking apart and critically analyzing elements of the old racial frame, while reframing means accepting or creating a new frame to replace that old white racial frame.” Individuals need to become aware that they act out of the white racial frame on daily basis. Once they understand the importance of deframing that dominant frame then the process can begin. The way to fight racism in this sense is critically thinking about the history of racism and the constant dominance of whites over resources and power institutions for most of the U.S. history. Deframing requires presenting that information to individuals in a critical and accurate way. Also encouraging people to consider a counter perspective has shown to be effective in changing their views. As for reframing, providing people with new and accurate facts and promoting fairness and justice helps in encouraging people to practice new way of thinking about racial matters.

Medical and nursing students and practitioners need much historical competence that teaches them about racist history, famous slaveholders, and unjust white enrichment of resources for many generations. Also, health care providers need training on the current status of average Americans and minorities, including Middle Eastern Americans, to understand the suffering of these populations over a long period of time. The contemporary racial data about the available resources for whites versus minorities



can create a realization that health care providers, as well of other whites, have been a part of the racist system.

## **CHAPTER III**

### **LITERATURE REVIEW**

Chapter III presents a literature review that serves as a basis for this research study. In this chapter, the purpose and scope of the review of the literature are explained. A review of relevant studies and gaps in research are also identified in this chapter. The goal of this review is to show that there is a need for a research study that focuses on the issues related to the experience of Middle Eastern American women at health care settings. Research on discrimination against Middle Easterners has been mostly conducted within employment, law enforcement, and education settings. The current research on the experience of Middle Eastern Americans in the health care system focuses on the barriers that may lead to lower quality of care among this population. Among these barriers, racial discrimination has been identified as one that causes dissatisfaction among patients. This literature review has three sections, and I will start with the current research on experiences of MEA with health care services. To do that, I include an extended number of research studies that have been focused on Middle Eastern Americans and the concept of cultural competence. In the second section, I include literature about MEA and their living experience in the United States. Last, I include some research studies that focused on the experience of discrimination among other minorities with a part about the distinction between Arab Americans and Middle Eastern Americans. For the purpose of this research study, the literature on the barriers of using health care services, which includes discrimination, is useful in explaining the

general dissatisfaction of this population. Then there will be focus on the literature related to the types and extent of discrimination in interactions with health care providers, as well as discrimination concerning language and accent, clothing, and other related issues. This extended review reveals the gap and need for a qualitative research study focused on the experiences of MEA in the health care system. After reviewing the related literature of Middle Eastern Americans and their experiences of discrimination and the health care system, the next chapter of this dissertation will be focused on the theoretical framework of this study, which has been developed out of the work of Joe Feagin (2006) in *Systemic Racism*. By using major concepts of systemic racism, the discrimination against this population can be analyzed through a more careful lens.

### **Middle Eastern Americans in the United States**

There is no way to determine the number of Middle Eastern immigrants residing in the United States. The major reason for this is that Middle Easterners are categorized as white on the U.S. Census. However, many mark their race as “other.” Additionally, some of the available data related to this population are merely limited to Arab Americans and do not consider non-Arabic countries of the Middle East such as Iran or Pakistan (Marvasti and McKinney, 2004). This phenomenon, which will be explained later in more detail, has prevented the U.S. government from having the correct data on how many immigrants from the Middle East live in the United States.

### **History of Middle Eastern Americans**

Middle Eastern Americans are from different countries in the Middle East. Arab Americans, who are only part of the Middle Eastern population, come from 22 different

countries. Half of the Arab Americans residing in the United States are from Lebanon, and others are from Syria, Egypt, Palestine, Iraq, and Jordan. The rest (about 18 percent) of Middle Eastern Americans are from non-Arabic countries of the Middle East such as Pakistan, Iran, and Turkey. To give an overview of their social status in the United States, it is necessary to discuss the educational achievement and income of this population. Arab Americans have a higher degree of education compared to white Americans. In addition, Middle Eastern Americans are economically successful compared to other minority populations. The average household income of Arab Americans is considerably larger than the household income of average American. Contrary to the case of Asian Americans, their high income is not attributed to the large number of people working in one household. In actuality, they have fewer people working in one household compared to the average American household. Most of the Middle Eastern immigrants are Muslim, but this does not mean that Islam is only limited to the Middle East. There are many other countries in the world, such as China, that have large populations of Muslims (Marvasti and McKinney 2004). The first few waves of immigration of Middle Eastern people (Arab Americans) were highly educated people and did not immigrate to the United States for the lack of financial support in their home country. According to Marvasti and McKinney (2004), early Arab immigrants had their economic assets available back home if they ever wanted to return. Their goal was to accumulate wealth in the shortest amount of time and then return home. This group of immigrants did not try to assimilate very much into American culture. Also, keep in

mind that more than half of U.S. Muslims are African Americans—black Muslims. Most non-black Americans are not aware of that fact.

The first Muslim immigration happened from the 1600s to 1800s when some Muslims were brought into the United States for labor. They were Muslims from Africa, but they were not Middle Eastern (Feagin and Feagin 2003). Before 1924, the first wave of immigrants from Middle Eastern countries came to the United States. In 1924, a restrictive immigration act was passed that barred immigration from Asian, southern European, and Middle Eastern countries. Then, after World War II, in 1946, a second wave of Middle Eastern immigration started, even though the Immigration Act of 1924 was still in place. In the 1960s, the act was amended, and an equal number of immigrants were allowed from each country. After the change in the immigration act, the number of Middle Eastern immigrants increased dramatically. For instance, half a million Arab Americans have moved to the United States since 1970 (Marvasti and McKinney 2004). This means that there have been two waves of immigration, one from 1880 to 1946 and a second from 1946 to the present. Middle Eastern immigrants come from at least 20 countries (Feagin and Feagin 2003). Clearly, there have been times in American history when the immigration of Middle Eastern people has been limited by regulations.

Middle Eastern people usually have good financial support and education levels, and they migrate to escape political situations such as war and political conflict, to increase their living standards, or to seek higher education. In contrast to the negative images, the reality is that Middle Eastern Americans are usually welcomed by the system because they have higher education and financial support. According to Feagin

(2006), compared to all U.S. workers, Arab Americans are more likely to be white collar and in managerial and professional careers. They are less likely than U.S. workers to be in blue-collar jobs. Also, the average Arab American is better educated than the average American (Marvasti and McKinney 2004).

### **Discrimination and Categorization of MEA**

For many decades, Middle Eastern Americans have been characterized as irrational, barbaric, and cruel in whites' racial framing of them. They have been called "sand niggers," which originates from anti-black images. According to Feagin (2006), whites position different racial groups on a U.S. racial continuum. In the case of MEA, whites position Middle Eastern Americans in the same position as blacks—meaning the lowest status in racial hierarchy. Racial profiling has been a major issue for Middle Eastern Americans post 9/11. In conjunction with these anti-black images, those MEA who have darker hair and skin (look more like Middle Eastern individuals) have been verbally abused, or physically attacked regardless of their association with Islam or Middle East. Some in this group might not even have seen their home country in the Middle East or practice Islam as their religion. This group of people has been discriminated against solely because of their looks. Earlier immigrants were either seen as economically opportunistic because they would not reinvest their profit domestically, or they were seen as different and inferior to whites (Marvasti and McKinney 2004). A study conducted on the experience of racism by Arab Americans revealed that 52 percent of the study sample reported that it has been implied that they were dangerous or

violent as a result of their ethnicity, and 77 percent reported hearing offensive comments due to their ethnic background (Awad 2010).

Since race is a socially constructed concept, there are different perceptions about Middle Eastern people. Since nationality can make a key difference in the formation of our identity, this research argues that categorizing MEA based on nationality is the most reasonable way to solve the problem of categorization. Middle Eastern Americans have been labeled by the U.S. Census as whites. However, there has always been a contradiction between the official racial designation of Middle Eastern Americans and their racial identification by average non-Middle-Eastern Americans, most of whom do view them as “nonwhite” (Marvasti and McKinney 2004; Feagin and Dirks 2004). According to Feagin (2006), there is a white-to-black status continuum. The continuum represents the social acceptance of a particular minority group in the eyes of whites. The far left-hand side of the spectrum is white and the far right-hand side is black. Any other minority group would fall in between, depending on how white they appear to be. When it comes to recent immigrants, elite whites are the decision makers as for where each group of immigrants can be placed on the racial spectrum. However, we see that in the case of Middle Eastern Americans, although they have been labeled white in the census data, they are neither perceived of as being white nor treated as white. On the other hand, after the 1960s, the identity of many Middle Easterners has been more influenced by religion than by their country of origin or skin color. This is why they have been seen as Muslims (Marvasti and McKinney 2004). The problem with this type of categorization is that none of these terms is a homogenous entity, and there is a wide difference within

each of these ethnic groups. For instance, the term *Muslim American* is not a racially based category because there are some whites and many blacks that do practice Islam too. Feagin and Dirks (2004) conducted a survey asking white students to categorize Arab Americans. Only a small percentage stated that Arab Americans were “white.”

John Tehranian (2009), an MEA law professor at Chapman, received a rather unusual call when he was in the job market several years ago. After he received a rejection from one of the major universities, someone called him and said:

“You shouldn’t take any of this personally...you were a great fit to the department, it was just a race issue....they objected to the fact that you are white.”

“They do know that I am Middle Eastern, don’t they?”

“Yes, of course. So they consider you white.”

I said the only thing that came to my mind. “White, huh? That’s not what they call me at the airport.” (p. 1)

This incident encouraged the author to think about the variable of racial classification of MEA and how one’s categorization can be changed due to the circumstances in which he or she finds him or herself.

### **September 11, 2001**

Researchers disagree on the effects of September 11, 2001. According to Cainkar (2011), 9/11 did not create anti-Arab and anti-Muslim mistrust; rather, those socially constructed images were created long before these attacks. Their negative image gave a green light to the political system to defend the use of racial profiling. Nevertheless, the author conducted interviews about the experience of Muslim Americans and found many examples where Muslim Americans felt insecure and vulnerable after 9/11.



Others argue that September 11, 2001, changed the lives of Americans in many ways. Middle Eastern Americans were no exception. Although they had lived as a minority group in the United States for a long time, the aftermath of September 11 created an undesirable environment for them to live in. Most Americans report that they are nervous about the prospect of sitting on an airplane with a person of Middle Eastern ethnicity (Salari 2002). After September 11, 2001, numerous instances of individual racism have emerged where members of MEA groups have been targeted for harassment, threats, injury, job discrimination, and even murder (Ibish 2003; Zogby 2001). According to a study by Zogby (2001), after September 11, 2001, approximately one-fifth of study participants reported that they personally had experienced discrimination. Foreign-born (27 percent) and young Arab Americans reported a higher rate of discrimination compared to others. Seventeen percent of those surveyed reported that their children or a member of their household had experienced discrimination, and the percentage rose to 33 percent among those with low incomes. One part of this study found that Arab Americans feel that officials are justified in engaging in extra questioning and inspections (Zogby 2001). According to Ibish (2003), 9 percent of the people surveyed were forced to take drastic steps to deal with some racist thing done to them, and 70 percent of them wanted to tell someone off for being racist. The prevalence of some events was particularly disturbing. For instance, 53 percent of the sample reported being treated unfairly by strangers because they were of Arab descent, 47 percent reported that they had been in an argument about something racist done to

them, and 46 percent reported that they had been called racist names at least once within the past year.

The June 2003 cover photo of *Time* magazine showed a man holding a cross with the caption “Should Christians Convert Muslims?” According to Marvasti and McKinney (2004), Middle Eastern Americans have been in the middle of an ideological battle between two religions. Marvasti and McKinney also argued that the notion that one culture or race is an essential part of becoming a loyal American has always been part of the American history. After 9/11, the public discourse on national security has been directed more toward Middle Eastern Americans and their religion. People argue that Middle Eastern Americans do not have the ability to assimilate and be loyal Americans. An editorial in the *Denver Post* asked readers, “What is a good Muslim? Is a good Muslim someone who will answer the call to terrorize and kill blindly? It is hard to tell these days who or what constitutes a good Muslim?” (Hamblin 2003:43). This process, contributing to the process of maximizing the differences between groups, is one part of the practice known as “othering.” In this process, the dominant group presents the other group’s differences as weaknesses.

Middle Eastern Americans, especially after the 9/11 attacks, also have been seen as a threat to national security. This again has created a justification for the white American to clamor to deport some of them to their home countries (Marvasti and McKinney 2004). As a whole, according to Marvasti and McKinney (2004:109):

The experiences of Middle Eastern Americans are similar to other ethnic groups in that they are placed somewhere in the racist continuum that supposedly marks the distinction between white Americans and people of color. Some of the same notions about exotic others are applied again and again to different minority

groups. The ideas are the same and so are the tragic consequences in the everyday lives of their targets.

The “terrorist” image of the Middle Eastern has been the dominant stereotype of this group for a long time now. Middle Easterners are not perceived to act as a positive agent of change, and the media does not usually portray their positive characteristics. The stereotyping is more extreme for Middle Eastern women who cover their hair because they are seen as oppressive and obedient characters (Feagin and Feagin 2003).

### **Other Minorities and the Health Care System**

It is impossible to discuss minorities and health care without reviewing the literature on health disparities. In recent years most of the research related to race in the health care system has been related to health disparities. Health disparities refer to differences in morbidity, mortality, and access to health care among population groups defined by factors such as socioeconomic status, gender, residence, and race or ethnicity (National Institute of Health 2003). According to the National Institute of Health (2003:2):

Health Disparities Research (HD) includes basic, clinical and social sciences studies that focus on identifying, understanding, preventing, diagnosing, and treating health conditions such as diseases, disorders, and other conditions that are unique to, more serious, or more prevalent in subpopulations in socioeconomically disadvantaged (i.e., low education level, live in poverty) and medically underserved, rural, and urban communities.

Race and socioeconomic status have received more attention from scholars because they are seen as stronger determinants of one’s health than gender or residence (Schnittker and McLeod 2005).

As a result of the large differences in morbidity and mortality rates between minority populations and whites and those with high and low socioeconomic status, reducing health disparities was one of the goals of the Healthy People 2010 initiative, a program of the National Institute of Health that is aimed at improving public health in the United States. Reviewing health status, morbidity, and mortality data highlights a difference between black and white Americans. As a result, many researchers have focused their attention on the issue of race throughout the years. According to Frank (2007:1977), “The debate over the role of race/ethnicity in determining disease susceptibility has re-emerged since it was declared that race was arbitrary biological fiction more than 50 years ago.” This change in perspective has encouraged many scholars in public health and humanities to focus their research on the effect of race and health status.

### **Definition of Race and African Americans**

Surprisingly, as much as 80 percent of the racially related research published in the latter part of the 20th century did not include any definition of race (Dressler, Oths, and Gravlee 2005). Social scientists have been able to see this shortcoming in public health research but little has been done to clarify the definition of race. Physicians, professors, and biological scientists were the ones who created the concept of race in the 18th and 19th centuries. This concept was part of the white racial framing where the white race was seen as dominant and in charge compared to other races (Feagin 2010; Roberts 1996). Elite white men had a central role in creating, practicing, and maintaining this white racial frame.

Some results of this framing were racist actions against African Americans and other minorities and the sexualization of black women and men. There are many examples in research where African Americans have been the victims of racial medical research studies conducted by whites. In many cases, African Americans died or suffered from diseases during these medical experiments. For example, James Marion Sims (1813-1883), a father of gynecology, is famous for doing multiple brutal experiments on enslaved African American women prior to performing them on white women. In many cases, black babies would pay the price for research in medical science by dying for the cause (Washington 2006). In other words, there are high rates of morbidity and mortality for minority populations, particularly African Americans, and health disparity research aims to figure out the reasons behind it. For instance, some diseases such as diabetes and hypertension have higher morbidity rates among African Americans than among whites. Moreover, there are also discriminatory actions toward minorities, including racialization of treatment and defining race as a biological concept.

Blatant discrimination against African Americans in the health care system has continued throughout the years. In 1932, the U.S. Public Health Service initiated an experiment in Macon County, Alabama, to determine the natural course of untreated, latent syphilis in black males. The test comprised 400 syphilitic men, as well as 200 uninfected men who served as controls (Brandt 1978). The research was done with an assumption that African American males have more intense sexual desire compared to white males. This is an example of white racial framing. The study resulted in the death of many black men after they were not given the right treatment. The reason for the lack

of treatment was that physicians wanted to see the result of the syphilis on the brain of these patients (Jones 1981; Washington 2006). Today, we still observe elements of that white racial framing practiced against African Americans and other minorities in the health care system. There is still a domination of whites in every dimension of the system, resulting in favoritism toward whites in the allocation of resources and power (Hoberman 2012).

### **Patient Satisfaction and Communication**

An extended range of concepts, including patient satisfaction, racial concordance of patients and physicians, and stereotypes, are related to research on discrimination and the health care system. Most of the studies have examined the satisfaction levels within different racial groups toward the health care system in order to understand the racial disparity of the minority patients. Most of the research argues that minorities, particularly African Americans, are less satisfied with the health care system compared to whites. LaVeist, Nickerson, and Bowie (2000), for example, concluded that patient satisfaction varies by race. The bivariate analysis found that African American cardiac patients were less likely to report being satisfied with the quality of medical care and the treatment they receive in medical care settings compared to whites. Another study found a significant difference between whites and Asian ethnic subgroups in their levels of satisfaction with primary care. Whites were more satisfied than Asians with their primary care provider. The study then concluded that this difference in satisfaction between whites and other minorities may represent actual differences in quality of care or variations in patient perceptions, patient expectations, and questionnaire response

styles (Murray-Garcia et al. 2000); however, the study failed to investigate whether the lack of satisfaction of Asian patients might be in fact due to negative feelings—originating from the discrimination of providers—that they experience during their use of health care services. One study asked minorities (African Americans, Latinos, and Asians) about their experience of discrimination over the phone. Minorities expressed that they think they would have received better health care and medical staff would have treated them differently if they were from a different race. The research did not include the experiences of MEA (Johnson et al. 2004).

A research study by Harris-Haywood et al. (2007) focused on the level of satisfaction among white and African American patients and also measured the association between patient satisfaction and how physicians spend time with their patients. The authors concluded that there are differences in satisfaction and how time is spent in the patient-physician outpatient visits between African American and white patients. The study concluded that despite racial differences in how physicians spend time in the outpatient visit encounter, these differences are not associated with racial differences in patient satisfaction, and to understand racial disparities in satisfaction of the health care system, researchers should address areas other than how physicians allocate time in the physician-patient encounter. This study found no association between patient satisfaction and how physicians spend time with their patients. The present research study is a parallel study that examined patients' compliance rather than patients' satisfaction. The hypothesis is that what happens at the physician's office can affect compliance.

Literature in the area of communication is more focused on patient and physician communication skills as one of the factors that may determine the level of satisfaction among patients. In a study that Johnson et al. (2004) conducted on communication differences between white and African American patients with their physicians, physicians were 23 percent more verbally dominant and 33 percent less patient-centered in their communication with African American patients than with white patients. Many of the studies have linked this low quality of communication to the lack of satisfaction. Among limited studies related to Middle Eastern Americans is one by Shireen S. Rajaram and Anahita Rashidi (1999) that studied breast cancer screening among Middle Eastern women. The study concluded that there are cultural barriers that prevent effective communication of this population with their physicians. It suggested that traditional methods of health education are inadequate and health intervention strategies should be culturally sensitive. However, there was no focus on the issue of possible discrimination and it explained the discomfort of the patients in terms of misunderstanding due to cultural differences.

To have a better understanding of the term *cultural barriers*, it is beneficial to define culture. There are numerous definitions of culture by scholars in many different fields. For instance, the Office of Minority Health, U.S. Department of Health and Human Services (2001:1) defined culture as “integrated patterns of human behavior that include the language, thoughts, communication, action, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.” Leininger (1985:208), a nurse anthropologist, provided a definition that includes the transmission of beliefs and values



from one generation to another, stating that culture is “the learned and shared beliefs, values, and life ways of a designated or particular group which are usually transmitted intergenerationally and influence one’s thinking and action modes.”

LaVeist and Nuru-Jeter (2002) focused on the effect of racial concordance of patients and doctors on patient’s satisfaction and concluded that among each race/ethnic group, respondents who were race concordant reported greater satisfaction with their physician compared with respondents who were not race concordant. According to Cooper et al. (2003), when there is a race concordance between patients and providers, there is a higher patient satisfaction. Based on the data, race-concordant visits are longer and characterized by more patient-positive effect. Some other studies did not find a positive effect in the race concordance of physicians and patients. According to Traylor et al. (2010), who examined a sample of diabetic patients and studied the risk factors among them of cardiovascular diseases, the patient-physician race concordance did not have any effect on managing the risk factors of cardiovascular diseases. Another study, however, concluded that patients’ perceptions of health care relationships might partially depend on the racial concordance with providers and staff. This means that their perception becomes more positive when there is a racial concordance (Blanchard, Nayar, and Lurie 2007). Regarding the effect of this racial concordance on patient’s behaviors, Konrad et al. (2005) argued that African American patients might use medication more often if their physician is African American, whereas African American patients who switched physicians may use medication more often if their new physician is white. This is related to the research question of this dissertation, which asks if the experience of

discrimination would reduce the medical compliance of MEA patients. A study by Chen et al. (2005) also found a positive effect in the racial concordance of patients and physicians. Their study argued that among African Americans, stronger beliefs about racial discrimination in health care were associated with preferring an African American physician. Although the study showed that only 22 percent of African Americans preferred an African American physician, those who preferred an African American physician and had an African American physician were more likely to rate their physician as excellent than were African Americans who preferred an African American physician but had a non-African-American physician. Latinos with stronger beliefs about discrimination in health care were more likely to prefer a Latino physician. One-third of Latinos preferred a Latino physician. Though not statistically significant, the findings were suggestive. Those who preferred and had a Latino physician rated their physician higher than Latinos who preferred a Latino physician but had a non-Latino physician.

### **Stereotypes**

The experience of individual racism increases with the strength of racial identity for African Americans. This means that the more they identify themselves with their racial identity, the more they are able to perceive the discrimination. Another factor that can affect this experience is internalized racism. Internalized racism is defined as the acceptance by a minority of the larger society's negative characterization of one's group as characteristic of the self. The more individuals feel the internalized racism, the less likely they will report discrimination. The reason is that individuals start seeing it as deserved (Schnittker and McLeod 2005).

Wagner et al. (2011) conducted a qualitative study by using in-depth interviews of patients to understand the negative health outcomes of micro-level racism. The result was a definite answer that exposure to racism (on the micro level) can cause negative health outcomes. In contrast to a previous quantitative study that could not provide that much of a vision about the issue of discrimination, this study was valuable in analyzing the roots of this type of racism in the health care system. One of the participants explained:

Anger. Frustration. I try to forget it, too, but I don't think it is ever forgotten . . . something else happens and it brings it up again. So I never really forget it.

Also, a diabetic patient noted, "If you're angry, then...you know, your sugar is going to go up." Another participant revealed:

I always say I don't want to live the life where I'm like a powder keg because I'm waiting to explode or that pressure cooker. I have to release it, because...it's damaging the inside of me. And I have to let it out...I mean, being a diabetic, that's going to cause that sugar to start flaring up.

However, only a few qualitative studies, such as the book by Feagin and McKinney (2005) on the costs of racism, have focused on linking the findings within any theoretical framework. Most of the studies only proposed solutions, such as offering stress management classes (Wagner et al. 2011).

One way to analyze the issue is to use a broader framework. For instance, as mentioned in the previous chapter, stereotypes are one major element of a white racial frame emphasized in the systemic racism theory (Feagin 2010). Viewed from the theory of systemic racism, today as in the past, most whites still view African Americans in terms of at least some of the old negative stereotypes. Whites pass along such views,

even when they find contradictions to what they believe about African Americans (Feagin 2006). According to one research study (Kilbourne et al. 2006), white health care providers may assume that patients hold some certain beliefs about certain treatments because of their race. This may sometimes lead to less aggressive treatment of the patients. This study suggests that it is important for providers to find a balance between what patients actually believe and the appropriate treatment. There is significant evidence that health care providers hold certain stereotypes based on a patient's race, class, sex, and other characteristics that could influence the treatment of the patients and quality of care. This study then goes on to claim that these stereotypes are practiced unconsciously rather than consciously. For instance, whites tend to think that whites are more intelligent, successful, and educated, and blacks are aggressive, impulsive, and lazy. As a result of these beliefs, whites may associate different health outcomes to whites and blacks (Burgess et al. 2007).

Another recent study by Burgess et al. (2010) focused extensively on the negative effect of stereotypes on the minority patients. Many studies have discussed the negative effects of stereotypes in general. When it comes to health, stereotypes can lower the self-efficacy of the patients, which affects the ability to follow up with the treatment. In addition, stereotyping has been linked to a lower effort and motivation of patients to adhere to recommendations of the physician. Since stereotypes by physicians increase anxiety, it may impair the patient's communication skills, reducing fluency, self-disclosure, and response to the provider's questions. For instance, a diabetic minority patient who feels that the provider has some negative stereotypes might not

even pay attention to the fact that she has elevated blood sugar level and should increase the dose of her medication.

Stereotypes may also lead to avoiding going to places where there is a chance of discrimination. If going to the doctor's office creates the feeling of inferiority, the patient might be more likely to avoid those experiences. The authors (Burgess et al. 2010) concluded at this point that the stereotypes might help explain why minorities are more likely to miss appointments or fail to receive medical care and preventive health care services. The process of reinforcement of stereotypes by health care providers happens if minority patients behave in ways that are consistent with stereotypes. At that point, the provider may be more likely to use race in making clinical decisions, resulting in racial disparities in processes and outcomes of care (Burgess et al. 2010). Unfortunately, there is not much literature on the existing racial stereotypes of Middle Eastern patients.

The present research found that MEA women experience discrimination and, as a result, dissatisfaction while using health care services. The experience of encountering negative attitudes from physicians, nurses, and receptionists varied and was dependent on the age, years of residency (in the United States), and nationality of Middle Eastern American women. The respondents also mentioned other times when they experienced racial discrimination in settings other than a health care environment.

### **Middle Eastern Americans and Health Care**

MEA face some barriers in using health care services. Some of these barriers are discrimination, language, and poverty. In one study, conducted by Inborn and Serour (2011), providers and patients identified similar barriers, including lack of providers'

understanding of patients' religious and cultural beliefs, language-related communication barriers, patients' modesty needs, patients' lack of understanding of disease processes and the healthcare system, patients' lack of trust and suspicion about the healthcare system (including providers), and system-related barriers. For example, due to cultural and religious issues, Muslim women might feel uncomfortable being alone in a room with a male physician or other male provider, making direct eye contact with a male practitioner, answering direct questions, being asked to undress for clinical examinations, being touched by a male practitioner during clinical examinations, being asked to wear a revealing hospital gown, or removing their headscarves (Hasnain et al. 2011; Inhorn and Serour 2011).

Another study identified social marginalization of Arab Americans in mainstream U.S. society, particularly after September 11, 2001, as a major barrier to providing sufficient health care to this population (Inhorn and Fakih 2006). Similarly, a more recent study suggested that Arab Americans' health status improves with more acculturation (Abdulrahim and Baker 2009). Both studies supported the idea that being less like immigrants would result in the improved health status of this population. Simpson and Carter (2008) conducted a study that explored the experience of Muslim women through descriptions of the women's encounters with health care providers in a rural area. The study was successful in identifying three themes, including (a) power of the provider, (b) religiously defined gender relations, and (c) being a stranger to the U.S. health care system. Each of these themes suggests a relationship to the experience of individual racism because they reflect a lack of trust and suspicion of the health care

system, and lack of understanding of patients' cultural and religious beliefs. Schnittker and McLeod (2005) suggested that discrimination might be more painful to report because the individual feels too weak to acknowledge the discriminatory action of the health care provider.

Stress related to discrimination, immigration, and acculturation leads to negative health outcomes. The events of September 11, 2001, resulted in some discrimination toward the MEA population, including the disrespectful treatment of Arab Americans by health care professionals, a lack of using health care services by Arab Americans due to fear of deportation, and Muslim women getting harassed for wearing a hijab (Inhorn and Serour 2011). A study that analyzed the association of discrimination and health status concluded that discrimination events are related to lower levels of perceived control over one's life, and lower perceived control in turn is related to lower self-esteem and greater psychological distress for Arab American individuals (Ibish 2003).

### **Research on Middle Eastern Culture**

Health care providers are able to better serve their patients when they have an awareness of the unique cultural beliefs and background of their patients. The safe environment makes it easier for patients to engage in health care related decisions and follow their doctor's recommendations (Wandler 2012). When it comes to Muslim women, both patients and providers express dissatisfaction about the exchange of health care. Almost all responding Muslim women reported that their healthcare provider does not understand their religious or cultural needs (Hasnain et al. 2011). Researchers have overwhelmingly argued that the lack of cultural understanding between the two is the

reason behind this dissatisfaction. Muslim women have special beliefs, attitudes, and perceptions that may directly impact healthcare received within a westernized health care system that may not share the unique sensitivities of the Islamic culture (Bennoune 2007). According to Lipson and Meleis (1983), relationships between Middle Eastern patients and Western health care professionals are often troubled by mutual misunderstanding of culturally influenced values and communication styles.

In the process of learning about MEA culture, many research studies have focused their attention on elements of culture that play a role in patients and health care provider interactions. Most of these studies, however, discuss the culture of Arabs or Muslims and fail to include non-Arabs and non-Muslims in their definition of the Middle East. There is a research gap for learning about the needs and issues of Middle Eastern Americans who are non-Arab or non-Muslim. Nevertheless, to look at the effect of Islam on the interaction of patients and providers, Padela and Rodriguez del Pozo (2011) analyzed the Islamic perspective on cross-gendered interactions, dress code, and physical contact. While analyzing the perception of Arab Americans toward health care, one study (Kulwicki, Miller, and Schim 2000) identified the complexity of the health care system, diversity of perceptions of cultural competency, and communication gaps as some of the major elements.

A recent study by Walton, Akram, and Hossain (2014) is significant in analyzing the health beliefs of Muslim women. They suggested that Muslim women do want to make health care decisions without the help of a male family member. They also believe that prayers and charity can improve their physical health and are willing to receive



different types of health care services if the health care provider is a female. Muslim Americans believe in the power of health care practitioners as agents of God. For that reason, they respect these agents entirely and believe in their healing hands (Padela et al. 2012). A dated study by Lipson and Meleis (1983:103) summarized the health beliefs of this minority group as follows:

Although Middle Easterners vary ethnically, they do share a core of common values and behavior that include the importance of affiliation and family, time and space orientations, interactional style, and attitudes toward health and illness. Problems in providing health care involve obtaining adequate information, “demanding behavior” by a patient’s family, conflicting beliefs about planning ahead and differing patterns of communicating grave diagnoses or “bad news.”

The question that remains after analyzing the different cultural background of this population is the solution to these cultural differences. There are guidelines that will provide an understanding of the cultural characteristics of Middle Easterners and, therefore, will improve their health care (Lipson and Meleis 1983). An online interactive simulation about the care of Muslim Americans was developed for medical students as a pilot study and showed a significant increase after the simulation in students’ knowledge about this culture, even beyond the cultural competence curriculum (Smith and Silk 2011). One study suggested that using cultural care theory to develop a curriculum for the nurses might be a way to prevent racism by nurses (Lancelloti 2008). More explanation about this research will be provided in the chapter on cultural competence. Although increasing the number of non-white medical faculty members might be one solution to solving the problem, they themselves are the victims of discrimination. The number of minority faculty members has remained rather low compared to other fields of study. They have even described being subjected to isolation or stereotypes, lack of

acknowledgement of their accomplishments, and feeling invisible in a medical setting (Carr et al. 2007). This makes one reconsider the idea of hiring more minorities as an ultimate solution to the problem of discrimination in health care.

In conclusion, the above review of the literature on discrimination against MEA in the health care system provides an understanding of the need for not only looking at the cultural differences but also specifically focusing on the experience of discrimination. Using a systemic racism framework provides a tool to analyze the experience of this minority group from a different perspective. The hope is that a different perspective shows the use of a white racial frame, a major element of this framework, during daily encounters of MEA women at health care services. The limitation of this literature is losing sight of the big picture and failing to see the similarities of the negative experiences of this population with other minorities, i.e., viewing it as an inappropriate treatment of racial minorities in the same way over and over.

The key research questions related to this research study are:

- Knowing that MEA women have expressed dissatisfaction in regard to health care services, what is their particular experience? Is racial discrimination one of the major dissatisfactions?
- How has the experience of discrimination, if any, affected the medical compliance of this population?
- MEA is a very broad umbrella for many different ethnic groups. Which group is more likely to report discrimination and why?

- What are some of the factors that could affect the experience of discrimination for this population?

## **CHAPTER IV**

### **METHODS**

This project was aimed at better understanding how Middle Eastern American women frame their experiences of using the U.S. health care services. In particular, I wanted to uncover the discrimination that this population might experience and the role of systemic racism in shaping the discriminatory actions of health care providers. It is important to outline the various methodological approaches I used in this project. Thus, a description of the recruitment process, sample population characteristics, and data analysis is provided below.

#### **Interview Process**

As mentioned earlier, this dissertation project employed qualitative methods to address the critical empirical and theoretical gaps in the literature. By applying Newfield interviews as a qualitative method, this study investigated the ways that the MEA female population experiences discrimination in the health care system and the ways they deal with it. The primary data came from in-depth interviews with 30 Middle Eastern women in Brazos County, Texas. In this case, participants were placed into two groups, those who cover their hair and those who do not, in order to compare the responses between the two groups and evaluate if the different clothing made a difference in how they identified racial discrimination. This research also considers if type of clothing (originated from religion) has anything to do with the experience of discrimination in the health care system.

Participants were eligible for inclusion if the Middle Eastern woman had lived in the area for at least two years and was able to communicate her experience in English. They were selected through the network of the Middle Eastern American community of Brazos County. The researcher had access to the network, which made the recruitment process easier. The data was recorded, transcribed, coded, and analyzed to examine recurring themes, as indicated in the research questions.

Most of the existing literature on the issue of discrimination in the health care system has used quantitative research methods, relying on surveys and questionnaires to measure results. For instance, two of the research studies used tools to measure (a) the experience of individual racism, and (b) blacks' mistrust and suspicion of whites. One of the tools was a nine-item instrument with a 5-point scale (0 = *no experience of racism*, 4 = *extreme levels of racism*). The other was a 48-item, 7-point response format (1 = *do not in the least agree*, 7 = *entirely agree*) (Benkert et al. 2006). Some studies used both quantitative and qualitative measures for their research. For example, Harris-Haywood et al. (2007) used both observation and quantitative methods to examine racial differences among African American women with diabetes. For this current study concerning discrimination and MEA, qualitative methods based on in-depth interviews were used.

The major limitation of the aforementioned studies is that we need more detailed and theory-based research that is focused only on the issue of discrimination in the health care system. In addition, there are few studies on racial-ethnic matters that deal with groups other than whites and blacks. Qualitative research using the method of face-to-face interviews with the minority patients might be more beneficial in detecting the

great range of subtle, covert, and blatant discrimination practiced by health care providers. The narratives of those women interviewed were collected and used as data.

Convenience sampling from local networks as it is required for research on human subjects was the strategy for the selection of in-depth interview participants. Participants were recruited through the community gatherings that the researcher had access to. In-depth interviews were an effective strategy for this research for the following reasons. First, an in-depth interview is an open-ended, discovery-oriented method that is well suited for understanding more about the research question from the perspective of the target audience. Second, it helps in deeply understanding the respondent's point of view, feelings, and perspectives. Moreover, participants were reassured that what they shared and discussed would remain confidential with the researcher. Each participant signed a consent form to allow the research team to record her voice during the interview. The interviewer (researcher in this case) had related knowledge toward research questions and was comfortable using an audio recorder. In case there was a need for clarification, the interviewer explained the question to the participant. After the interview, the interviewer listened to the recorded conversations and sent the interview for transcription to a company that specializes in transcribing. The answers then were coded and analyzed for the purpose of finding answers to the research questions.

Among the interview questions, there were a few related to the issue of self-chosen identity and how each of the participants identified herself racially. There was a focus on how most of the health care professionals have viewed respondents during their

adult lives and if the respondents felt that the professionals' behavior was based on common stereotypes or if they operated out of a white racial framework. Also, there were some questions related to the imposed identity. During the interview, there were several secondary questions depending on the answer to the primary issue. Participants of the study were asked if they have ever switched doctors due to experiencing discrimination in order to understand if any self-selection process of physicians had occurred during participants' adult lives due to negative experiences. The interview questions also included any other interactions at the doctor's office with other personnel, including interactions with nurses or other staff members that might have affected the issue of compliance. By relying on probing questions, the interviewer asked respondents some additional questions if necessary in order to elaborate on a point. The last part of the questions included four different vignettes involving four hypothetical episodes in which MEA patients experienced racial discrimination, and the participant had a chance to say if a similar scenario had happened to her or anyone she knew. If not, they were asked to share their opinions about the hypothetical incidents.

Following the interview, some inventory questions were given to the participants to answer. Respondents were contacted to arrange a time and location for a 45- to 60-minute interview at their convenience. Each participant received a \$25 Amazon gift card following the interview. The data gathered from interviews were analyzed based on systemic racism theoretical framework. The full list of questions is included in the appendix of this dissertation.

## **Participants**

For nine months, I conducted interviews with 30 Middle Eastern American women who were residing in the Brazos County area of Texas. Most of them resided in College Station and Bryan. The participants' ages ranged from 18 to 65 years old. Out of 30 women, seven of them were from Iran, four from Iraq, five from Turkey, two from Lebanon, one from Sudan, one from Jordan, two from Kuwait, two from Saudi Arabia, two from Libya, two from Pakistan, one from Qatar, and one from Egypt. Participants were primarily college educated, with an average of over 16 total years of education. This means that the average participant completed a university degree. In terms of education, the respondents fit the general description of MEA as "highly educated," provided by previous research studies (Marvasti and McKinney 2004). Out of the 30 women, 10 covered their hair, and the other 20 did not. Nineteen were married, two were divorced and single mothers, seven were single, and two were living with a partner. This demographic shows the variety of perspectives among this sample. Although most of them believed in the value of family and marriage, some, who would still identify themselves as Muslim, lived with their partners, and the rest were single. There was also variety in the religious belief and practices of participants. With the exception of two respondents, the other 28 claimed to be Muslim, but some of the Muslims did not practice their religion and had just been born into the heritage. The two non-Muslims were Baha'i and Christian, respectively.

Each interview took approximately 45 minutes to 1 hour, depending on how engaged the respondent got in the process. The personal information of respondents, if



expressed during interviews, was removed from quotes in the following chapters to ensure privacy and anonymity. Every participant was required to sign a consent form before the interview process.

**CHAPTER V**  
**DISCRIMINATION OF MIDDLE EASTERN AMERICANS BY HEALTH CARE**  
**PROVIDERS**

*When I look upon a patient, may I never see anything other than  
a fellow being in suffering.*

*—Moses Maimonides, 1135-1204*

This exploratory research study examined the discrimination experienced by Middle Eastern women in the U.S. health care system, the most common discrimination practiced, factors leading to these negative experiences, and the effect of this discrimination on compliance issues. Discrimination can lead to mental and physical distress among this minority population (Pascoe and Richman 2009), and was recognized as one reason for dissatisfaction with health care services among Middle Eastern Americans. The U.S. health care system is a rather large institution that consists of different personnel; however, physicians and nurses are perhaps the most influential and visible players in the health care system, and their attitudes are significant in shaping the patients' overall opinion about health care services. This chapter is focused on the experiences of MEA women with physicians and nurses. The main question or concern of this research study was whether health care providers, affected by a white-dominated setting of health care system, bring their biases and racial stereotypes about MEA to their work environment.

## **Physician Discrimination**

As noted in the literature review, many MEA patients have previously reported negative experiences with the health care system and in particular with physicians. The purpose of this research study was to learn about the types of discriminatory behaviors that MEA women experience. The major element of the framework of systemic racism, white racial frame, was used to interpret the data. The argument was that white racial frame, used by the large number of Americans as a dominant frame, creates negative images, narratives, stereotypes, and emotions that may result in discriminatory actions. Acting out of this frame is not necessarily an overt act of discrimination. When a health care provider has biases toward MEA and those biases cause the provider (a physician in this case) to ignore the patient's comments and questions, it is a clear example of subtle discrimination. This means that the discrimination may not be easily detected but the patient will still experience the negative effect. For instance, Green et al. (2006) argued that as physicians' pro-white implicit bias increased, so did their likelihood of treating white patients and not treating black patients (i.e., lack of clear diagnosis). The next few paragraphs summarize the experiences of MEA women with physicians.

Many of the respondents noted discrimination in their interaction with white, and in a few cases, non-white physicians. A similar pattern for nurses' discrimination against MEA women was found. Similar to nurses, physicians discriminate against patients by having negative attitudes toward them, ignoring patients' comments and questions, or expressing negative verbal comments. In addition, physicians discriminated against patients due to their lack of sufficient English language skills or a foreign accent. Among

these, expressing negative verbal comments was the most overt type of discrimination. In some cases, personal accounts showed physicians' lack of cultural awareness. The personal accounts provided are examples of physicians' discrimination.

### **Negative Attitudes**

Physicians' non-verbal comments can reflect subtle racial bias, which may in turn be related to negative health outcomes. According to Levine and Ambady (2013), physicians in general do not want to appear prejudiced to any minority patient. The U.S. society values non-prejudiced treatment and physicians want to be accepted. According to Green et al. (2006), who conducted a research study with the Institute of Medicine, there is an unconscious race bias among physicians. The unconscious race bias can be described as white racial frame. However, in their process of avoiding visible discrimination, physicians may engage in subtle or non-verbal discrimination. In their attempt to prevent any negative verbal comments, the physicians disengage from the patients and engage in non-verbal discrimination. There is limited research on this type of non-verbal discrimination in a medical setting. Levine and Ambady (2013) provided an example of the study that used audio recordings of doctor and patient interactions and revealed that non-verbal discrimination happened when doctors were more dominant, had less positive affect, and were less patient-centered in their communications with African American patients. In return, patients reported less satisfaction when physicians engaged in this behavior. The negative images about non-white patients that cause non-verbal discrimination originate from the stereotypes that physicians ascribe to.

Additionally, being in a position of power (in this case a physician) makes stereotypes more likely to come to mind.

Some respondents experienced a great deal of negative feelings following physicians' verbal comments. They also experienced that the physicians ignored their presence or questions. A 53-year-old Pakistani respondent, who has lived in the United States for over 30 years and does not cover her hair, noted:

I went and somebody come to the office and he said, "You're fine, everything is good." I was sitting and then nurse said, "Yeah you can go." I said, "But I'm waiting for the doctor." She said, "This is the doctor." I said, "But when I come here, there was another person who ordered to run the tests." She said, "Yeah but he was a nurse or something. Okay, so I am doing all the tests and you're fine and that's it?" Then I went to my doctor who sent me over there. "Oh, we didn't get the results because they will tell you what's wrong with you." Uh, I don't like that and again, he sent me to the allergy specialist, and they run the tests for the whole month like the entire grid thing and something. I came back and I said, "Yes, I have allergy, but it's because of the other medicine I'm taking, so can you ask him what he thinks?" But nurse said no!!

In this incident, both the nurse and the doctor (both white) treated the Pakistani patient with a negative attitude. During her first visit at the clinic, the physician who came in and said "you can go" acted as if she did not want to initiate a conversation with the patient. Without introducing herself, the Pakistani respondent thought that it was another nurse. Finally after all the tests that she had to go through to receive a diagnosis from the physician the second nurse answered just "no" without explaining why she could not see the doctor. As mentioned in previous chapters, the MEA respondents interpreted the short responses of health care providers as discrimination. This might be due to the fact that MEA place a high value on social context. According to Al-Krenawi and Graham

(2005:302), many Arab people are highly influenced by the family, community, and institutions that surround them:

High-context cultures tend to emphasize the collective over the individual, have a slower pace of social change, and tend to value social stability. Low-context cultures tend to emphasize the individual over the collective, have a faster pace of social change, and tend to value social flux rather than stability.

Specifically, this respondent saw the very abrupt response from the nurse as just “no,” without providing any explanation, as a sign to end the conversation. The responses of this health care provider show the lack of respect and attention toward this minority patient. Feeling ignored in health care settings has been reported as one common type of discrimination for Muslim people (Martin 2013). This could also be confirmed by looking at the expectations of this patient.

Below is what this respondent said when I had asked her about her expectations from the health care provider:

Should be knowledgeable, of course, have a good bedside manner. Must treat me well...like my last doctor, a wonderful doctor...he come to the room and he had a very nice discussion with me and he answered my questions. Then he sent me for the test. So [if] I feel like I'm talking to a machine, then I say nah.

This patient expected her doctor to communicate with her and have a good bedside manner. It might be that the major expectation of MEA patients from the health care provider is focused on communication. In that case, cultural awareness of the health care provider is needed. The next two accounts might provide evidence for this argument.

The personal account presented below also demonstrates an example of this negative attitude. A 33-year-old Iranian respondent, who lived in the United States for six years with no head cover, noted this about a white physician:

He was a very young man and I had this feeling that he's kind of rude so I just prefer not to follow up with him anymore. First of all, he came to see—I went for my skin problem, I remember. He came with three other women nurses and he spent like less than five minutes. He just looked at my rashes and asked some quick questions and immediately he gave me some prescription. And I really felt that I needed to explain more about my problem, because I didn't have this problem back in my home country. Immediately after I came to the United States it gradually starts, my problem start. So I felt that I needed to explain it more to him but he just left the office and I think that was rude...I felt like angry.

She continued speaking about her experience by explaining how the white physicians are the ones with no interest in knowing minority patients:

I think that I got some reaction from non, how can I put it, non-American physician here in the United States. Because based on my experience I had a visit to a Chinese doctor and a doctor from India. And when they found out that I'm from Iran they keep asking a lot of questions. But I never get this expression from white American physicians.

This respondent could specifically see the difference between the attitudes and actions of white doctors and non-white doctors. She had concrete evidence of differential and discriminatory treatment. According to Levine and Ambady (2013), white doctors are more likely than non-white doctors to treat their minority patients in discriminatory ways.

A respondent who had issues with her dentist and the dental procedure told me the following about their earlier encounter:

For example, I was telling my story and he was reluctant to hear. Okay, that's it, I know, something like this that I didn't like that.

She expressed her dissatisfaction after the physician acted in a negative way in response to her conversation. Later on, the dental procedure resulted in a severe and a life-threatening infection leading to immediate surgery. When she went to his office

following the dental procedure to discuss the possibility that something might have gone wrong, she got this reaction:

He himself didn't even come to listen to me. He himself and he said, "Talk to my secretary." I argued with the secretary and she was a rude lady, so she said that, "You do whatever you want. It wasn't our [fault]. We did what we could and here are the doctor's [referrals]." I went to the—because it was something so serious.

It is possible that the physician was avoiding face-to-face communication as a reaction to a potential lawsuit. However, in the eyes of the patient, the physician's hesitation for direct communication sent the message that he actually made a major mistake and was afraid to admit it. In another chapter, her quote showing her disappointment in not filing an official racial discrimination complaint will be provided.

### **Bias in Pain Management**

The lack of attention to physical or emotional health was articulated by many of the respondents. Many reported that their physicians did not diagnose them for their physical or mental condition, did not give them the correct or enough medicine, or they did not take their complaints seriously. Some of them interpreted these actions as racial discrimination. This finding was in line with findings of several studies where authors concluded that minorities receive less treatment for pain compared to whites. They found that physicians were more likely to treat white patients and less likely to treat black patients. Furthermore, they complained more about their black patients compared to white patients. Negative stereotypes toward minority patients are one of the leading factors for this pain disparity (Green et al. 2003). Why are there lower numbers of white



patients complaining of untreated pain compared to minorities? The answers will follow through reading the personal accounts.

In two cases, physicians advised their patients to seek mental health solutions in place of receiving treatment for their pain and discomfort. One 33-year-old Iranian respondent said:

Yes. I went to an endocrinologist and he was one of the top I think physicians in Houston. But then he gave me something that I did not trust. So because he—basically he told me that I had depression and he gave me antidepressant. I argued with him that I don't have depression but he said that no, you are depressed, so I didn't take that medicine so.

The physician related skin problems of this respondent to depression without even evaluating her mental condition. Even when the patient said that she did not believe that she was depressed, the physician insisted on linking her physical problem with mental health. It is possible that the physician was correct, but the negative attitude and lack of communication caused the patient not to trust him.

The same pattern can be seen in the diagnosis of one Saudi Arabian respondent. At the time of data collection, she was around 35 years old and had lived in the United States for eight years and did not cover her hair. She told me that that she went to see a family doctor when she had some severe pain in her toe:

He did not understand the pain—what I was saying exactly. Then when he went outside and was talking to his intern or something he said, “Maybe she's just anxious,” and I could hear him. This is something that I should go to do a podiatry doctor or something, not for him, but he was rude.

The mentioned accounts are similar to one of the vignettes included in the interview questions, where the MEA woman was complaining about the pain and the doctor ignored the level of her pain by relating it to high stress.

According to Mossey (2011), who agreed that minorities receive less pain management compared to whites, there are factors that lead to this disparity. First minorities tend to underreport their pain intensity compared to whites, and the physicians, on the other hand, seems to have limited awareness of cultural beliefs of minority groups. Part of the solution is to empower minorities to accurately report their pain intensity level, but it is also incumbent on physicians to overcome the negative stereotyping of minority patients. There is considerable evidence that stereotypes can influence interpretations of behavior and symptoms, diagnoses, and treatment decisions.

According to Burgess et al. (2006), stereotypes are particularly likely to be a factor in pain management—first when physicians perceive stereotypic information as clinically relevant and second when the decision is complex. When providers must make complicated judgments quickly, with insufficient and imperfect information, knowledge associated with a patient's social categories (e.g., the patient is a low-income elderly black male) allows the provider to fill in the gaps with information that he/she thinks relevant to diagnosis and treatment. This may include epidemiologic data on populations. As others (Lutfey et al. 2010) have observed, decisions about pain treatment are inherently complex. As pain is a subjective matter, its existence is hard to prove. As Burgess et al. (2006) argued, it is likely that health care providers use the racial stereotypes in their mind when they do not have medical answers for the patients' questions. The racial stereotypes in their mind are only one part of the white racial frame that most Americans use in their daily interactions. According to Feagin (2006), acting out of this frame can be done unconsciously as the white elites have reproduced this

frame through different institutions such as media and the frame has transferred from one generation to another. This means that at the moment of making decisions about pain management, it is very unlikely that a health care provider “decides” on using the stereotype and concludes that African Americans can, for instance, tolerate the pain. Instead, the frame comes into play unconsciously, and that is why many do not know that they are using it.

In the following encounter, the respondent was concerned about her son’s physical condition, but the physician did not take his pain seriously. At the time of data collection, she was a middle-aged physician who covered her hair and body. She said:

My youngest one when he was three to four years, he has asthma and he’s got a fever and the doctor says, “It’s just a virus.” The second time I went they gave him an antibiotic, and the third time I went they didn’t give him an antibiotic; “Maybe it’s an infection, which is okay and not a problem. But after 24 hours if the fever doesn’t drop that means that something is wrong.” The fever didn’t drop, and he also become more lethargic and sleeps more. It’s not going in the right direction regardless of the cause, and it was Friday and Saturday and I said, “You know what. I need to see the doctor right now.” He’s really going to pass out this guy.

They call me. The nurse was the same in public health. I know her son and she said, “Okay come in. He really needs to be seen.” When we went there, everyone was running around because he had pneumonia. What bothered me was the doctor who ignored my comments. I kept saying it is serious and he did not listen. This is a fight. They are like, they just want to see you and you go. They don’t really care what else happens. It makes a difference when they know you speak English. It makes a difference. If you don’t speak English, things get worse.

This respondent, a physician herself, reminded the physician about the severity of her son’s medical condition. The doctor, who was a white middle-aged man, ignored her comments. Similar to the previous accounts, the physician underestimated the level of pain or severity of medical problem. “What bothered me was the doctor who ignored my

comments. I kept saying it is serious but he did not listen” is a statement that shows the frustration of this respondent (mother) when the doctor did not listen to her. The incident has two likely explanations. The first explanation is that the physician did not want to listen to what she had to say about her son’s condition. The second explanation is that the physician did not give the right diagnosis. While giving the wrong diagnosis is an inevitable part of medical procedures, ignoring the comments of the woman shows the negative attitude of the physician, which can be connected to lack of sufficient treatment for minority patients.

A Lebanese respondent had the same experience with a physician when she brought her daughter for treatment. The physician minimized the level of her daughter’s discomfort:

My daughter would wake up every hour in the night screaming, yeah—she had bad—the doctor would say she’s just a bad sleeper, just let her cry, let her cry it out. Soon enough we discovered that she had a health issue.

As for ignoring the severity of medical condition, another respondent also reported an incident that demonstrated this issue. She had a negative experience while using mental health services. The respondent was a 44-year-old Iranian woman who did not cover her hair and immigrated to the United States 13 years prior. Her response confirmed the same pattern of the physician ignoring pain and discomfort:

I used to go to this Egyptian American family doctor for a while. He had given me some medication for depression but it was not helping. I went in again to see if he could give me some different medicine. But the doctor acted as if I was lying about still feeling depressed. He kept asking, “Why do you need more medicine? Are you giving it to someone?” I said no! He tried to minimize my pain in a very strange way. He was suspicious that I am up to something. I stopped going to that doctor.

This account was an exception because the physician was not white. According to Feagin (2010), immigrants, like this doctor, are constantly under the pressure to conform to the white racial frame. This frame becomes so common that even new immigrants practice it. They have negative stereotypes and images about other minorities and even their own race and accept this frame as a way of living and surviving in this society.

During one of the interviews, a respondent reported feeling a great deal of discomfort by the attitudes of paramedics who came to her house to take her to the emergency room. The respondent was a 33-year-old Iranian respondent, and the paramedics were two African American men. She noted:

One night I was in a terrible abdominal pain and was vomiting and stuff. At some point, I found myself lying on the floor and feeling very sick. I grabbed the phone and called 911. By the time paramedics got into my apartment, I was feeling a bit better and could open the door. They came in and acted as if nothing was wrong with me. They asked if I could walk, I said no. They brought in the stretcher and put me on it.

After two minutes, they said ok we cannot take you down the stairs, you have to walk. I was shocked to hear that...one of them said you look fine. I think you can walk to the ambulance. They acted like I am 200 pounds or something while I am very average. I felt I was an annoyance and that's why they did not communicate with me or acknowledged my existence except for taking me half a way to the ambulance. Maybe didn't believe the level of my pain. Kind of same attitude in the emergency room too.

This respondent's main concern with discrimination was again related to pain management. The way the paramedics treated her as she was faking the pain or she could move by herself and did not need any help is sure a sign of lack of pain management and negative attitude. Research on pain management and emergency room practices revealed that minority patients are more likely to be ignored and not receive

pain medications. For example, Hispanics are two times more likely than whites to receive no medications for pain related to bone fractures (Green et al. 2003).

### **Names, Language, and Accent**

Historical events such as September 11, 2001, had an effect on the health outcomes of Arab Americans. Some research studies have focused on the effect of having different (in this case Middle Eastern) names on one's overall health status. For instance, in one study Arabic-named women had a higher relative risk of giving birth to low-birth-weight infants in the six months immediately after 9/11 compared with Arabic-named women who gave birth in the six months prior to 9/11. The reason for this difference has been explained by possible hostility and discrimination toward this group (Lauderdale, 2006). This finding shows the negative implication of having Arabic names versus having non-Arabic names.

A 32-year-old Iranian respondent felt uncomfortable by the comment that a physician made about her name. She noted:

Respondent: I got this response from the doctor saying, "What a long name!" or I felt he had that face expression saying, "How do you pronounce it," or something like that. I don't know if I can put it in the discrimination or not.

Interviewer: Okay. How did that make you feel?

Respondent: Yeah, it's not a comfortable feeling. No.

Some respondents reported the negative reactions of health care providers when they did not know a word in English or when they brought their elderly parents, with limited English, to the health care settings. One Iranian American respondent, who had

lived in the United States for more than 40 years and was not Muslim, told me this about her mother:

She [her mother] has had so many doctors and some positive, some negative. Some who don't look at her and talk to me only—which, she's a person and she needs the respect of being faced, the doctor needs to talk to her and then I translate it for her. So I didn't like that, I'd rather a doctor face her and ask questions and then I translate for her. So I just thought maybe that's just a personality, I never see it as a negative thing, but I prefer that they would give respect to the person who doesn't know the language and face her, ask her the questions.

A respondent from Lebanon reported that mostly white physicians were annoyed with her when she asked them to repeat their sentences. She said:

That, yes it has happened. More when I just arrived to the U.S. I mean I speak English, but some accents were hard for me to understand. So sometimes I would ask the physician to repeat what she was saying and they would get annoyed.

Most of the research studies on accent and use of health care services has focused on Chinese American populations and their experiences with discrimination. This population, more than other minorities, experiences language and accent discrimination. In their case, language-based discrimination influences patterns of mental health service use (Spencer and Chen 2004). There are certainly examples of discrimination against the common accent of most MEA (which speak English with an Arabic accent in most cases).

From a linguistic perspective, everybody speaks English with an accent. The term “standard English” is actually a racist term because it means the “white middle-class accent of English.” Middle-class (and other) whites who discriminate against Middle Eastern Americans because of their supposed “foreign” accent are operating out

of framing that privileges their particular (and just as distinctive in a linguistic sense) white middle-class accent.

Some of my Middle Eastern American respondents reported a negative reaction of physicians to their foreign accent. For instance, one Saudi Arabian respondent felt the discomfort when her psychiatrist acted like she did not understand her accent:

I've seen it with one psychologist—like as soon as she noticed the accent she was like—as if she's like not understanding, and we didn't continue with her.

The lack of attention and understanding of this psychiatrist resulted in the lack of continuation or severing the relation that resulted in not following the doctor's treatment recommendations. One would expect that a training of at least those involved in mental health services would be sufficient to teach them about dealing with non-native speakers; however, the literature shows otherwise to be true. According to Loring and Powell (1988), sex and race of the patients and physicians can influence the diagnosis even when diagnosis criteria are clearly presented. This means that the race of patients can play a vital role in their interaction with mental care providers.

A Sudanese respondent discussed another example of negative reactions to her English language skills:

I feel like they don't understand what you are saying. Some of them they feel like okay how can you not speak clearly or say it clearly. That is the feeling sometimes that come. Some of them they try to understand. Some of them they, I'm talking about some people around me they look at them really down because they don't know how to speak right.

Akomolafe (2012) conducted a major study on the discrimination toward nationality and foreign accent and found that of the major types of discrimination, the one that gets the least attention is discrimination toward nationality and in particular



accent. One would assume that with much attention to diversity, a debate on discrimination toward national origin is inevitable. Akomolafe found that the heavier the accent is, the more severe the discrimination is, which was likely the case for this respondent who spoke English with a heavy accent. Further, Akomolafe argued that the only advantage of white Americans to the immigrants is that they speak English with a “flawless” accent.

This study is in line with the argument of systemic racism. People, mostly whites, act out of a pro-white frame, and language is part of that pro-white frame, resulting in people seeing those who speak American English with no “foreign” accent as superior to others. Quinn and Petrick (1993) argued that grouping foreign born in two groups is a good idea. One group who might be educated or not educated but have no heavy accent due to being born or raised here, for instance, second-generation Hispanics, and the other group might be the more educated group that immigrated later on in their lives and speak English with a heavy accent. Those with more education but heavier accents face more discrimination and humiliation compared to the first group. This argument may fit the characteristics of MEA since they are the more educated group compared to average Americans and more likely to migrate to the United States later in their lives due to political and social distributions in their home countries. The pattern of interviews shows that those with a heavy accent are the first-generation immigrants and suffer more discrimination due to their lack of language skills and foreign accent.

The names of many medications used in the United States are the same as those used in other countries; however, most of the pronunciations are different. One 33-year-

old Iranian reported the negative reaction of the physician when she pronounced the name of her medication differently. She said:

When it comes to pronounce the name of a medication, well, I pronounce it as I read. But then they ask me what? What? I've never heard of these and then I have to write it down for them and they pronounce it with their own accent or whatever and say wow, it should be—you should read it as—at this. Yeah, they—you know, the way they make this face expression it seems like it's really difficult for them to communicate with me because, you know, the case is not that hard. Because, for example, the name of a prescription, what was it, Trinitor [ph. sp.] or something like that and then when you pronounce it Triniton [ph. sp.] or something like that, you know, it's not a big deal. It's not very different and I think that they understand it but they want to say that you have to pronounce it correct, you know? But they understand what you're talking about.

The respondent's statement of "they want to say that you have to pronounce it correct" is related to the idea of "othering." This process is defined as presenting the other's difference as a shortcoming, and presenting the familiar self as superior to other individuals (Marvasti and McKinney 2004). By correcting the person's pronunciation of a particular medication, which can be understood but might be pronounced differently in another country, the physician magnifies the difference between him and his patient. Also by saying "what? I've never heard of this," the physician is disregarding the fact that she might have the correct information.

### **Negative Verbal Comments**

Some of the respondents received negative verbal comments from the physicians. The personal accounts show that the negative verbal comments cause more emotional distress for Middle Eastern Americans. One Sudanese respondent expressed her disappointment about an incident that happened at the doctor's office with her son. She said:

Yes, with the doctor sometimes [she experiences discrimination]. I think he [her son] was going to kindergarten or something so for the vaccination shot and we got into a conversation. The doctor asked my son, "What do you want to do?" [In the future] He kept telling him, "I want to be a baby's doctor." But the doctor kept telling him, "Don't you want to do sport?" He meant it's not your area. Go to the sport box, where you are supposed to be. That is a way you feel like his mind is set up that this child is not supposed to be going that way.

So you figure out that person has something [discrimination against you]. Sometime the way the conversation goes you can tell. I tell him yes, we don't...I tell him we know the sport but we really don't follow the sport. We don't care. He is telling you that he is going to be a pediatrician, that he is going to be a baby doctor; he is going to be a pediatrician. At that time I will bring to them who I am. I tell him I have a medical degree and my husband he is a professor. My kids one of them has already graduated. Establishing myself so the conversation will change. That is kind of comment that you pick up [thinking] "what the hell he is talking about?"...I wait until I feel like they start something and then I will go into that. I see that is a lesson. When doctors start talking to you, they think you don't know anything knowledge wise. Because you are black.

Due to her dark skin color, this respondent's experience is probably very similar to the experience of many African Americans. Being judged based on the color of their skin, people thinking that their skin color makes them capable of doing and not doing certain things. This is again when people, especially whites, look at minorities through the white racial frame (Feagin 2010). The white racial frame includes **racial** stereotypes. One common stereotype for African Americans is that they are intelligently inferior and not capable of doing certain things (Feagin 2006). The current study is an attempt to find common ground in a discussion about discrimination toward other minorities and other settings. So far, the negative attitudes toward skin color of MEA is similar to the experience of African Americans, discrimination toward accent and language is similar to the experience of Asian Americans, and a health care provider's ignorance of pain was similar to the experience of every minority groups but specifically Hispanics. When

I asked this respondent if covering her hair and body makes a difference to see the effect of religion or nationality she said:

Yes, The impression is a black Muslim housewife equals ignorance and controlled by her husband. Housewife means controlled by her husband and black means ignorance. This is how I see that.

There is a stereotype about Muslim women's passivity (particularly if wearing a hijab). The clothing makes these women a perfect subject for those who want to engage in acts of racial discrimination toward this group (Tyrer and Ahmad 2006). According to Cainkar (2011), the author of the book *Homeland Insecurity*, for some Americans, the hijab is invested with a host of imputed meanings that symbolized their worst fears, including loss of freedom, and a Muslim take over. This group of Americans, who are mostly white, did not invent these fears; they learned them. The group and society that the individual lives in affects this learning (Cainkar 2011). According to Feagin (2010), the collective memories are used as a tool to the practice of white racial frame. The past events related to the MEA, for example, can shape the white racial frame. Those with power, mostly whites, have the authority to choose among these memories. In the case of Middle Eastern Americans, the terrorist events linked to this population have been recorded as part of the white racial frame. Some of these memories are accompanied by a sense of fear. Through this process, as mentioned earlier, the women's hijab become the symbol of MEA, and in particular Muslims, taking over or limiting other people's freedom. In his book titled *Racist America*, Feagin (2000:78) explained that "fear is central to the ideology and attitudes woven through the system of anti-black oppression." Therefore, racism is caused by obsessively emotional fear of subordinate groups. This is

similar to the fear developed toward blacks (Feagin 2010), undocumented immigrants (Bacon year), and Asian Americans (being labeled as “dangerous”; Chou and Feagin 2008). All this is to argue that the stereotypes of Muslim women who cover their hair and are supposedly being controlled by their husbands, originated from the fear that white Americans have developed toward this population. Furthermore, this is the learned process that Cainkar (2011) talked about in *Homeland Insecurity* related to the experience of MEA women who cover their hair.

### **Nationality**

Some respondents received negative comments due to their national origin from physicians. This usually happened after the physicians discovered where the patient was from. Some physicians’ positive comments also were seen as negative, showing the fine line between making patients feel comfortable or feel like an outsider. According to Marvasti and McKinney (2004), it might be that doctors are just being curious when they ask the question “where are you from?” However, the authors also argued that in a setting where there is a difference in power relations and one person, the physician, is in authority and the other person, the patient, is in need of the physician, asking this question is not wise. It is either poor judgment or indicates that the treatment of the patient would make a difference based on the answer. That being said, some respondents saw questions about national origin as a positive sign that shows the doctor’s interest in patient’s life. The next few accounts provide the evidence for this fine line and how some patients appreciated being asked about their national origin and some did not.

In one case, the physician's stress on the patient's nationality caused discomfort for the patient. One 29-year-old Iranian respondent talked about the negative feeling she felt when she went to see her dentist:

My dentist had this friend from my country when he was young. Every time I went in for my teeth he would say I had this friend from your country. This happened even when I had to go to him back to back for two weeks...every time. I felt like all he sees in me is that I am from Middle East. I thought he was trying to be nice and say I don't have any stereotypes toward you or your country but he actually made it worse mentioning my home country every single time.

Another respondent did not appreciate the comments from her physician after he heard that she is from Egypt. This young Egyptian respondent, who covered her hair, noted:

Sometimes they say, "You are lucky you are here. You are lucky that you are in a country that has freedom and something like that." I get sad, but they don't—I think they don't mean it, but I get sad.

Historically, European Americans have defined themselves and their nation in a hierarchy that places European Christians as superior and others as subordinates. This historical perspective has resulted in Americans believing in the American Dream. This may be what this physician is talking about—being lucky to live in a country where you can supposedly benefit from "freedom." The American Dream assumes that certain values, like equality, freedom, and justice, are available to any person in the United States. However, considering the widespread racial discrimination in the country, equality, freedom, and justice are frequently not granted. In *American Dilemma*, Myrdal (1995) wrote about the failure of U.S. society to live up to its stated values of equality and justice for everyone regardless of race.

A Turkish respondent who is married to an American man had a negative experience at the doctor's office due to her national origin. She noted:

Yes, we had a very bad experience with pediatric cardiologist. And they were located in Austin. They came in here once a week to St. Joseph Hospital in Bryan. And my husband hated him and I hated him, too. First of all when we took our second child we explained. He asked why you're here. So what happened was in Turkey we found out that our second child has a—the Foramen Ovale, the hole in the heart did not close. And we were looking answers for maybe that's the reason for the migraine headaches. So when we came back from Turkey, we would like to see a cardiologist, pediatric cardiologist, to have just that information in the record and for the follow up because that's risky, as the kid grows up she will have, you know, she can have paralysis from that you know if the clot can move up—anything happens.

So the cardiologist that we see he was thinking that we were just a regular “Joe from the street.” Has no idea whatsoever. And someone else had told us that that the hole needs to be closed so that's why we are here. And he is telling us things like we never told him, like we did not want him to close the hole. And he was like so you want me to close the hole and you think that the migraines are gonna be gone. And my husband was like no we did not tell you and we are not here for that. And then so he's asking me about whether I'm Turkish and my husband is Turkish. I said no, my husband is American. And then his reaction kinda changed towards us. Then later in the conversation he learned that I'm a nurse practitioner his behavior to us changed even more you know from worse to becoming kind of positive. And then after he learned that my husband is American and he's a professor at the university and I'm a nurse practitioner so he became kinda like from an insulting person to a normal person. So he had a very poor bedside manner. And he—

Interviewer: So you think he had a negative reaction to your racial background?

Respondent: Yes, yes because he was thinking that we are not educated. And because I'm from Turkey, it's a different country than America, you know, screw them, that kind of behavior that's—and we did not see him. We complained about him, and my husband and I, in fact, wrote a letter to one of those places that you need to write. I don't know which website, but you know we complained about him to our physician too to pediatrician. And so—

Interviewer: How did that make you feel?

Respondent: I was pissed. I was very angry and I just felt like it shouldn't be like this and everybody should be treated the same way. It doesn't matter where they are from. I pay the money to you. That's it. And you did get education and you're over there because of my taxes, my insurance, me paying money to you so I need to be treated like a regular human being.

This respondent explained her experience in much detail. She pointed out what made her upset and how it made her feel. First, she was upset because this white physician did not listen to her and made an assumption that they wanted to do a surgery before they had even talked about the surgery. Second, the physician started acting completely different after he heard that the woman's husband was American and not from Turkey, and even more different (more friendly) after he learned that the respondent was a nurse practitioner and her husband was a professor at the university. As she put it, he changed "from an insulting person to a normal person." This is probably related to the way that whites see MEA, like other immigrant minorities, assimilated to the American culture. For instance, Latinos receive negative comments from whites if they are not assimilated enough to the white-dominated culture. Assimilation for whites means assimilating to the white culture. Any different behavior, in this case speaking with a different accent, may start the unconscious process that puts any non-whites in a different category, which in response creates insulting or unusual behavior (Feagin 2010).

As for the racial spectrum, defined in previous chapters, the more "white" this patient's parents became to this cardiologist, the more he started acting normal. His negative comments were based on the assumption that these patients were far away from the ideal picture of whites, the one proposed by the American Dream. Her marriage to an American might have been a clue of that assimilation process (Feagin 2006). This couple could identify discrimination by indicators such as the negative verbal remarks and



attitude of the health care provider, including his negative reaction when they mentioned that their daughter had received treatment in Turkey.

A young, modern-looking Turkish respondent found it offensive that her physician spoke negatively about her home country. She reported the following about a white dentist:

With one dentist I've had an issue, I mean but that was only one doctor so far. When I asked for some standard procedure he, he wants to do some extra procedure just to get some money basically. And then when I objected to that he told me, "Oh, in this country we do things perfect." You know, this very arrogant way. "You come from a Third World country so you wouldn't know. We know we're better here. So I'll do this to you." This was the way he talked to me. He was extremely rude. Very discriminate in some sense. Actually, I did change him immediately after that and I reported that issue, and talking to some other friends, I learned that he did the same to other international students here.

This white, male health care provider made a comment that caused the patient to feel uncomfortable. She said the health care provider did this in a very "arrogant" way. This incident resulted in her changing her dentist and filing a racial complaint. Surprisingly, she found that some other MEA had received negative comments from this physician as well. The physician believed that the United States is superior to other countries in the world and the American way of life and science is not practiced anywhere else other than in the United States. The statement of "Oh! In this country we do things perfect" is a reflection of the perspective that Feagin (2010) discussed about whites feeling superior in knowledge, markets, technology, and political institutions, meaning that the United States is the "best country" in the world (Feagin 2010). It is clear to see that such a belief in superiority over other countries would lead to lack of respect for people of other countries and acting arrogant toward them.

## **Lack of Cultural Awareness**

Many respondents felt discriminated against by the way that health care providers judged their religious or cultural ways of life. No matter how hard physicians try to avoid making judgments on their patients, apparently there are times when they cross that line and create an unsafe environment for the patients to share their values. This means that physicians are not different from most other educated whites. Middle East American culture is not necessarily based on the religion of Islam. Some of the respondents who shared these concerns either did not practice their religion or they were not Muslim. It is true that culture plays a major role in shaping this minority group's value system.

An Egyptian respondent, who was a dentist, reported feeling discriminated by a doctor who asked her to remove her scarf. She said:

Yeah, there was a foreign doctor in Dallas—I was having very bad flu and I have to go to see a doctor and I pay for it out of my pocket. So he wasn't American—I think he has some origin, I don't know where he's from, Europe or something. He told me you have to take it [scarf] off to examine you. So I told him I can expose my, fully expose, my ear without taking it off. Then he made like bad expressions and he told me so you have to take it off to examine your lymph nodes. He thought that it's like it's professional to take it off, but I can do it without taking it off and I understand the places you need to examine and I can show it for you clearly and it will not affect the examination or anything. And he did the examination without me taking it off, but he was very annoyed and said, "Why you didn't want to take it off? It's a professional place."

In the experience of this respondent, the physician (the respondent could only remember that he was foreign) was unaware of the cultural and religious restrictions of Islam or Muslims. He was disrespectful in the way that he made a comment about why she did not want to take off her covering. The patient saw it as an invasion of her

privacy, and since her father specialized in ear, nose, and throat, she knew that uncovering her hair was not required for the examination of her ears or lymph nodes. According to Inhorn and Serour (2011), after September 11, 2001, some Arab and other Muslim women wearing the hijab were denied access to housing and public services, including health care. This example is certainly not an extreme case of that discrimination, but it can show how those extreme incidences of discrimination have made it easy for the subtle ones to happen on a daily basis.

When asked if the health care providers believed in the common stereotypes about MEA, the same respondent said:

Yeah, most of the time, but they are more professional than like make me feel this. But most of the time you are wearing hijab and his (my husband's) name is Osama so you are terrorist maybe, or something like this. So yeah, most of the time. But I have someone—like in my daughter's clinic—who is a nurse that wearing hijab, so they are used to see her and she is American Muslim so they know her and they love her so they're accepting me more. That's what happens. When they have someone—

Interviewer: They have more knowledge?

Respondent: Yeah, when they have more knowledge, they act better. But the worst thing [is that] they act professional, they don't treat me bad and they do give me my rights, but you can feel that they are stereotyping you.

Some of the points that this respondent made are significant. First, she talked about the discrimination of being less visible in the health care setting because the minority patients are dealing with people who are at work and have to stay professional. However, the health care providers still hold stereotypes against people who have an Arabic name (especially if the name is as alarming as Osama, like this respondent's husband) and wear a hijab. On the other hand, awareness and having personal contact

with people from the same religion, ethnicity, and so on, could make a difference in ways of interacting with them. In this case, the respondent talked about how knowing someone who wears a hijab, for example, can be helpful in gaining that understanding. Finally, the comment that was likely something that many respondents thought of was this: “They don’t treat me bad and they do give me my rights, but you can feel that they are stereotyping you,” meaning, having a negative feeling not because someone acted in a negative way, or avoided giving your rights, but because he or she made you “feel” that they believe in stereotypes.

A second-generation Iranian respondent felt discriminated against because she thought physicians judged her personal decisions. She said:

I’ve heard people with—because of their background, or even religious background, I’ve heard—I mean, even because I volunteered, so I’ve seen a lot of that. Sometimes I feel like maybe people, because they have certain like religious beliefs or something, that—like there are certain religions that they don’t accept—they don’t believe in transfusions or some types of medical interventions that could help you—they don’t believe in that treatment plan or something and they feel like the doctor doesn’t really understand or like judges.

There’s a lot of like I feel people think that there’s judgment from the doctor’s part. So like even culturally they think that doctors judge them. Like with birth control or a lot of it with you know—reproductive—doctors that are reproductive health and things like that. Or like even for me, I’m actually proud to say that I’m a virgin. I don’t, even though I guess they recommend it, I don’t get like a pap smear because I’m not sexually active or anything. But there have been times where a doctor asks me do you get regular—because of my age, like 29. I guess they sometimes assume—like they don’t even understand that culturally that that’s like something that I—it’s cultural and like a personal decision and they think you should get a pap smear, you should get this, you should get that. I think they don’t understand like—they judge against that, they think, “You should still get it, it doesn’t matter.” But culturally that’s important for me and personally. Culturally and personally, that’s important for me. I think they don’t understand that. I feel like they pass judgment. They go even past that and I feel like they pass judgment against what my personal and cultural values are.

According to the cultural and religious beliefs of Middle Eastern countries, young women are encouraged to practice sexual abstinence until they get married. This practice is, however, changing among the modern young women and it is becoming more normalized to have sexual relations before marriage. That being said, there are still those who favor practicing traditional religious beliefs and should feel respected accordingly.

A Sudanese respondent described the lack of understanding behind her religious practice as a lack of cultural awareness:

They [physicians] don't understand the religion part of wearing hijab or jilbab.<sup>1</sup> This is what you believe in, that's why you do it. It's not your husband; another thing is that this type of clothing is also part of your culture. There are so many layers to why you wear [hijab], but they don't understand. All they see is a husband who is controlling every word she [his wife] says and especially he's translating everything so she doesn't understand [what is going on].

## **Appearance**

Some respondents talked about how their appearance (in the case of these women, their hijab) made a difference in their interaction with the physicians. A Sudanese respondent said:

I know he did that because of the way I'm dressed. I'm sure he sees the way I'm dressed, one hundred percent. And she [nurse] figured it out and she said, "You should tell him you are a doctor." I tell her, "I don't have to, he's supposed to treat my son well regardless of who I am."

Interviewer: How about anyone else that you know? Have you heard stories about other people experiencing anything negative from family or friends?

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<sup>1</sup> The term *jilbab* refers to any long and loose-fit coat or garment worn by some Muslim women.

Respondent: Yeah. It's a lot. Especially when people they wear their jilbab too. That's worse.

Interviewer: Do you have any stories to tell me?

Respondent: I don't have a specific one, but they feel like at the doctor they don't understand them and they don't treat them right. They have two problems: they don't speak language, they go to their husband, and they are wearing jilbab. That makes things worse.

A respondent talked about female doctors acting more discriminatory than male doctors toward the hijab:

It's harder for women who cover themselves, and if you have a female doctor, it's harder to deal it. Because some of the female doctors are feminists and they think different ways, so they look at you like oh what are you doing to yourself. It is even harder if you are wearing jilbab and stuff. They think your husband is controlling you. Why you letting him do that to you?

In previous research studies, respondents reported feeling that men and women experience discrimination toward their religion in different ways, and this was linked to their greater visibility as Muslim women wearing the hijab (Tyrer and Ahmad 2006).

A Sudanese respondent talked about how the appearance of her son caused misunderstandings at physicians' offices. Again, this experience is similar to the experience of African Americans. She said:

My sons they have braided hair. Their hair is very long and you can see, the impression anywhere you go, the doctor's office or anywhere, they think they are African and they have this long hair that means they are doing drugs or something. People will try to avoid you unless they have to. Will you steal or this kind of thing? I'll go in the store when they go there and we'll find somebody following them. It's kind of like, for the male especially if you are not typical. If you dress well, for the male is important. If you dress well, clean there is a different perception even if you are black. But they tell you, "Okay you are clean." They don't give that assumption of the drug on you immediately, but if you look casual wearing something with holes and with dreaded hair and all that, oh you are definitely from this group [doing or selling drugs].

Interviewer: How about religion? Do you think your sons will experience anything because of their religion?

Respondent: No.

Interviewer: Because they wouldn't know.

Respondent: They wouldn't know. For the men they don't think about religion unless you really have a long beard and stuff. That is a different perception but even if he has a long beard and he is black, the religion don't come in.

According to Seguino (2011), non-U.S.-born black women face inequalities, and research should look at the forces that create those inequalities. Adding being Muslim to this combination resulted in a more negative experience for this respondent and anyone from the area of the Middle East with dark skin color. Some research studies focused on the experience of discrimination based on intersectionality theory. Intersectionality theory, formulated by the famous feminist Kimberlé Crenshaw (1989), is defined as paying attention to unequal power relations such as race, gender, nationality, and so on, and to treat them not merely as demographic characteristics. According to Crenshaw, intersectionality theory has its roots in the writings of U.S. black feminists who challenged the notion of a universal gendered experience and argued that black women's experiences were also shaped by race and class (Hill Collins 1990; Davis 1981). Intersectionality theory argues that these systems of oppression usually work together to produce inequality (Cole 2009; Hill Collins 1990; Crenshaw 1989; Schulz and Mullings 2006). It is known that black women, for instance, are more likely to face different and double discrimination compared to black men because they have to fight two battles instead of one. Adding the element of nationality to the health of the Middle Eastern population may make them more likely to experience discrimination. Seng et al. (2012)

conducted a research study where they looked at the effect of intersectionality on experiences of discrimination in health care system. They defined intersectionality as effects of race, class, and other marginalization characteristics. Intersectionality can affect the health of individuals. The adverse health effects happen through the process of discrimination.

The question that remains here is, which physicians practiced more racial discrimination toward their patients? Those respondents who reported discrimination mostly had white male physicians. One respondent described it as follows:

They were all American...yes, they were all American, white Americans...and most of them were old people.

The answers of respondents are in line with what previous research found on the perceptions of American people about Muslims. According to Zainiddinov (2013), white men have the highest negative attitude toward Muslims compared to other groups. The findings show that blacks report significantly more favorable feelings toward Muslims than whites. Those respondents who are female, more educated, and Catholic also hold significantly higher favorable feelings toward Muslims.

In this chapter, I introduced the concept that white physicians, more than other physicians, treat their Middle Easterners patients with discrimination. Acting out of the white racial frame, they discriminate against their patients based on their accent, nationality, religion, clothing, and cultural differences. The white racial frame has a pro-white frame that endorses the elite whites' accent, religious practices, types of clothing, and life choices. In addition, the anti-minority frame of the white racial frame rejects the minorities' ways of living. The stereotypes that they hold against this population results



in different issues including lower pain management, patients feeling rejected and unwelcome by the health care services, and lack of compliance by the patients. Framing of those Middle Eastern Americans who have darker skin color put this group in a more inferior position and toward the position of African Americans on the racial spectrum. Furthermore, negative comments and reactions of the physicians toward the patients' nationality created feelings of exclusion and subordination. Most of the respondents of the study were Muslim and some covered their hair or body. Some physicians had an undesirable reaction to the patients' choice of clothing, and in two cases, physicians even made negative comments to the patients. Some of the physicians were also unaware of the cultural and religious values of Middle Eastern countries pertaining to clothing or reproductive issues.

Cultural competence education that includes anti-racism training might be needed to address the issues that Middle Easterners face in their daily encounters with physicians. As mentioned in the theory chapter, the element that is missing from the cultural competence theory is deframing and reframing. Deframing is a process that health care providers including physicians, nurses, and other staff members who have interactions with patients have to go through first. Deframing is removing and erasing the engraved elements of white racial frame from people's mind. It is a long process and needs patience and time. This process should include giving information about the long history of slavery and white benefiting from the resources and higher positions. After individuals learn about the wrong frame that they act out of on daily basis, then the reframing process can begin which is learning about the new ways of looking at minority

people, learning about their culture, and treating them in a way that shows respect for the suffering that their previous generations have gone through. If educators add these two different processes, which can be called anti-racism training, to the existing cultural competence education then there might be a hope that physicians act differently in response to their patient's different racial identification.

### **Nurse Discrimination**

Discrimination by mostly white nurses also affects Middle Eastern patients and was one of the major elements of the interviews. The interactions between the two should be analyzed more carefully to understand the emotions that MEA experience. Participants mentioned many different forms of these negative experiences, including being rejected, ignored, or looked down upon due to accent, name, or language skill. The lack of cultural awareness of nurses was also mentioned in the interviews. Throughout the interview process, many of the MEA women ascribed the lack of communication as being an indicator of discrimination. When asked if they had any negative experiences interacting with nurses, many participants answered yes, particularly those who covered their hair. Participants were asked about the ways that nurses ignore or stereotype them, and the following quotes exemplify the common mindset of most nurses toward minorities and, in this case, Middle Eastern people. Two forms of discrimination—overt (or visible) and covert (or subtle)—were detected. Also, examples from the nurses of a lack of cultural awareness emerged.

## **Covert Discrimination**

**Lack of communication.** Critical race theorists discuss a type of racism called aversive racism, which is defined as attempts to avoid people of color or to be formal, correct, and cold in dealing with them (Delgado and Stefancic 2001). The following personal accounts provide evidence of this type of racism. Although patients cannot file racial complaints because nurses have been cold to them, such behavior gives them a feeling of discomfort and exclusion.

One Iranian explained that health care providers make patients who cover their hair feel uncomfortable. In answering the question regarding which group made her feel more uncomfortable, she said “nurses,” and then she noted:

With doctors, I'm more comfortable. Maybe because nurses, they don't see that [Middle Eastern women], they don't have experience with Muslims, or they are so young and then they differ frequently. For example, a doctor, I just go to one doctor, and she knows me. But for nurses, they change their shifts. For example, I see that with Americans [American patients] they [nurses] start conversation and want to become friends. But for us they just [say] okay, this is the thing you need to do, do this, do that. Probably they are afraid that maybe we don't have the efficiency in language, but I see that they [white Americans] feel more comfortable with their nurses, some nurses, not all of them.

Feeling pressured because of the type of clothing she wore and being ignored as a human being made her dissatisfied with the health care services. A recent dissertation by Martin (2013) showed that clothing was a major source of discrimination against women.

Comparing the type of conversations that nurses have with white patients and MEA patients, the above participant noted the difference between the two. The nurses, who are mostly white, view the MEA patients as outsiders and do not engage in conversation with them. The negative reaction toward Muslim women who cover their hair originates

from the image held that these women's value system is un-American. In this process, Middle Eastern American women in a hijab are easily transformed into enemy aliens who can be commanded by neighborhood defenders to "go home" (Cainkar 2011).

Feeling like an outsider is a common feeling of minorities in a white-dominated society because whites have their own circle of friendships and only allow minorities to enter if they prove their assimilation into the white culture. This can be tied to the white-to-black racial spectrum discussed by Joe Feagin (2006), which he described as a spectrum with whites on one end and blacks on the other end. Other racial minorities, excluding blacks, are moved up and down this spectrum by powerful whites based on their assimilation into white culture. In this example, the participant saw herself being treated as if white nurses were placing her further down the racial spectrum.

This respondent looked for "friendship" or at least small talk, but she did not see any initiation of that. According to Rowe, Kellam, and Stott (2013:35), the challenge that the health care system faces nowadays is how patients and providers can communicate their expectations, and most patients need to know that their provider "takes a personal and professional interest in them as individuals." This research study shows that when individuals from different cultures meet in a clinical setting, confusion about dynamics of interaction can occur.

In a reflection similar to the previous account, one Lebanese middle-aged respondent gave these remarks when asked if she believed that whites and non-whites receive the same treatment in the health care system:

That's a—I would say, in many cases, no. Well, I feel that some, especially nurses and people in front desks, are a little bit more talkative with the local people.

One middle-aged Turkish woman who wore her hair uncovered said this about communication and the possibility that results might be different if she were white.

If I were a native [meaning a native non-foreigner, i.e. white] American, they, perhaps there would be, I don't know, maybe there would be more close communication. Sometimes I see that that's kind of, you know, people if they have similar backgrounds, raised in similar environments and things like that they may click more [i.e., communicate better].

Another participant who was accompanying her friend to a dentist was surprised by the negative reaction of the nurse. She said:

I remember one time I was accompanying a friend to a dentist, and that dentist really messed up my friend's teeth. And we went there for I think the fifth time; I think it was the fifth visit to that dentistry. Then it takes a long time, like more than three hours. And my friend was in the surgery room. And I went to the nurse there and asked, "How is my friend? Is she good or—," and then they didn't answer my question. And I checked for the second time, and they didn't answer my question. I said [to myself], she's good, just keep quiet, and keep silent. My friend was—she was in a very, very bad pain. She was not in a good condition. And then I really wanted an answer after two or three hours, and then I start, like, making my voice loud and in front of others and told them that who do you think you are? I mean, you should answer my question. I'm a friend of her and it's like after three hours I should know. And then as she went there and the doctor came in and she and the doctor talked to me.

When asked about their racial background, she replied:

Yeah, all were white and then after I raised my voice then—and the doctor came and talked to me, and then I saw that they look at me in a very angry fashion that [wondered] "Why she's doing like this?" Or she doesn't know how to behave in this dentistry or something like that. But I didn't get it, you know? They should answer the questions.

This respondent felt frustrated because the nurse ignored her by not answering questions and was annoyed enough to raise her voice to get the nurse's attention. As to

whether she saw that as a sign of discrimination, she said, “I do not think that a white person would have experienced that for asking a question.” A Pakistani woman recalled a similar account. She told me that after waiting in a waiting area at some doctor’s office, she noticed a note saying, “*After 15 minutes of waiting you can come to the front desk,*” so she went to the window and asked them. She said, “They don’t give me any respond, like they’re ignoring me.”

One Egyptian woman, who was a dentist, brought up an example in which the nurse provided no explanation about the side effects of her medicine. She interpreted that as a sign of discrimination. She noted:

But I have an experience related to this situation because in one of my miscarriages, they sent me to clinic and the nurse gave me pain medication. I didn’t know what it is, and she didn’t explain to me what it was. Actually, it was a very strong pain medication that it affects you—you cannot drive after it, or something. So she didn’t tell me this detail; she just gave me the medication and that’s it. She didn’t explain for me the details about the medication.

It is possible that due to regulations of the health care system, one sees fewer examples of direct verbal discrimination and more non-verbal ones. Ignoring a person of color might be one form of this non-verbal discrimination.

The experience of Middle Eastern Americans with dark skin provides a unique lens through which one can look at the intersection of skin color, nationality, religion, and gender. According to Klonoff and Landrine (2000), dark-skinned blacks are 11 times more likely to experience frequent racial discrimination than their light-skinned counterparts. Sixty-seven percent of the respondents of this study who reported high discrimination were dark skinned and only 8.5 percent were light skinned. Similar to the experience of African Americans, the darker-skinned MEA women suffered more

discrimination than lighter-skinned women. Previously, I mentioned that the negative attitude of the nurses toward MEA women left them feeling rejected and with a lot of anger and frustration. Adding the element of dark skin color to the existing stereotypes about religion and nationality makes doctor visits much harder for this population. As mentioned earlier, according to Feagin (2006) whites tend to put minorities on different spots on the white-to-black racial spectrum. If we assume that MEA are placed somewhere in between whites and blacks and mildly closer to blacks, having a dark skin and being a MEA might mean being placed at the very end of this spectrum, possibly even lower than blacks. The discrimination that this population would experience is a result of failing the standards of the white racial frame in **every** aspect instead of just one. Having dark-colored skin, being from the Middle East, practicing Islam, covering the hair, and being a female might be a combination that does not result in a positive reaction from anyone practicing within the white racial frame, including health care providers. A woman from Sudan who has dark-colored skin told me that:

With nurses, sometime you go, and you feel rejected because of what you wear and you are black.

In response to whether she ever received any mistreatment because of her hijab, she said:

Sometimes, yeah, they do. Sometimes they do. It's more from the nurses than from the receptionist staff. Some nurses, they do things and they always...anytime to go to a new doctor or a new setting of healthcare for the first time, you are treated like an ignorant person. That [covering your hair and body] is a sin. It's kind of like we're going to go through, and they are going to be fixated on that. As far as clothing, you feel the pressure more from the nurses than from the doctors. [In a familiar setting] they don't because they are used to it, and I think they are trained to and there is not that much interaction. They ask you your name and stuff, and there is nothing more to that. But you go in a new setting, sometime go to the emergency room or something you have to go to, you

get that first with your hijab and your accent, so it takes a while for them to start doing the right things or saying the right things.

This woman experienced racism particularly when she did not have a chance to prove herself. People mostly judged her by her innate characteristics rather than acquired ones.

Conversation with a second-generation Iranian American respondent showed the discomfort that she experienced when nurses asked her the “where are you from?” question:

I don't feel like telling them Azeri, Iranian, and Persian, so I just say Persian a lot of times. Then they'll say, “What is that Persian?” So they'll say like, “What country?” I'll say Iran—what today is Iran, and then they'll say “Oh,” or they'll be—you can tell there is a negative connotation with the reaction. But they won't behaviorally or action wise they won't do anything that is openly discriminatory. But just the behavior, the demeanor it's like oh, you're from there.

The expression of disappointment after learning where she was from made her uncomfortable about her identity. Verbally expressing “you are from THERE” is a visible sign of being discriminated based on country or nation of origin. The negativity toward her country is a result of the media portraying that country as a dangerous place. Through the mainstream media and other socialization agents, the idea that some countries are a threat to the United States has been visibly advertised. The fear that media has created has led to the negative reaction of people in response to even hearing the name of some countries. Elite whites are in most cases in charge of the mainstream media and protect their power by reproducing that fear toward any person or group that is different. Feagin (2010) suggested that today, most Americans believe in the common U.S. nationalism that ignores other nations and countries. In this example, acting out of the white racial frame means believing that the United States is the best country in the



world and forming opinions based on the negative messages that the media portrays about the Middle East. Based on that, the expected expression of whites when hearing the names of some countries could result in a negative reaction from the average American.

In response to the scenario in the questionnaire where a nurse was putting a blood pressure monitor on a Middle Eastern woman, the same Iranian American woman brought up an interesting point about possibly negative experiences of Middle Eastern men. Creating a feeling of fear is one of the elements of the white racial frame. For example, the whites' stereotype of the dangerous black man is a formed idea combined with the emotion of fear toward black men. This emotion causes some whites to take precautions during their daily interactions with black and other dark-skinned men (Feagin 2006). This respondent talked about the existence of possibly the same reaction toward MEA men. Although this study was focused on women, it might be interesting to consider this research question for future work in this area. She said:

I have personally like seen this, and even heard of personal accounts where this has happened before. I think this one is like a hard one because a lot of the health care nurses and a lot of health care professionals that are assistants to nurses like—the allied health fields like nursing and physical therapy and a lot of that is actually female driven. So this can be like a conflict whenever a male—I think we always think of the female perspective and things like that. I think that I'm glad that you put this in because like what about the Middle Eastern men? Like what their experiences are too. How can you say there is not a Middle Eastern male nurse to come and take you—or even just a male nurse to come and take like your blood pressure or something.

Future research might be needed to analyze the experiences of MEA men and whether their skin color or their type of clothing creates resentment and fear in health care professionals. This participant also mentioned that religious Middle Eastern men do

not want to have direct contact with a female nurse. The avoidance of direct contact with the opposite sex has been suggested by religious texts in Islam:

Even my Hispanic friends, for instance, some of them look actually very Middle Eastern. Even they, because they have had those experiences, because they look Middle Eastern or something. So they've had experiences where like they feel like the nurse—here it says the nurse comes into the room and they don't like—doesn't make eye contact and they don't make eye contact. You know, I think that it does happen. But I mean this guy, I guess was lucky because his nurse was a male. A lot of times I know the Middle Eastern men that are very, very religious—like specifically Muslim—they don't even want a female to have like that contact with them.

This personal account shows the need for further research on the experience of Middle Eastern men with white nurses.

One of the respondents believed that being white could make a difference in the way of receiving treatment. This Egyptian woman was aware of the benefit of being a white patient. She said that nurses treat people well only if they are white because whites may have the power to punish them for their wrong behavior:

When I was in my second miscarriage, and we were in the hospital, and I was terrified, there was a nurse there, and I told her that I just need to drink juice or water. She told me, wait you maybe have a surgery, so wait. I didn't know anything; surgery or what I'm going to do, and the doctor didn't tell me there is a possibility for surgery. She made me terrified, and after that, I told her, like, you don't have the right to tell me this, if the doctor did not... she ignored my pain and ignored how terrified I can be and said something, thinking that I would probably not give her a hard time later on if I am not white.

This respondent argued that whites' access to resources might make health care providers more careful about their actions with whites. She believed that whites are more likely to follow up on the wrong actions or attitudes of health care providers than other minorities. Answering this question needs a lot of research and inquiry. However, one research study reviewed the attributes of patients who are more likely to sue and found

out that having anger, mistrust, severe childhood punishments, addiction, and college education make people more likely to think about suing their physician (Fishbain et al. 2007).

Some of the women did not want to label the negative behavior of nurses as discrimination. An Iraqi respondent did not want to believe that there could be discrimination against her. She did not see people who act in a negative way as racist.

When asked if she had ever had a negative experience with nurses, she replied:

Yeah, yeah, sometimes you feel like someone don't like you, but you cannot trust your feeling. But if he says something, like, you know this is discrimination maybe that's another thing—I don't know. Yeah, I don't have experience for this situation, I don't know.

People of color often do this kind of “rescuing” or “excusing” of whites. It shows an effect of systemic racism’s pervasiveness, and probably their fears.

One Iraqi respondent believed that racist acts happen, but not very frequently:

I think it may happen, but not a lot. Like some of nurses are afraid of men when they feel they are from Middle East, but I don't think that happens a lot.

Ignoring racism and labeling the negative experiences as something else is a common coping strategy that minorities engage in. They think that the less they think about it, the more they can go on with their lives. According to Brondolo et al. (2003), individuals are hesitant to report racism because they associate it with loss of control. Personal characteristics such as a tendency toward denial may also be related to the tendency to minimize reports of stress. Coping with racism by using denial and anger suppression can complicate understanding the racism or level of a person’s exposure to racism. In this study, there were multiple times when the denial of racial discrimination resulted in

the inability of the researcher to collect sufficient data. As for lack of communication, there is similarity between the lack of communication of nurses and physicians.

However, with physicians, there might be cases when they do not like to communicate with Middle Eastern patients but they have to so they can give diagnoses and treatment information. Nurses might be more likely to have brief conversations, especially with those who cover their hair.

**Names, language, and accent.** Speaking English with a different accent or not fluently speaking English can add to the difficulty of patient and health care provider communications. Negative reaction to accents and names is part of the pro-white frame that is part of the white racial frame. According to Smith (2012), inadequate communication between patients with limited English proficiency (LEP) and providers can be associated with lower access to health care. For instance, those patients who primary speak another language other than English or Spanish are less likely to get an appointment when they want compared to those that speak English or Spanish. However, compared to those who speak primary Spanish, those who speak another language (including MEA) are less likely to receive prevention screenings. Those who primarily speak Spanish or another language are almost twice as likely to feel that their physician did not explain the treatment, more likely to feel that their physicians did not treat them with respect, more likely to think that their physicians did not spend enough time with them, and more likely to not understand the treatment options.

Some participants expressed their dissatisfaction when nurses did not want to, or could not, due to the difficulty of pronunciation, pronounce their names. This may be

seen as a sign that some nurses are not willing to make communication easier. It is very likely that patients who are greeted this way are less likely to trust their health care providers in treating them the same as they treat white patients.

A Lebanese respondent reported negative experiences with a few nurses who did not want to try saying her name. She said:

You always do see that because they're saying [asking] how you say it. I would say it's... and they say, "Oh, I cannot say it; I'm going to call you Marie." So they assume either way they can call me Marie because it's easier for them to call. I will say it's so easy, like, it's spelled... so you can see the frustration when they cannot say your name.

A second-generation Iranian American said this about pronouncing her name:

I have seen that [discrimination]. Like, even if it's not verbally that they express some type of discrimination, sometimes when they look at your name and you know—you can tell by the communication of their body language, even like facial expressions, like they look at it. Sometimes they don't even try. But I feel like sometimes they look at it, and they make like a scrunch face—you can tell that it's like, oh, this foreign name. You know what I mean? Or, oh, this—it's like a foreign person, I don't even know how to pronounce the name, I don't really care. There's kind of like a facial expression, even if you know, they can't verbally express it.

In response to experiencing any negative reaction from the health care providers in response to a different accent, a Pakistani respondent who has lived in the United States for over 30 years said that she experienced racism from nurses, not doctors. She noted:

Yes, not the doctors, but the—who check the blood pressure with that cuff. Nurses. Yes, they're the ones who look at you funny. Speaking and they don't understand. Okay, and then I am just explaining more and—what? Then they start talking loudly. I want to say, I can hear you. You don't understand what I am so I'm telling in a different way, and then oh—that's it.

She blamed herself, as illustrated in the following statement:

So I think it's my fault. It is, and I blame myself, yes...still I am living here for such a long time and I couldn't speak well...I mean, they treat me well, but again, I blame myself...I know everything, but maybe with the receptionist, maybe the team [health care providers beside doctor], if I can communicate well with them. Or if they are open with me [communicate more] I can be better at it. I will be better.

The white racial frame includes features such as racial stereotypes, racial narratives and interpretations, racial images, racialized emotions, and language accents. Acting out of this frame means that over a long period of time, this frame has created positive orientation to whites and a negative perspective to other racial minorities (Feagin 2010). The negative reaction to accent originates from acting out of this frame on daily basis. There were similarities in the way nurses and physicians discriminated against Middle Eastern American women. Negative facial expressions, acting as if they could not understand the patient, or acting upset when they had to repeat phrases were common behaviors of both groups.

### **Overt Racism**

**Verbally negative comments.** These are examples of visible discrimination where the nurses were bold enough to overtly show their dislike of these patients. A question that remains is where this dislike comes from. The white racial frame explains the pro-white and anti-other elements (Feagin 2010). A Lebanese respondent, who herself worked in a health care setting reported some conversations with nurses during her doctor visits. These conversations happened during the Israel and Palestine war that occurred in July of 2014:

Recently I have a bad experience with two nurses because this nurse asked me how is your family? Are they affected with Gaza war and what do you think? She asked me. I said it's not fair. She said what do you think? She start telling me

how—yeah, how Egypt even open for Palestinian, how—she was telling me about Israel, how they are the good people. So I said do you think what is happening to Palestinians, they deserve that? It was a long conversation like this, and so she was upset with me because I defended the Palestinian. She used to be very friendly, now when she sees me, she says hi, bye. Like—so there is this experience.

She further explained:

Another girl [nurse] asked me, “Are you okay? Is your family okay?” I said, “Yeah, we’re far [from the conflict]. I feel bad [that] it’s happening.” I said, “I don’t like war. I have lived during war; I don’t like wars.” She said, “Yeah, it’s so terrible. I have friends; I’m so worried about them.” She has Jewish friends. She was like, “They should stop; they should—.” So I asked, “Do you think they [Jewish people] have the right to the land?” She said, “Yeah, it’s their land. God gave them this land.” So you see doctors who are educated who are more open-minded, but you see nurses who are still, still not very educated. You know? I don’t think they’re educated in cultural issues. They have this idea in their mind.

These two conversations show the perspective of most Americans toward issues in Middle East. When whites hear a different opinion toward major issues they may experience discomfort. The reason is operating from the assumption that the white experience is the universal experience (Feagin 2010).

The following discourse illustrates the extreme example of these negative remarks. One respondent from Lebanon said:

It was a time when the prophet Mohammed cartoons came out and all these riots in Europe and the protests.

Q: From Denmark?

A: From Denmark. I was sitting there and—in a clinic—and one of the nurses said, “We should let the Jews wipe off all the Muslims in the world.” I looked at her and said, “You mean everybody? You know some of those people are grandmas and daughters of somebody. Are you a mom? Are you a grandma?” Certainly she avoided answering that. I didn’t say I was from that part of the world, and she didn’t certainly wanted to know, but certainly she felt embarrassed.

Q: Yeah, how did that make you feel, just hearing that comment?

A: Oh I was very angry. I couldn't hold myself, really. Then I regret I said that, to be honest, I wished I didn't, but I was feeling very angry...I mean wiping a whole group of people off the map is something that is lightly said in this part of the world—oh yeah. But when you make them think about the implication of this, it's just too embarrassing, or maybe she was thinking, "What is this lady talking about? I don't know, but it was just a quick incident, but I really felt very angry.

The comments of the nurse in this account are a repetition or a version of the message that mainstream media may send to its audience. As for verbally negative remarks, both groups of physicians and nurses may express negative verbal comments to this minority group.

**Lack of cultural competence.** Data show examples of a lack of cultural competence in health care provided toward the MEA population. Cultural competence is defined as "acknowledging and incorporating the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt et al. 2003:294). For instance, this lack of cultural competence may result in health care services providing male nurses to women who cover their hair. One respondent shared her embarrassment while explaining her medical condition to a male nurse:

The only problem [was] that I wanted to see a lady physician because I was embarrassed to share with a guy physician, but I remember that the nurse that wanted to record my health admission, he was a guy. For the first time, for the first time it was a guy and I was—I felt some embarrassed to. And maybe it was that because in this culture it's okay to tell the guys, but for our culture it's different. And we feel shamed, for example, trying to say some problems to the guys.



A Kuwaiti respondent criticized the health care services for having providers that are not aware of the common rules of courtesy in Islam. She said they mostly view Muslim women as being obliged to follow certain rules. As a result, providers do not consider the restrictions that Muslim women might have:

Actually, I'm surprised that they don't know much about what the restrictions are for Muslim women. Even if I wear the scarf, they think I wear it for my husband because he told me to cover myself, which is not the case.

Nevertheless, in most cases, women were satisfied with the way that they are always given the option to choose a female physician. Those who covered their hair were more likely to be given the option to choose a female physician in urgent care or emergency rooms. A second-generation MEA described this lack of cultural competence by explaining cultural values. She shared an example about her grandparents:

You know, even my grandparents lived here...they were sick a lot, actually. I know that when we took them to the health care—like my grandma went to the hospital, my grandpa went to the hospital, and they interacted with doctors and nurses. They didn't even speak any English, but whenever the physician or the nurses would explain something, there was, no, actually—a lot of times it would just be like medical terms they care; they would just regurgitate what they learned in their medical textbooks. Or what formality, like, what they were supposed to say, and they wouldn't go beyond that to make sure that you understood what is the condition, what are the treatments, what are the options... It's not like a caring process; does the patient come from a different culture? Do my suggestions even fit with the cultural values of the patient that I'm treating? They don't even think of that, they just know of what they were taught in Western medicine, and what I can tell them based off of what I learned, and they don't go beyond that. They don't think that this person is a different culture and do my suggestions or options or treatments—do they fit in line with this person's cultural values?

Institutional racism in nursing education has been cited as a critical social issue ignored by the nursing profession (Georges 2004). A review of several nursing textbooks revealed that most included culture, stereotype, or prejudice in the index, but none

included racism (Ball and Bindler 2006). According to Lancellotti (2008), racism is largely unacknowledged in nursing education. In teaching beginning nursing students, the focus has been on “ignorant” individuals and did not cover a critique of racism. Also, in regard to non-white nursing students, the focus has been on the success in nursing education, which means changing the student's behavior to fit the dominant culture of nursing education. The bottom line is that nursing education needs more attention to a specific training or education that would focus on anti-racism. For instance, cultural competence education has been offered as a solution to increase diversity and cultural awareness but fails to include training regarding racism. The mentioned personal accounts in this chapter call for an edict to add anti-racism training to the cultural competence education of nursing. According to Lancellotti (2008):

Whiteness is so deeply embedded in our educational system that it may seem invisible. Racism is seen as a problem of people who are different, not a problem of white people. Being white is considered the norm in the United States, and this idea of normalcy has naturally extended into nursing education. Nursing care of a “typical patient” may be presented as that of a white middle-class American person. When assessing skin color, healthy skin is routinely charted as “pink” and then students are taught how to assess skin tone in people with non-white, hence “different” skin color.

The pro-white sub-frame of the white racial frame needs to be addressed in this anti-racism training. As mentioned in previous chapters, it also needs to include the history of whites’ domination over people of color over a long period of time. The sufferings and lack of access to resources that minorities had to go through should be included in teaching that history. The process of this anti-racism education is called deframing the major elements of white racial frame and reframing them with new ones based on fairness and equality.

## **Inventory Questions**

Following the interviews, participants were asked to answer “yes” or “no” to some inventory questions concerning discrimination during doctor visits. Following is a list of those questions.

During a doctor visit, did you experience racial mistreatment:

1. As soon as the physician entered the room and saw your face?
2. When the physician attempted to pronounce your name?
3. When you were explaining your health condition to the nurse?
4. When you were explaining your health condition to the doctor?
5. During your physician’s examination?
6. When he or she was talking to you about your diagnosis?
7. When he or she was prescribing something for you?
8. When you had some additional questions to ask?

A copy of this list is included in the appendix of this dissertation. The general belief was that a few would answer “yes” to all of the statements, but even those respondents who reported incidents of discrimination did not answer “yes” to all the inventory questions, which might lead to the conclusion that every respondent experienced discrimination in a different way. It may also mean that the respondents understood the English wording in different ways. There might be some explanation for this result. First, although respondents experienced what would normally be considered discrimination and reported some events of that nature throughout the interviews, they did not want to label it “discrimination,” just as has been reported in studies of African

Americans. It might be that discrimination to them meant an overt type of discrimination, and they were not able to relate what happened to them with that. Another explanation is that many of the respondents who reported mistreatment did not want to believe that it was due to their race. It seemed as if they had a conflict in their mind about whether they should see it as a racial discrimination or not. Furthermore, it might be a case of feeling pressured to excuse whites' actions and not label it as discrimination. The reason is that whites are positioned as superior in the white racial frame, and people of color may feel obligated to rescue them. The interview questions showed that many of the respondents did notice and suffer from the white racial frame, but that finding did not show up as much in the inventory.

The most reported discrimination by the above scale was related to pronouncing names. Out of 30 respondents, four reported discrimination when the physician entered the room and saw their face; eight experienced it when the physician wanted to pronounce their names; two reported that it occurred when the nurse was listening to their health condition; one reported that it happened when the doctor was listening to her health condition; one stated that it occurred during the physician's examination; two reported that it happened when they were talking about the diagnosis; one said it happened when the doctor was prescribing something to her; and three reported that it occurred when they had additional questions from the doctor. Although this is a report of more than 21 incidents of discrimination, it is still lower than the number of incidents that were reported during the interviews, which was a number greater than half of the respondents.

The existing discrepancies in reports of discrimination by participants lead to the discussion in the next chapter of factors that influence discrimination experiences.

## **CHAPTER VI**

### **FACTORS INFLUENCING RACIAL FRAMING AND DISCRIMINATION**

This chapter discusses the factors that may make a difference in the experiences of discrimination in the health care system, including self-identification, national identity, language and accent, immigration status, and mass media influence.

#### **Self-Identification**

The way respondents identify themselves may contribute to their experience of discrimination. Ethnic identity emerged as a predictor of perceived discrimination for Middle Eastern Americans. For the purpose of this research on Middle Eastern Americans, ethnic identity means one's ties to her country of origin. Some relevant literature shows that individuals with a strong ethnic identity reported more discrimination than those with a weaker level. The rejection-identification theory suggested by Branscombe, Schmitt, and Harvey (1999) helps to explain this relationship. Either the discrimination results in higher in-group identification or their already high in-group identification results in more ways of exposing their ethnic minority, thereby resulting in discrimination. According to Awad (2010) looking at the data, some MEA strongly identify with their ethnic group and others solely want to be American or downplay in their lives the role of being an ethnic minority. A recent survey of Arab Americans showed that Muslim Arab Americans who identify themselves as non-white more frequently reported discrimination (Abdulrahim et al. 2012).

Having a stronger self-identification with an ethnic minority may result in a higher chance of experiencing discrimination. One middle-aged Iranian respondent who did not report discrimination in health care services had a different self-identification compared to others. She saw herself as American. She noted:

You know when people ask me where you're from, my daughter gets kind of offended. She says, "You're American, if I say I'm Persian." I always tell them I'm originally from Iran, and I'm proud to say that. I have no hesitation to share with them that I'm from Iran, but I also let them know that I've been here longer than I've been in Iran...but this is home, you know? I see myself as American, but I know other people see me as non-American.

She could see that other people saw her as non-American due to her different accent or facial features, but her argument probably made sense to her in that she had been in her home country less than she had been in the United States, thus demonstrating how the length of time that has passed since one's immigration can make a difference in one's experience. However, that being said, the discussion about immigration pointed out that most second-generation MEA identify themselves with their ethnic identity instead of saying they are American. In the above example, the respondent was not a second-generation immigrant but a first-generation one.

It is impossible to engage in the discussion about less self-identification with the ethnic minority without talking about assimilation. Research shows that Arab people, especially Muslims, find acculturation within the United States more difficult than other immigrants; with increased racial marginalization, many of them feel they are outsiders, and many may ultimately wish to return to their home country (Al-Krenawi and Graham 2005). Those who pursue more assimilative practices feel the pressure from those who feel they should be more traditional, even while being more traditional may result in

discriminations against their identity (Erickson and Al-Tamimi 2001). Many Middle Eastern Americans feel a need to internalize a number of identities (Arfken, Kubiak, and Farrag 2009). Various literature has pointed out that many Arab American men and women live between at least two cultures or identities and as a result are subject to a high risk of physical and mental distress (Al-Krenawi and Graham 2005).

### **National Identity**

Some of the respondents experienced discrimination when they revealed their national identity. The personal accounts in this section provide the general opinion of the respondents on how their national identity may affect their experience of discrimination in health care. The way MEA self-identify and their national origin affects their experience of discrimination. For instance, respondents from Turkey believe that Americans do not identify their country as a typical Middle Eastern country, so they experience less discrimination compared to someone from Arabic countries. The reason might be that part of Turkey is in Europe, so they are generally somehow associated with Europe too. For instance, a respondent from Turkey said:

People in the United States do not have much perception about Turkish people anyways either. They don't have perception that Turkish people are Middle Eastern either, so because of that, I'm not really having bad experiences [i.e., discrimination].

She described her experience when she tells native-born Americans that she is from Turkey:

They give a very typical American response. "Oh, that's great." Or "Awesome," or "Wow," or, you know? But I guess they don't really put it anywhere in their minds. Like, I had an internship before coming to the United States in Germany for six months. There, if you say you're Turkish, you would face discrimination and racism, and I had it anywhere and everywhere, you know, in the streets. So I



can't compare it with that. Like, there, there's a prejudice against Turkish people. But here they don't have any positive or negative prejudice against Turkish people.

Another Turkish respondent stated:

Turkey? No, they [Americans] know nothing. Actually, we were always involved with NATO and—but they have no clue. If they know something, it's because they had somebody they knew from the army who was stationed in Turkey. We have a lot of army bases in Turkey where American soldiers are stationed, so I met a lot of people here whose parents were stationed there. They were in Turkey for a couple years. Even they, they don't, you know, they're very friendly and they had a good experience. They see Turkey as an American ally. It's positive normally, especially with the military personnel family.

Q: So probably the political relationships between the countries make a big difference?

A: I think it does. I mean, I can see it with the European reacting to me being Turkish. And I know that they do see me as Muslim even if I tell them I don't believe in anything. I'm Muslim for them and that's it, but not in the United States.

This account is significant in demarcating what Middle Eastern means to most native-born Americans. This respondent believes that the political relationship between the two countries can affect the way that Americans define Middle Eastern Americans. Turkey is one of the major countries of the Middle East; however, due to its close ties with the Western world, the typical American does not consider Turkish people as being Middle Eastern people. Middle Eastern Americans are those that might have political conflict with the United States or engage in terrorist attacks. Most of the respondents defined the Middle East based on the location of the countries, but the definition of Americans might be based more on politics and more socially defined. Those MEA from countries that are the target of news agencies and have a history of terrorism are more likely to face discrimination than others. For instance, Iranians, who come from a country that is

always embroiled in Middle East news, may face more discrimination following the revelation of their national identity.

Except for Turkey, which benefits from its association with Europe and less radical government (in most cases), citizens of other countries of the Middle East are the victims of the perspective formed by the white racial frame. One Iranian respondent said, “Whenever I say that I’m from Iran, I see that people have a big change in their reaction.” When asked if she wishes she were white, she replied:

I never wished that I was white, but there were times when I wished that we lived in an area where they were more cultured. But I never wished I would change, or I wished that I was white or another race or culture. I never wished that. I just wished—like I wished that I grew up more in an environment—like my brother, he never liked growing up in Texas because there were a lot of people that were predominantly white and Christian and very conservative in their values. Which is perfectly fine, but you know whenever people, like, judge against you, or they impose their religious beliefs or cultural beliefs on you or have kind of that judgment or discriminatory behavior, or even if it’s not behavior, like facial expressions or attitude, then it makes you wish you were somewhere else. People’s cookie cutter, their cookie cutter beliefs and their conservative values.

The conservative attitude that this respondent described is similar to the elements of the white racial frame. Imposing religious or cultural values on other people, believing that what one does or believes in is superior to what others believe in, and engaging in discriminatory behavior or displaying an attitude toward others as a result of that mindset are the typical examples of acting out of the white racial frame. Many whites watch Fox News and other reactionary media that intentionally make Iran and some other Middle Eastern countries into a big threat and enemy—that is, the aggressive white negative framing of Iran.

## **Language and Accent**

This study further found that the MEA population experienced racial discrimination by health care providers based on their language and accent. Their experiences ranged from a negative attitude of the health care providers to a lack of pain management. Negative reactions from white physicians and nurses to accent and names are part of the pro-white sub-frame of the white racial frame. Part of the white racial frame is middle-class white standards for the media accent. The media accent is the white middle-class Midwestern accent. From a linguistic perspective, everybody speaks English with an accent. Some of the respondents believed that not speaking English with the standard American accent resulted in discrimination in a health care setting.

According to Ingram (2009), Americans are less likely to directly discriminate against others based on race, nationality, or social class, while discrimination based on language seems to be “fair game.” This is similar to the argument of Feagin (2010) regarding the blatant discrimination toward race being less visible in the front stage. The argument is that today’s form of racism has changed from blatant racism to more subtle form. Whites tend to hide their negative emotions in the front stage when strangers or minorities are present but act differently in front of other whites (in the backstage). However, as Ingram explained, the discrimination toward accent happens all the time in the front stage with no efforts to hide it. Ingram (2009) supports his arguments by discussing how millions of Americans who are foreign born, speak English with a foreign accent, and in some cases have funny-sounding names continue to be conspicuously under-represented and in most cases unrepresented in positions of high

authority. Ingram also discussed how not all accents are considered negative, for example, French and Australian accents are considered positive by many. It is unfortunate that while white Americans perceive someone with a French or British accent as “cute,” a Hispanic or Asian or Middle Eastern accent is looked down upon (Holmes 1992). Because there is less negative stigma associated with European accents, the courts do not contain records of native speakers of Dutch or Swedish experiencing job discrimination because of their communication difficulties (Lippi-Green 1997). However, the so-called low-status accents are the worst victims of accent discrimination. According to Ryan et al., in this country, one’s ability is often judged on the basis of how well one speaks English. Unintelligence is associated with those who speak English with a heavy accent (as cited in Ingram 2009).

The negative attitude toward the accent may vary based on the accent of the patient and his or her racial identification. This means that a person of color enters a space that is dominated by the pro-white frame, these people (of color) would speak with a different accent, depending on their origin. For instance, a person who speaks English with a New York dialect may not receive the negative looks that a person from another country would receive. Reactions to accent and name that are not familiar are a product of the white racial frame. The white racial frame, which has a pro-white sub-frame, assumes the whites’ ways of living as normal and anything different than that as abnormal. The white racial frame assumes certain types of names and accents to be normal. All of these are connected to the anti-MEA sub-frame that includes negativity toward Middle Eastern Americans. To have a better understanding of discrimination

toward language and accent, the next few paragraphs will provide examples to explain this concept briefly.

Some respondents believed that speaking English with a different accent or not speaking English fluently might add to the difficulty of patient and health care provider communications. An Iranian respondent said:

Definitely. Definitely, because the way you first go and sign in and everything, you know, when you can communicate with them with their own accents I can see that their impression is totally different.

The respondent explained that the impression of the health care provider could be different based on the patient's accent. She believed that a positive impression is associated with speaking in a standard American accent. It might be that the standard American accent is proof of virtuous whiteness. This means that the white person has no ongoing interrogation of what might be lacking or morally imperfect in oneself and one's community with regard to issues of race (Feagin 2010).

Another respondent talked about her negative feelings after she saw that people would not attempt to pronounce her name and would just call her "hey."

I get used to that. Because even they cannot pronounce it and sometimes they just want to call me, hey, that's it. I wish that they could pronounce my name because I like that but I'm fine, I accept this.

The respondent has accepted the fact that her name might be difficult to pronounce but it seems that she secretly wishes for people to try saying it anyway, instead of using "hey" to call her.

A second-generation Iranian said the following regarding people's reaction to her mother's accent:

She [her mom] also has really light skin and light hair, like me like light brown with highlights and stuff. So I think people might be a little shocked when she has an accent just because she might—she doesn't look as Iranian as some other people.

This example is similar to one of the vignettes in the interview questions in which a light skin and hair Middle Easterner would receive a negative reaction when he starts speaking to the health care provider as if he was expected to speak English with no foreign accent. The light skin and hair color is the normal look for the white Americans (certainly far from the stereotype of Middle Eastern Americans) so they would assume that a person with a similar look would speak English in a standard American accent. However, as soon as this group of Middle Eastern Americans starts to speak, then they receive a negative reaction. In addition to accent, the white racial frame creates a false image of the MEA that they all have dark-colored skin or hair while many, for instance, MEA from Turkey or Iran, have very bright skin color and hair. The reason for this explanation is to show how this frame can be far from the reality of the characteristics or lives of Middle Eastern Americans.

As the data present, Middle Eastern American women face discrimination based on their foreign accent, language skills, and different names. As mentioned earlier, the literature argues that the negativity toward accent is not toward every accent. A person with a Hispanic accent would receive more discrimination compared to a person with a German accent. It is the same case for a Middle Eastern accent as there are no positive affiliations with the racial identification of this group to receive a positive response toward their accent. The positive affiliation, or at least not a negative one, is related to the racial identification. As the research showed, those from European countries who are

considered white may receive a positive reaction to their accent, as funny or cute, but those from other countries have to deal with the negative reactions of whites to their accent, which may be even easier to understand than an accent of someone from France or Germany, suggesting that the discrimination that Middle Eastern Americans experience is greater than some other immigrants in the United States.

### **Immigration**

In this study, the time of immigrating to the United States, the country of origin, and ties to cultural values of the home country were also found to affect the degree of racial discrimination. It seems that the experience of discrimination is thoroughly different for first- and second-generation immigrants.

### **Comparison Point**

The two generations' comparison points could explain one reason for this difference in experiencing discrimination. First-generation immigrants tend to compare their life experiences (including the use of health care services) with those in their home country. In comparing the U.S. health care system with the health care system in Middle Eastern countries, one would certainly find many differences. The major difference between the two would be in organization. The U.S. health care system is certainly more structured and organized than in many Middle Eastern countries. For instance, the medical records are easy to find and accessible. For these reasons, some of the respondents believed that the U.S. health care system is organized and the doctors are respectful and there are no signs of racial discrimination toward Middle Eastern Americans. Through this comparison, issues such as racial discrimination may seem

minor and insignificant. This means that the participants who had a more negative experience in their home country were more likely to mention positive things about the U.S. health care system than those who emigrated from more developed countries.

The country of origin, as a result, made a difference in how the respondents viewed discrimination. For instance, respondents from countries involved with war and conflict reported a more positive experience of using U.S. health care services, compared with respondents from countries that have stable and more developed infrastructure. An Iraqi respondent told me the following:

Actually, I am lucky to come to the United States. Maybe I have my own reason, my husband like when we came here after one year he start to have some problem in his back and in his movement. He went to many doctors to see how they can treat him, then after that they find—they diagnosed him with MS, multiple sclerosis, if you know.

A Pakistani respondent who did not report experiencing any discrimination said this at the end of the interview: “We have had a better life here [in the U.S.] than we had over there [in Pakistan].”

On the other hand, when it comes to the health care system, new immigrants are certainly concerned about more life-changing issues such as access to health care and insurance (Ku and Matani 2001). For this group, the experience of racism in the health care system might be in the bottom of their priorities. As Maslow (1943) described, people are motivated to achieve certain needs. When one need is fulfilled, a person seeks to fulfill the next need, and so on. At the bottom of his pyramid, he listed physiological needs such as food, water, sleep, and so on. The next set of needs is safety, love, self-esteem, and self-actualization. One must satisfy lower levels of basic needs before



progressing on to meet higher levels and the associated needs. Once these needs have been reasonably satisfied, one may be able to reach the highest level, called self-actualization. We can argue that being offended by the negative experiences including discrimination requires individuals to pass the first levels of satisfying their basic needs. Based on Maslow's Hierarchy of Needs, those immigrants who have recently migrated to the United States are more likely to be concerned about their essential needs than the experience of discrimination. When asked if she wished she were a white American, an Egyptian respondent said:

No, I just wish I have insurance, that's the wish I have—that's the only wish. Don't care about being treated right.

This respondent's sentiments are a great example of how a relatively new immigrant is more concerned about her physiological needs and safety (e.g., health insurance) than about her self-actualization needs (being treated right.)

Another argument about the effect of immigration on comprehending discrimination is that the longer immigrants reside in the United States, the more likely they are to comprehend external treatment as racially discriminatory. Also, they are more likely to understand the anti-racist counter-frame of other people of color. Immigrants often arrive without an understanding of how U.S. racism works. Often, they come from places where discrimination exists, but it may be based on other social group memberships, like between ethnic groups, or with respect to gender or religion. With acculturation or assimilation in the United States, immigrants of color are more likely to observe and understand their experiences as racism and see that they are becoming racial beings with time. Such experiences are more recognized among the second generation,

that is, they notice racial discrimination more than their immigrant, i.e., first-generation, parents. The reason might be that first-generation immigrants do not know what the “norm” is to compare to. They compare what they see with their experiences of their home country. According to Chou and Feagin (2008), interviews with Asian Americans found that most had an underdeveloped anti-racist counter-frame. This means that the experience of Middle Eastern Americans, as an immigrant group, with shorter histories and learning experiences, can be similar to those of Asian American immigrants. These new immigrants are not able to identify the elements of the white racial frame including stereotypes, images, narratives, and others, including the positive elements mostly related to whites through the pro-white sub-frame or the negative elements related to Middle Eastern Americans through the anti-MEA frame.

### **First Generation vs. Second Generation**

As mentioned earlier, the first-generation immigrants and second-generation immigrants frequently experience racial discrimination differently. Second-generation immigrants are more likely to notice little daily encounters that involve racial discrimination as opposed to first-generation immigrants. According to Gee et al. (2006), self-reported discrimination was strongest for African descendants, then Mexican Americans, and then other Latinos. These patterns may be explained by differences in how long a respondent has lived in the United States. Minority immigrants view discrimination differently than their U.S.-born counterparts and report more discrimination with increasing time in the United States. According to Viruell-Fuentes (2011), the simple meaning of acculturation in our mind is learning the new ways of

life. However, in reality, the processes in which immigrants and their descendants become American involve more than changes in norms and behaviors. Rather, these processes include learning about social dynamics of U.S. society and knowing one's social status. Viruell-Fuentes interviewed first- and second-generation Mexican women about their experiences with discrimination. The women's narratives pointed to discrimination as a way they learned about their status within the U.S. racial hierarchy. The two generations differed in their experiences in that the second generation reported "frequent and clear encounters" (Viruell-Fuentes 2011:530), while the first generation reported fewer. Also, the second-generation women grew up with the tacit knowledge that they were different.

A second-generation Iranian respondent said the following about understanding racial discrimination:

I have seen that. Like even if it's not verbally that they express some type of discrimination, sometimes when they look at your name and you know—you can tell by the communication of their body language, even like facial expressions, like they look at it.

This respondent's understanding of racial discrimination, as noted, is not limited to verbal interaction, but she even noticed the looks of the health care providers when they saw her name.

A study by Goto, Gee, and Takeuchi (2002) of a Chinese American community showed that retention of cultural practices and age of immigration were associated with racial discrimination. The argument made by Goto et al. was that first-generation immigrants were more likely to practice their cultural practices, which meant that they had fewer contacts with people from other countries or Americans. In this way, lower

acculturation (i.e., practicing U.S. culture) resulted in fewer experiences of discrimination. The more-acculturated Chinese Americans were more likely to report experiencing unfair treatment. In the case of this research study, those respondents who had people of their country as their social network were less likely to report discrimination, as they had fewer interactions with the outsiders.

My conversation with a respondent from Jordan, who did not report any negative incidences with health care providers, showed elements of this reality. She said this about her social network:

Respondent: We have friends from Middle East; we don't have a lot of American friends, no.

Interviewer: Okay, how about friends from your own country; do you choose friends?

Respondent: Yeah, we do have. We have several families [Jordanian] that we know.

A more extreme example of this would be my attempt to interview a woman from Libya. I say attempt because I went to the woman's house and I took out my recorder to record her voice, but she did not give me permission. In addition to covering her body, she also covered her face, and the only visible part of her body was her eyes. I, myself, never had an encounter with anyone as religious as she was. On my way to the interview, I was nervous about the questions and her reaction. I had failed to consider that she may not allow me to record her voice due to religious beliefs. Some very strict Muslims believe that unknown men should not hear women's voices. Nevertheless, I asked her if I could write down some notes as we were having our cup of coffee and she agreed. She barely spoke English but could understand me well. When I asked her about

her social network, she said only people from her country or other Middle Easterners, only those who know Arabic. Then I asked if she has ever experienced any discrimination especially due to her unusual clothing, and she said, “No, not at all.” I was surprised by her answer but thought about the possibility that practicing her own culture in extreme ways (arguing that the type of clothing is based on the culture of the country) orients her perspective in another direction and she may not “see” the possible discrimination toward her. This might be due to the restricted social interactions of this respondent so she would encounter fewer people who might discriminate against her.

Recent immigrants to the United States are more likely to be subject to discrimination because of their foreign status. However, they are less likely to detect this discrimination because they attribute it to their recent immigrant status such as speaking with an accent, clothing, and so on, rather than their religion (Awad 2010). Gee et al. (2006) argued that first-generation or new immigrants might use their unfamiliarity with U.S. culture as an explanation for discrimination. Second-generation Muslim MEA, instead, hold the expectation that they should not be discriminated against and are more aware of the dynamics of discrimination. As a result, they may report the discrimination more often than others.

In this study, the second-generation MEA were able to point to incidences of racial discrimination in settings other than health care (discrimination in other settings will be fully discussed in an upcoming chapter). The reason that they did not mention as many incidences for health care services as they did for other settings may be attributed to their age. Second-generation MEA in this study were relatively young. Some were

completing their undergraduate studies, and some were in their early 30s. It might be that the younger the people are, the less likely they are to use health care services. For instance, according to the U.S. Census Bureau (2012), in 2009, adults over 44 years old were 6 percent more likely to have 4-9 visits a year compared to adults aged 18 to 44 years. Therefore, the number of visits increases as individuals age. Their fewer encounters with health care services caused them to report less racism in this setting compared to other settings, such as school, where they reported racism more frequently.

One's time since immigration to a country can make a difference in the experiences and in the learning of the meanings behind people's actions and words. This difference has two important aspects. First, recent immigrants make comparisons to their home country and may view the provided service as better than the one that they received in their home country, ignoring issues such as racial discrimination. Second, those who have resided in the United States for a longer period are more likely to know of the dynamics of discrimination and what "normal" (defined as behavior of individuals toward a white person) behavior should look like. Third, the country of origin can make a difference in the attitude of health care providers, as discussed previously.

### **Mainstream Mass Media**

The term *mainstream mass media* indicates a variety of media sources designed for circulating news and information to a large audience. There is no doubt that the media holds significant power to influence the perceptions of the general public concerning certain news or social issues (Muin 2011). In the United States, much of the mass media seems to feature Arab Americans and Muslims consistently in a negative

way. The portrayal of these negative images is the result of associating Islam with terrorism, violence, extremism, and hatred toward America (Lalami 2012; Saeed 2007). Anyone from the Middle East is usually associated with some sort of negative stereotype(s). In this study, one of the sections of the interview focused on the effect of media on the experience of discrimination. Not surprisingly, all of the respondents expressed their anger and dissatisfaction of the way that MEA are portrayed in media. All of the 30 respondents believed that media shows an extremely undesirable image of Middle Eastern people and Islam. According to Smith (2013), followers of Islam are perceived to be misinterpreted and are often feared due in part to negative images of media. This has been the case both prior to and after 9/11. According to Mobasher (2012:51), Iranians rarely appear in media, but when they do, they are portrayed as “irrational, alien, terrifying, or barbaric people who threaten our national security.” Mobasher argued that the stereotypes of media become a justification for practicing prejudice against this population or other minorities. Feagin (2010:141) argued that media, along with family, political discourse, academia, and faith communities, reproduce the contemporary white racial frame, which is deeply imbedded in people’s minds and has many different sub-frames: “The white racial frame is so institutionalized that all major media outlets operate out of some version of it.” This means that the images, stereotypes, narratives, and all other elements of anti-Middle Eastern sub-frame that are formed through white racial framing circulate through the materials presented in media. Reviewing movies, songs, and TV shows can reveal the negativity of MEA being portrayed on regular basis. The literature on the effect of media and discrimination of

MEA is extensive. However, for the purpose of this research study, the focus is only on respondents' accounts that relate to the effect of media. It is worth considering that some of the mainstream mass media are much worse at demonizing and caricaturing Middle Eastern people (for instance, Fox News). In the area where this study was conducted, Brazos County, Texas, white Texans and other white southerners are more likely to watch the racist Fox News network than whites in the North or West.

Some of the respondents believed that negative stereotypes in the media greatly affected the attitude of health care providers. One young Turkish respondent said:

Because of the media, probably they [health care providers] have some bias to this kind of people [Middle Eastern People]. They may think, like, because of their religion or their governments, the woman had to cover, the women are like, second place persons, something like that. They may think, "Oh, they are poor, they live in desert. They travel with camels." They may have something in their mind...because media is too much dealing with Middle Eastern people, showing them, like, in war or something. Their places are not, like, safe to travel. They don't have any money. They don't have anything. Something like that they are thinking. Or even in the cartoon I saw. There was an alarm in a cartoon, and you know the morning alarm to wake you up? And it was, like, saying Allaho Akbar [God is Great in Arabic] and then bombing. Even for the small children, they just like, inject this, this kind of behaviors to the unconscious. Like, involuntarily they will learn it, and when they grow up, probably they will not like Middle Eastern people. It will have negative effects in their minds.

This respondent shared some of the common stereotypes about Middle Eastern people and their countries. The stereotypes include viewing MEA as poor or their countries as places where people have primitive lives. For example, many Americans think that people in Middle Eastern countries use camels as a primary means of transportation. Also, due to the climate condition of the area, many Americans think that Middle Eastern people still live in the desert or do not have clean water. Furthermore, this respondent's perspective was that the media included negative images about



political and social situations of Middle Eastern countries on the programs that are made for children and the programs still would portray MEA as terrorists or dangerous.

Most respondents talked about the common stereotype of irrationality and about MEA. The media also portrays MEA as emotional people. One Iranian respondent explained how some of the media stereotypes related to MEA have shaped American perception over the years:

Like the way I think the media puts an image of Middle Eastern, so the American, they can easily get some kind of picture from the people there that they're very, very emotional, they cannot control their emotion.

In this regard, Erickson and Al-Tamimi (2001) and Soheilian and Inman (2009) summarized the discrimination against Arab and Muslim people in the press and in the general media. It is a cutting negative stereotype, labeling Arabs as bloodthirsty, barbaric, hot-blooded, irrational, anti-Western, and dangerous terrorists, people who have no control over their emotions and who may become dangerous in times of anger and distress.

One Iranian respondent said this about her health care providers and how media may affect them:

I consider this probability that health care providers can be, their thinking might be affected by the media and by the broadcasting, and it happens every day that someone from Islam or Middle Eastern countries, they do something wrong, and we are all victims of something that someone else is doing. Even if they try not to show, but they're...I think in the back of their mind feel something, maybe just a fear or something that they try to treat you more carefully. Yeah. That's just a feeling. They don't tell anything or they don't react. At the worst case, they may not to become friend with you.

This respondent talked about the effect of negative news or images of MEA in the attitude of health care providers. She argued that it is true that health care providers

might not discriminate against their patients, but they have all those negative stereotypes about MEA in their minds. This is a direct reference back to the discussion earlier of the white racial frame and about how the elements of the white racial frame, including the anti-MEA sub-frame, can be reproduced through tools such as media and affect people's unconscious minds. Feagin (2010) argued that the messages in media that are in line with the typical elements of the white racial frame have a better chance of grabbing people's attention than other messages. For example, it is possible that a media story about terrorism and Middle Eastern people has a better chance of lasting a long time because it echoes the "terrorist Middle Eastern image" in the white racial frame, specifically the anti-MEA sub-frame.

One second-generation respondent said this about health care providers who ask her offensive questions:

I'll get the questions from health care providers—aren't you afraid when you go back? I get that question all the time, and I know why—it's the way media portrays it.

This respondent associated the negative image health care providers had of her country to the images being portrayed in media. Discussing the effect of media on those other than health care providers, one Egyptian respondent said:

Yeah, each time I was in MacDonald's and the news flash news, and now there's the ISIS and anything, they keep looking at me, yeah—that's happened a lot. But actually, if you watch any program, you will find that that's what they know, that's it. Like, less knowledge more than not respecting you—that's less knowledge.

This respondent blamed the media for the lack of knowledge Americans have about Middle Eastern Americans. She feels discomfort when people look at her after watching a program about the Middle East on television.

A research study by Naber (2000) reviewed the image of Arab Americans portrayed by media. There are several issues with the ways that this group has been portrayed in media. First of all, Arab Americans are a diverse community but are represented as one group in media images. Second, as mentioned earlier, they are racialized both as whites and as non-whites, meaning that they have been put in both categories. Also, they are usually racialized based on their religion and not their phenotype. So what media does is erase the difference between Middle Easterners, Arabs, and Muslims and create an imaginary hierarchical relationship between the superior white American and the inferior Arab-Middle Eastern-Muslim. Furthermore, the media is used to justify the U.S. intervention in Middle East affairs. The common stereotype for Arab-Middle Eastern, Muslim men is an irrationally violent one, particularly toward women, and the one for Arab-Middle Eastern Muslim women is a supra-oppressed group of women in comparison to white American women, who are representative of justice and equality. An extensive list of the programs that portray these negative stereotypes was provided by the study of Naber (2000). Erickson and Al-Tamimi (2001) and Soheilian and Inman (2009) argued that Islam is denounced as oppressive, fundamentalist, violent, fanatical, close-minded, and a great deal more. As with all stereotypes, small pieces of traditions, religious doctrine, and other experiences are taken out of context and pieced together as labels that aggravate the suspicions that

already exist between each party. For example, an Aladdin movie set in an Arab kingdom will portray the good people speaking English with a common American accent and the bad people speaking English with an Arabic accent (Lippi-Green 1997). The example about accent in this research study is evidence for what the current project has been establishing about the white racial frame and accent. The media associates the negativity with the Arabic accent and good and moral with the American accent.

One of the respondents associated media with the U.S. government. She blamed the system that allows immigrants from the Middle East to immigrate to the United States but at the same time promotes programs on media that portrays negative images of this population (referring to systemic racism):

I mean, if people, for example, health care providers, don't like internationals, they shouldn't let internationals to come here to work or to study or to do anything. If they are not ready for them, for the different culture, and they don't really like it, then they shouldn't take anybody from different countries. If they are taking the people, they have to give them some respect and safety.

She argued that it is responsibility of the government to protect people from harassment and disrespect. She was able to see that the discrimination has its root in the system and not the people.

To summarize, it is worth noting that the images that are being portrayed through the media are tools for the reproduction of the white racial frame. A majority of Americans live in regions without large Middle Eastern communities. Due to this fact, many citizens only ever interact with this minority group through the media (Iqbal 2010). This is problematic because, as the literature and the personal accounts show, the media's representation of Middle Eastern Americans reflects the constant struggle of

good versus evil. It also associates them with terrorism and Islamic extremists. If health care providers also receive their information about this minority through the use of media (which is very possible), then their interactions can certainly be affected by the negativity of these media messages.

### **Summary**

This chapter explained the effect of self-identity on one's experience of discrimination in the health care setting. Those respondents who identified themselves by their national origin were more likely to experience discrimination. In cases where respondents were not sure if they should still identify themselves with their national origin they were less likely to report discrimination. It might be explained that the second group, as well as whites, think through the white racial frame as well and might be unable to recognize the incidents of discrimination as clear. Those from the countries less associated with the usual image of terrorism are more likely to be treated as non-Middle Eastern. All of the respondents said if they have to choose they would identify themselves with their national origin than saying Middle Eastern. Except for one respondent from Saudi Arabia who said she would say she is from Middle East, all the others avoided using the term Middle Eastern to separate their identity from the negativity that exists toward this term. Also, some of the respondents reported discrimination following revealing their national identity to the health care providers. Some from countries such as Iraq that is involved with war would get questions from the health care providers but not a negative reaction. Likewise, respondents reported discrimination based on their language skills and accent.

In addition, this chapter showed that immigration affects discrimination experiences in that first- and second-generation immigrants perceive and react differently to discriminative actions. Second-generation immigrants are more likely to report discrimination. Finally, this chapter examined the effect of mass media on discrimination, showing that it has a great influence, particularly since 9/11. The next chapter examines discrimination of MEA in settings other than health care.

## **CHAPTER VII**

### **COPING STRATEGIES**

The chapter on the experiences of racial discrimination by Middle Eastern women in health care focused on the connections to systemic racism and one of its major elements, called white racial frame. The personal accounts of respondents focusing on different parts of the white racial frame and how the minds of whites operate out of this frame on a daily basis were analyzed. This chapter examines how Middle Eastern American women deal with the racial discrimination of health care providers and find similarities and differences between their coping strategies and other minorities. Two major frameworks are used to explain these coping strategies. First is the framework that Villegas-Gold and Yoo (2014) used to identify the different coping strategies employed by Mexican Americans in response to racism. In addition, the theory of systemic racism—and its concept of counter-frame that Americans of color have developed as a way of resisting racial discrimination—is used to examine ways of resisting daily encounters with racism. Feagin (2010) argued that using counter-frames to oppose the dominant racial frame has helped racial minorities resist oppression. These frames have borrowed their elements from the cultural backgrounds of those in the group and from the frame of liberty and justice claimed by whites.

Some of the respondents of this study engaged in coping strategies that showed elements of their home culture. All people of color have a home-culture frame, which often has at least passive-resistance tactics in it, such as insisting on using their own

language or dress in spite of white barriers. The more-aggressive anti-racist counter-frame usually builds on the implicit or passive resistance of the indigenous home-culture frame.

Using their network, relying on their community, and remaining true to their religious background are some of the components of home culture. However, many of the respondents believed that resistance to systemic racism is not an easy task to engage in. They believed that change in the perception of health care providers toward minority patients cannot be changed through resistance but is instead a rather complicated process. As for comparing the different minority groups, while some Middle Eastern Americans' coping strategies were similar to those of African Americans, in some cases, MEA used a resistance strategy out of the home-culture frame. This is similar to the experience of Asian Americans, who did not resist discrimination as often as they experienced it (Chou and Feagin 2008). Few of the respondents directly confronted the situation, while many stayed quiet. Some resisted the discrimination by wearing their different clothing, which is again using an element of home culture. Because confrontation is not an easy task to engage in, some of the respondents adapted some of the elements of the white racial frame to cope with the encounters of racism.

Race scholars have defined coping strategies in many different ways. The major and common element of all the definitions is the response of an individual under a stressful situation. Lazarus and Folkman (1984) defined coping as a cognitive or behavioral response used to manage or tolerate stressors. In their definition, coping is a mediator between a stressor and the outcome of experiencing the stressor. Before



learning about the different coping strategies used by the MEA population, it is important to discuss the critical function of coping strategies. For instance, Moradi and Hasan (2004) argued that discrimination events against MEA cause psychological distress and lower mental health for this group. They found that perceived discrimination was related to lower levels of perceived control over one's life, and lower perceived control in turn was related to lower self-esteem and greater psychological distress for this group. They suggested strategies for personal and collective action against discrimination might prevent the discrimination from causing such distress in the first place. Basically, Moradi and Hasan suggested a reasonable coping strategy that can prevent psychological and physical costs of racism. The type of coping strategies used varies from one person to another, meaning that individuals cope with the stress associated with racial discrimination in various ways, from confronting the discrimination to minimizing or even avoiding the discrimination (Miller and Kaiser 2001). According to Villegas-Gold and Yoo (2014), racial minorities choose engagement coping or disengagement coping in response to racial discrimination. The details of each type are provided in different sections of this chapter. In general, more respondents chose coping strategies that are not confrontational to white racism, arguing that confrontation either does not change the situation or could make things worse. Only a few reported confronting the white discrimination.

### **Disengagement Coping**

Disengagement coping is defined as an attempt to either remove stressors or orient mentally, emotionally, and physically away from stressors; some of these coping

mechanisms include problem avoidance, self-criticism, wishful thinking, and social withdrawal (Tobin et al. 1989). In the interviews, the respondents indicated that disengagement coping was clearly practiced more than the other forms of coping.

### **Problem Avoidance**

Some respondents reported that avoiding the problem (i.e., no confrontation) was their coping strategy. One common way of disengagement coping is avoiding the situation or denying discrimination. It can mean just walking away from the problem, perhaps because first-generation MEA have difficulty confronting in a second language. In addition, as systemic racism fully explains, Middle Eastern Americans, similar to other Americans of color, are aware of their inferior position in the U.S. racial hierarchy, and confronting whites is frightening to them. As a result, the denial of discrimination seems like an easier coping strategy than confronting white racism. Below are some personal accounts that reflect this avoidance.

One confident respondent from Saudi Arabia, who covers her hair, explained her coping strategy in response to racism:

What they see in the media is just negative, negative, negative, then I wouldn't blame them, but I would just be positive. If the doctor asked, then I would answer, but I wouldn't just confront or do anything like that, no.

This respondent did not blame the health care provider but the system that encourages negativity toward Middle Eastern people. She knew that white racism is a reproduction of a negative image through the media, and, as a result, people receive those messages on a daily basis and act negatively. Her official response was that she does not want to engage in a conversation and prefers to stay quiet if the physician makes a negative

comment. However, in reality, the same respondent acted differently when she was faced with an incident of discrimination toward her daughter. It might be that Middle Eastern women may not confront the situation if it is toward them but will make sure that they protect their children. The example of her confrontation is provided in the next section.

One Lebanese respondent believed that staying quiet (or disengaged, as Villegas-Gold and Yoo [2014] described) makes people more prone to the experience of discrimination in health care settings. She provided an example of her sister in-law and how her passivity has increased her chance of receiving low quality treatment at health care settings:

My sister in-law, she has some anxiety issues, so she goes to the urgent care with fast heartbeat or something, she's really scared, she basically needs more reassurances from health care providers. Most of the time when she talks to them and they hear her accent, the answer is take this medicine; we cannot do anything about it. And if she insists they say okay, we'll give you an appointment with a specialist, but it's twenty days or fifteen days down the road...I think the situation gets worse when the person gets intimidated. So if I start asking questions as of why things are being handled like this, things change. But if the person is shy to say like, like this case saying, then the situation gets worse.

Being shy, not asking why things are being handled a certain way, and feeling intimidated by the attitude of health care providers are some disengaging coping strategies that can have a reverse effect on individuals' health status. The above respondent talked about the social withdrawal after the experience of discrimination. In most cases, except for cases of pain management, when respondents talked about discrimination or coping strategies, they mentioned that the act of discrimination did not have a negative effect on their overall treatment. In the above account, the respondent talks about the experience of her sister in-law, who did not receive adequate care due to

her accent. Since the health care providers act out of the white racial frame, they act negatively when they hear her accent. The white racial frame has a pro-white sub-frame in its center that assumes that the white worldview is the “natural” order of society and that people of color should assimilate into it (Feagin 2010). Those who are out of that normal order will experience racial discrimination. In this case, although the sister-in-law of the respondent experiences discrimination because of her accent, she is too frightened to resist this white racial frame and does not question the low quality of her care.

One second-generation Iranian relied on avoiding the problem when facing discrimination:

I just let it pass...I just think it's another human, that, of course, they're not God, they don't know everything and they just tried to click with me. Maybe there was something they tried to connect with me and they weren't—just didn't know how or something—and they just said something that wasn't right, but they tried. So I just take it as a positive thing...It has to be something that—a motivation from within that person to want to make any type of behavioral change.

This respondent also engaged in wishful thinking by reframing the action of the health care provider as “maybe there was something they tried to connect with me just didn't know how or something.” Cognitive strategies that include denying that an event has occurred, reframing, or symbolically altering the situation is called wishful thinking (Villegas-Gold and Yoo 2014). She also argued that the change has to come from the inside and her resistance to discrimination is not enough to change that health care provider. Her argument was that if she complains, the only thing that might change is that the health care provider avoids acting racist to her face but will still be the same behind her back. The deframing of the white racial frame requires the conscious

participation of whites in criticizing the existing white racial frame (Feagin 2010). In that sense, the respondent might be right in arguing that her resistance is not going to make the white provider's attitude change.

### **Wishful Thinking**

Wishful thinking, according to Villegas-Gold and Yoo (2014), refers to cognitive strategies that include denying that an event has occurred, reframing, or symbolically altering the situation. Some of the respondents chose to believe that they do not experience racial discrimination, which matches with the definition of wishful thinking. Those respondents simply said no when asked if they could report racial discrimination. This wishful-thinking coping strategy is again a kind of "rescuing" or "excusing" of whites. It illustrates the pervasiveness of systemic racism and is perhaps motivated by fear stemming from the fact that whites are positioned as superior in the white racial frame.

One Iraqi respondent ignored her feelings of discomfort, saying that she cannot trust her feelings when she experiences discrimination. She said:

Yeah, yeah sometimes you feel like someone don't like you, but you cannot trust your feeling.

According to Benkert and Peters (2005), who conducted a study on coping strategies of African American women in health care, African American women engage in a coping strategy called "learning to unlearn." One of the definitions of this strategy is to give the person the benefit of the doubt. This strategy is similar to wishful thinking in the sense that the minority person denies the reality and thinks positively about the

situation. In this case, the respondent can feel the negative vibe from the health care provider, but she does not want to believe her feelings.

### **Self-Criticism**

One common coping strategy for this group was relating the negative experiences to her lack of understanding of American culture. As mentioned previously, one middle-aged Pakistani respondent, who runs a business as a hairdresser at home and does not cover her hair, blamed herself after the physician acted very negatively toward her accent. She noted:

So I think it's my fault. It is, and I blame myself, yes. Still I am living here for such a long time and I couldn't speak well.

Although this respondent did not show any signs of difficulty with the language while doing the interview, she experienced discrimination based on her accent. The physician, acting out of the white racial frame, believed that the standard English spoken by most people is normal, and anything different from that is not. He reacted very negatively toward the patient, as discussed earlier, and caused her to blame herself. As part of practicing white racial framing, he had a negative stereotype toward MEA and their accent, which is a part of the anti-MEA sub-frame. The respondent wished that after so many years she could speak English with no accent in order to protect herself from experiencing discrimination. Gee et al. (2006) explained that new immigrants may be able to protect against the mental health effects of discrimination by arguing that their negative experiences are the result of their unfamiliarity with U.S. culture, rather than their racial background.

One respondent from Kuwait, who participated in a PhD program in a difficult field of study, blamed herself and other MEA for experiencing discrimination:

I think Middle Eastern people who move to the U.S. and decide to live here they leave behind a lot of like traditions and a lot of not only traditions from their countries but also religious restrictions things they need to follow. If you are called a Muslim, you need to like—there are many things you need to practice, you need to do. They don't do them. So when other people live with them and then they like see someone like me they don't expect these restrictions because other people left them, you know? Like I don't shake hands with a man all the time.

She argued that the reason for discrimination against Middle Eastern Americans is not their religion; it is white Americans' unfamiliarity with their religion or culture.

However, she believed that it is MEA's fault that Americans do not know enough about Muslims or the Middle East. This respondent failed to see that the lack of whites' cultural and religious understanding of minorities (in this case MEA) is not merely due to lack of information but to the belief that people of color should accommodate and assimilate to the white-dominated society. She blamed too much assimilation of some groups of Middle Eastern Americans for the discrimination against those who practice their religion or culture. The respondent was unaware of the system that makes it easy for whites and even other minorities to discriminate against Middle Eastern Americans. It is true that having enough information about someone else's culture can reduce racial discrimination but, as systemic racism discusses, the common white racial frame that most whites use needs complete deframing and reframing to eliminate the problem.

One Iranian respondent was regretful that she did not take any action against the physician who racially discriminated against her when she had just moved to the United States:

The other problem is that I didn't do something. It happened to me three years ago and at that time I didn't have the confidence that now I have because if something like this happened now I may go to court and may sue that guy just because he's wrong. He doesn't have to continue doing this to others.

The physician and his clinical staff had an extremely negative attitude toward this patient, who ended up suffering a serious infection following the procedure of the doctor. They claimed that it was not their fault and she could "do whatever she wants." The details of this racial incident are included in the chapter that discusses the physicians' racial discrimination. The respondent wished that she had engaged in a more confrontational coping strategy at the time of the incident. At the time, she lacked self-confidence, which could mean that she saw herself as culturally unaware of the U.S. health care system, and thus depended upon her disengagement coping, the practice that many immigrants choose in response to discrimination, to weather the incident. She was not confident enough to directly confront white discrimination because she feared that confrontation might make things worse. Chou and Feagin (2008) identified this quiet coping as a way of conforming to racial hierarchy, which is a part of systemic racism. Also, those who practice disengaging coping accept discriminatory behaviors as being the price one must pay in order to gain acceptance.

### **Engagement Coping**

#### **Racial Identity**

Another common coping strategy for combatting racism is identifying with one's own ethnic identity. Denying discriminatory comments or actions by thinking about one's ethnic identity helps some of the respondents cope with racism. This finding was similar to the study done by Marvasti and McKinney (2004) on Middle Eastern people.



They provided an example of an Iranian mother advising young Iranians to remember that deep down they know that they are not terrorists. Similarly, Hill Collins (2000) argued that resisting racism could be done internally as a rejection of the racist action and by believing in your positive self-definition. Although this type of coping is far from the organized ideology of counter-frame, it is similar in the way that it has elements of home culture, meaning the culture of the region or a group that they have grown up in. This strong identity is also typically part of the home-culture frame.

Quotes from the few respondents who used their ethnic identity as a coping strategy in facing discrimination follow below. One second-generation Iranian respondent said this after describing her experience of discrimination:

I learned that overall, like I said, I'm very strong in my identity, I don't know if that is the reason that I am, but I am very proud. I am very proud of where I come from.

She was thinking out loud as she was making these statements, asking herself if this is the reason that she can cope with discrimination. According to Mossakowski (2003), having a sense of ethnic pride, involvement in ethnic practices, and cultural commitment to an ethnic group may protect mental health. This study found that ethnic identity buffers the stress of racial discrimination, suggesting that ethnic identity is a coping resource for racial minorities. According to Al-Krenawi et al. (2009), increased perception of discrimination often causes Muslims, especially male Muslims, to increase their religiosity rather than submit to pressure. Rather than assimilate, some Arab American men decide instead to assert their traditional identities more resolutely; some

even counter-rebel and become more steeped in tradition than parents, who may have become more assimilated than their children.

One second-generation Iranian respondent, who was a junior in college, had parents who were more assimilated to the core white culture than she was. She said:

My mom tells me to tell people I'm American: "If someone asks you, you're American." I don't do that; it's who I am.

This respondent used ethnic identity to cope with the racism that she experienced in school at a younger age. She noted:

People ask me are you afraid when you go to Iran? They're all terrorists. Then I have to bring out all the pictures I have and say no, this isn't what you think. Iran is one of the most peaceful Middle Eastern countries, if you compare it to the countries surrounding it. You don't see random car bombings going off there. I have to show people.

This respondent was using the picture of her home country to create some kind of positive self-definition. Many scholars have discussed developing a sense of ethnic identity as a common coping strategy. During this process, some attempt to fight the negative images associated with their racial identity. The pictures are the way this respondent fought against the common stereotypes of the anti-MEA frame, which is a part of the white racial frame. The anti-MEA frame, reproduced through the media, has negative images of Middle Eastern people and their countries. One of those negative images is showing Middle Eastern countries as uninhabitable for living due to danger and instability. This is the negative image that this respondent tries to eliminate by showing pictures of her home country.

A positive sense of ethnic identity can resist negative meanings supplied by racial discrimination. According to systemic racism theory, this counter-frame has

helped minorities to better understand white oppression. According to Viruell-Fuentes (2011:46), the experience of discrimination causes immigrants to construct a sense of ethnic belonging: “In attempting to arrive to a positive sense of self, [immigrants] engage with and actively resist [the] negative meanings” ascribed to their group. One Kuwaiti respondent coped with the experience of direct racial discrimination, which happened at a toy store, by explaining that her ethnic identity is not similar to the terrorists from the Middle East and not far different from that of an American:

I’m just upset because if someone did something bad, that doesn’t mean that all the people of the same region are bad or have the same sort of ideas. Why making this so general that we are all the same and have the same terrorism thinking. The thing that I was with my kids and he was with his kids, what make our kids like violence than the other kids and why we have the thoughts? Why they thinking like this? We didn’t do anything. We came looking for toys, the same thing he was looking for.

As discussed in the literature review, one common negative meaning associated with being Middle Eastern is terrorism. This respondent criticized the stereotype that all Middle Eastern people are terrorists and attempted to explain that the majority of the people of that region do not believe in extreme acts such as terrorism. Terrorism is one of the common stereotypes of the anti-MEA frame that whites have used to discriminate against Middle Eastern Americans. The respondent was thinking out of a counter-frame that establishes ethnic minority and self-development in response to racism. She did this by showing that she and her kids are humans just like the white man and his kids who came to the toy store to buy some toys. Yoo and Lee (2005) found that a combination of a strong ethnic identity and engagement coping buffered the effects of racial discrimination.

## **Social Relations**

Villegas-Gold and Yoo (2014:405) defined expression of emotion as one engaging way of coping with racism: “Expression of emotion refers to the verbal and non-verbal communication of an internal emotional or affective state.” According to Lee and Ferraro (2009), social relations may be helpful for minorities in buffering against the adverse effects of discrimination. Being friends with other immigrants means that they can share their experience of migration and the settlement process. Noh and Kasper (2003) explained that through supportive relationships, ethnic minorities could not only obtain practical aids but also feel empathy and comfort by sharing their experiences. According to Chou and Feagin (2008), second-generation Asian Americans also use their social relations as their ultimate coping strategy, a way of using an element of their home culture. Their social group usually includes non-white and other Asian Americans who share the same experiences and feelings with them. Expressing their emotions through those social relations gives them relief from the anger and frustration that they experience following incidents of racial discrimination. As for this study, many of the respondents did not have any family members in the United States, but they were friends with people from their home country. For instance, for some of the newer immigrants, the few people they knew from their home country were their only social network. As a result, some of their friends were involved in the respondents’ coping process after the respondents experienced discrimination in the health care setting.

One respondent, who migrated from Iran five years ago, experienced discrimination at the doctor's office, but her only coping strategy involved sharing with her friends. She said:

Yeah. I couldn't do anything, just talking with friends and to stop going to that physician. So that's it, all I can do.

The respondent saw herself as unable to engage in any other coping strategy other than sharing her feelings within her network of friends. The same respondent described her network as being limited to Iranians and people from Middle East:

Definitely I see more Iranian and even people from other countries rather than Americans. I don't know. I think that we have more common things to share with like people from other countries in Middle East than Americans.

This example demonstrates that the respondent felt that she had more things in common with people from her home country and other Middle Eastern countries than Americans. She, therefore, shared the experience of discrimination with these friends because she thought they would understand the pain and distress that she experienced. Those friends could themselves be the victims of whites' discrimination, or even people of color who act out of the white racial frame, including both the pro-white sub-frame and anti-MEA sub-frame.

One example that supports social relations as a coping strategy against discrimination is marriage. For most ethnic identities, married couples usually cope better than singles when confronting the experience of discrimination. Married couples can encourage each other to engage in a better coping strategy. However, some ethnic minorities did not show the positive effect of marriage for coping with discrimination,

suggesting that there are differences in the process of coping depending on ethnic identity (Lee and Ferraro 2009).

The Sudan respondent, who, as mentioned in previous chapters, experienced a great deal of racial discrimination, encouraged her husband to engage in a better coping strategy. She herself believed in educating people (as will be noted later) as a coping strategy. She noted:

My husband is completely different. He just flips. He feels like [it is] too much insult if something happens, and I look at him and I have a conversation with him...He feels talking about it this way is an action and for me I don't believe in doing that. I still want to take care of that person but in a way, when you are angry and you talk something nobody will listen to you. Even when you have kids and you are angry with them, they won't listen to you. There is a chance to teach people. It doesn't have to be that time but it will be.

According to Lee and Ferraro (2009), a married couple can be a team to cope with discrimination. Married couples may share their experiences, feelings, and empathy. In this study, when a couple was faced with discrimination, partners emotionally supported each other by sharing the same feeling. One example is the racial incident for the Turkish woman and her American husband. The Turkish respondent said:

Yes, we had a very bad experience with pediatric cardiologist...and my husband hated him and I hated him, too.

Similarly, one Iranian respondent who experienced discrimination at the physician's office said:

I remember the feeling when my husband and I came out of the first doctor's office how frustrated and upset we were.

Sharing one's feelings with another person allows one to discredit the idea that the experience of discrimination was somehow related to personal flaws but instead was something that actually happened and would make anyone feel uncomfortable. Sharing may ease the process of knowing that racial discrimination is not an individual act of one person, but it originates from a system that reinforces and reproduces a white racial frame on daily basis. The Turkish couple, because of their shared animosity toward the physician, participated in another coping strategy by filing against the physician. The Turkish respondent said:

We complained about him and my husband and I in fact wrote a letter to one of those places that you need to write. I don't know which website, but you know. We complained about him to our physician too, to pediatrician.

This couple not only shared the negative feeling but also took action together. This reflects how married people are sometimes better equipped than singles to deal with racism.

### **Confrontation**

One common type of coping strategy that has always been used by people of color is confrontation. However, confronting racial discrimination in a health care setting might be difficult. First, patients may have to stay in the physician's office due to their urgent need to receive care. Further, the physician is in charge and has authority and power, which makes him or her different from a person who racially discriminates against people in a public place, such as a restaurant. As mentioned in the literature review, there is a great deal of literature focusing on the communication between physicians and patients and how there is often a gap in communication. Considering

both the experience of Americans of color and the conditions of the health care setting is important when discussing the issue of confrontation. The confrontation process, in this case, begins with controlling or suppressing negative emotions that follow racial discrimination. It is only after controlling or disconnecting their emotions (for example, anger) that the respondents can engage in actual confrontation.

Many respondents explained that they would confront the racial incidents. The ways of confronting the situation, however, can be different from one person to another. According to Villegas-Gold and Yoo (2014), one of the ways of engagement coping is problem solving. The problem solving refers to behavioral and cognitive strategies designed to eliminate the source of stress by changing the situation. For this study, changing the situation involved filing racial complaints with authorities or trying to educate the health care provider (or other people if the incident happened in another setting).

Some of the respondents filed racial complaints against their health care providers. For instance, one young Turkish respondent said:

I was really angry. I was very angry . . . I reacted to it. I tried to explain to him that I do know about dental system but I mean I didn't confront him about racism because it was useless at that point basically. I told him I don't want the treatment. I'll contact him later. I just left. And then I just asked for my dentist to be changed. [I complained] To the network—dental network—because they assign you to them. So I told them what happened and I told them I don't want to be with that dentist any more. I want a new dentist. But it's not like I wrote a letter and submitted it. But they changed the dentist immediately.

This respondent experienced a great deal of negative emotion after the encounter with the white male dentist. She could not directly confront him about racism but wanted things to change. It is true that she left his office without saying anything except to



refuse the procedure, and acting angry and frustrated was her way of telling him that his comments were not appropriate. Also, she took immediate action by complaining to the network and changing dentists.

The same respondent, however, when asked what she thought of what happened, denied labeling it as racism:

But when I heard that he did all this stuff to other people too, I was like okay, just a stupid doctor. You know, just a stupid person. Just—he's going to probably lose all his patients, probably.

When asked if she thought the same doctor would do such things to Americans too, she replied:

I do not know. I think that doctor just cared about money and nothing else. But of course he's not gonna—I don't know, maybe he can be racist to non-white Americans. I'm not sure. But I know with international students he had this looking down on people attitude. And it wasn't only me. And I've never really seen anybody like that before him, really, I don't remember.

In the beginning of the previous quote, the respondent used a disengaging coping strategy, saying that the physician was not racist by saying, “[he] just cared about money” or he was “just a stupid doctor,” but then she explained, “with international students he had this looking down on people attitude.” This attitude of looking down on international people is certainly not an action of someone who is after money or is unintelligent. Instead, it is a characteristic of doctors who act out of the white frame. That doctor, like many others, assumed that the way whites talk, dress, and behave is normal and anything out of that range is not. People with this attitude have negative reactions to anything out of the ordinary, and that negative reaction is what makes every international person who goes to that doctor's office uncomfortable. Although this

respondent did not label the incident racism, it is certainly considered racial discrimination (the physician made a comment about doing things “right” and different in the United States).

For some respondents, coping with racism in a confrontational way meant writing a negative review of the physician and his clinical staff. This type of confrontation is associated with less fear of repercussion, since the reviewer can stay anonymous, but still affects the physician’s reputation and career.

One Egyptian respondent wrote a negative review for the physician who had asked her to take off her head cover:

Actually, for the doctor in Dallas I give him very bad review. I wrote a review about the clinic, about this, I didn’t feel comfortable and he didn’t accept my hijab. I feel sometimes the higher positions have more professionalism to treat.

This respondent coped with the incident of racism by taking action against the physician and writing a review about him and the clinic. She thought his comment was far from professional. She had a hope that those in higher positions at his health care services might have more concern about professionalism. Her use of terminology was interesting. She knew that the U.S. society in general is a white-dominated society and there are many people that may engage in racial discrimination of minorities. However, she believed that the health care system might be an exception in that there might be a bit more professionalism there that prevents people from engaging in racial discrimination as often. This is what Feagin (2010) argued as being an example of front- and backstage. He explained that whites have an easier time engaging in racist comments or actions while they are backstage (behind the scenes) because they have to be politically correct

and socially desirable when front stage. Whites know not to engage in negative stereotyping in front-stage interaction settings such as health care that include white strangers or people of color. Instead, whites engage in negative stereotyping only in backstage settings that are all white and where there will be no objection to the performance.

One second-generation Iranian explained that educating people was her way of coping with racism:

It makes me mad just because the Middle East is affiliated with terrorism, it doesn't mean that everyone there is a terrorist or it's bad. So I do get mad when things like that happen. Sometimes like if you catch me on an off day I'll say something back, but then sometimes I just kind of look at them, like why did you just say that?

This respondent explained different issues. Her first point was that the negative stereotype associated with the Middle East originated from the anti-MEA frame out of the white racial frame. Also, she explained that on an off day she would confront the situation and would say something back, implying that in those cases she cannot suppress her emotions anymore and must engage in confrontational coping. It could be that facing a white's racism should get to a level where minorities will not engage in any other coping strategies but confrontation. Living through the experience of racism for such a long time and on daily basis may make one more likely to react to it. This is why second-generation respondents were more likely to react due to the fact that they have a better understanding of the process and dynamics of racial discrimination. As for the Villegas-Gold and Yoo (2014) model, the respondent's simple action can be seen as engaging in problem solving. Problem solving is defined as an attempt to change the

situation. The respondent said she may also get emotionally engaged and say something back. Engaging is a more visible way of confrontation and resistance.

One middle-aged Lebanese respondent, who was raised in Mexico during her childhood and is highly educated and wears no hair cover, said:

Oh no, I don't stay quiet. I usually use those opportunities to say what I think. You know, I don't feel bad anymore, because I was raised in Mexico as well as a Lebanese and people there are a little bit more open maybe, but they still do comments, you know, from the media stereotypes. So what I do if I receive a comment like that is just say oh no, things are not like that.

The respondent talked about using opportunities to resist the white racial frame and engage in deframing, to use systemic racism's terminology. In this case, teaching the health care providers that things are not like that means deframing the ideas, stereotypes, images, etc., that the white racial frame and in particular the anti-MEA sub-frame has created about Middle Eastern people. She acknowledged that media is a tool for reinforcing those sub-frames and individuals are not guilty of this so much as is the media and the system. Because she had lived in another country other than the United States, she mentioned that people in Mexico are a bit more open compared to Americans, which may tie back to the long history of South American countries and Muslims sharing some cultural background historically (perhaps suggesting the dominance of Spain by the Muslims at some point, who then transferred some elements of their culture to Spain and via Spain to South America later on).

Just as the Lebanese respondent used the opportunity to educate individuals, the Sudan respondent did exactly the same thing. She said:

I can't tell you how other people feel but for me always if somebody rejected me I feel you behave according what information you have. All of us we do that.

You make an idea; you have anything according to what information you have. I see okay they are ignorant. I don't let it get to me. When I came here I know I'm going to find different culture, different stuff so you have to learn to live in the culture and if there is a chance you tell that person about it, this you can do. That's how we change as a human, as a society. This is the way I look at it.

This respondent first talked about how people would act based on their accumulated information. Information in the context of U.S. society can be what whites and then other Americans of colors have learned through the white racial frame. Information that they have about minorities mostly comes out of the white frame. Seeing whites in the center of the frame as normal and anything out of that context as not normal reinforces whites in a positive way and minorities in a negative way. She brought up an important point in her quote, and that is the role of information and education in changing how people interact with minorities. She saw it as an opportunity for telling people about her country instead of experiencing emotional or physical distress due to their negative attitude. She was aware of the role of education in changing humans and society. Her explanation about education, like the previous respondent, is in line with the discussion about deframing and reframing. It is true that her suggested strategy may not work in eliminating the systemic racism but she, among all the respondents, was the one who had a vision for changing this. Clearly, her vision was the result of her life experiences. She was the respondent who reported multiple incidents of racial discrimination, but she had a logical way of confronting it instead of addressing it only through emotions. It is possible that in her case, religion worked as a buffer against discrimination.

As an example of coping strategies of the respondents in other settings beside health care, one respondent from Saudi Arabia confronted the situation when she had an

issue with her daughter's teacher in school. The white teacher had made negative comments about Middle Eastern people in class when teaching about the Middle East.

This is how she reacted:

I emailed the teacher, she responded maybe like five minutes after that, "Okay, I can meet you tomorrow before the school"...you could feel she was very uncomfortable. I was the one [who said], "It's okay. Things happen. My daughter misunderstood something. I'm an educator, you're an educator, and I mean whatever." She said this was a lesson that we have to do and I did not mean to generalize, but she was biased. Like I did not mean to do this, this was the first half of the lesson. Today, which was Monday, we're going to continue with the lesson and I will make sure that I stress that not every Muslim is a terrorist or something. I was like, deep in my heart, excuse me, it doesn't make any sense to say to them on Friday, before they go home, those are terrorists, Middle East is the home. Sleep on those for the whole weekend and come on Monday and say, well you know what, we can't generalize and keep going, it doesn't make any sense to me.

I was very angry at the beginning. Like excuse me, this is a pre-teen girl, she's already having problems with friendship here because of the stupid things, sorry. I mean really, she's not being bullied or anything, but she's isolated and she wears hijab. I didn't force her; I did not even want her to wear hijab here. So I mean if anything happened this is going to be, you're just like adding salt to the injury. If anything happened, if she was bullied or anything it's going to be because of your lesson plan...[so we went to the class together] So even [in the class] she was like, okay now, tell me now, can we say all the Middle East are terrorists? And the kids, some of the boys, were saying yes, yes of course and things. She was like, no, I'll say the question again—they will say yes. I was like who on earth would say this, you are just making it worse and it sticks in their mind.

So this was the worst experience ever. I mean [after that day] she came home once saying that I don't feel comfortable, blah, blah teacher and I overheard some of the students talking that Muslims go and wear these explosive belts and explode themselves and by something...

This respondent confronted the situation and took action following the experience of racial discrimination that her daughter had to go through. In this case, the respondent became worried about the safety of her daughter, which motivated her to

contact the teacher and make sure that she corrects her comments about Middle Eastern people. Although she thought it was a late fix and the harm had been done, it made her feel good that she stood up for her daughter. It appears that she did not believe that her action had any chance to change things; however, though it may not have had a positive impact on her daughter's class, for future Middle Eastern students may have a different experience in that teacher's classroom. Whites lack knowledge about Middle Eastern Americans, the Middle East, and Muslims, even though the majority of U.S. Muslims are African Americans whose ancestors have been in this country for many generations.

### **Religiosity**

This section focuses on the effect of religiosity as a coping strategy. Research shows that the religious involvement of minorities may act as a buffer effect against the experience of discrimination (Bierman 2006). The major example in this study is related to the experience of a respondent who was actually not Muslim. She was a middle-aged Baha'i and her religious beliefs, which are very much focused on viewing the world from a positive perspective, made a difference in the way that she explained her experience. She said, "Maybe because I never paid attention to negatives, I usually look at positive." In responding to another question, she revealed:

I have noticed some of that, but not necessarily in the health care, you know. But some people do that; you know they are not—because of the accent they may not understand well. So I never took it as a negative thing. If they tried to understand what I'm saying, I never got offended for that.

When asked what she would do in case of extreme racial discrimination, she noted:

Well, I think a lot of times if people mistreat you it could be due to misunderstanding, so I confront and if it's something that is bothering me and I feel that the doctor is not fair, I discuss it. Because if I like my doctor and I have

chosen this doctor and there's one negative thing, then I like to share it and see what happened. I don't know, a lot of times things happen with misunderstanding so I believe in discussing things instead of running away.

After describing to her a hypothetical incident of discrimination, she simply divided the physicians into positive and negative by saying, "That's the difference between negative and positive of a doctor." Her ultimate confrontation was limited to discussing the issue since she did not believe in the existence of a frame that people would act out of and engage in discrimination. She did not report any negative experience, although an average person and this researcher from theory would have labeled what she had experienced as discrimination. Religion made her give everyone the benefit of the doubt.

According to Byng (1998), religiosity has been shown to moderate the effects of discrimination for Muslims. For instance, the African American women revealed the significance of the sense of community. These women, who had mostly converted to Islam, reported finding a "safe social space" from the racial, gender, and religious inequalities that they experienced in society. This small community (the Arabic word is *ummah*) provided them with resources for coping with the discrimination (Byng 1998). The present research study can provide data on this finding based on the conversation that I had with one of the respondents. This very religious respondent, who did not allow me to record her voice due to religious restrictions (it is only believed by a small group of Muslims that the voice of the woman should not be recorded), reported no cases of discrimination and believed that the Muslim community would support her in a time of distress. Also, other evidence to support this was found during several trips to the



mosque to recruit participants for this study. The women at the mosque, mostly older and more religious than the average of my sample, participated in different religious-related classes and knew each other for a long time. During one encounter with these women, when the research study on the topic of discrimination was presented to them, all but a few answered promptly that they have each other if any of them experience anything negative (e.g., discrimination). In other settings of recruiting respondents for this study, many volunteers approached the researcher. However, no one from the mosque classes volunteered. Even the religious individuals who were included in the study sample were not involved in this community and did not know people through those programs.

Middle Eastern Americans use different coping strategies for dealing with racial discrimination. The strategies fit into two categories: engaging and disengaging. Some respondents prefer to let the racial incident pass while others engage in confrontation and even file a claim against the health care provider. However, even those who file official claims or submit letters to authorities avoid labeling the incident as racial discrimination.

There are ways that minority groups have resisted and developed counter-frames to the oppressive conditions of systemic racism. Feagin (2010) argued that anti-racist organizing and social movement building across racial lines are essential to challenging racism and race inequality (see also Byng 2013). According to systemic racism theory, the counter-frames are defined as the anti-oppression framing of Americans of color.

These counter-frames were initially made for survival, meaning that they provide solutions to Americans of color to fight everyday discrimination. This counter-frame

usually includes and builds on elements of one's home culture. Americans of color who have been victims of racial discrimination due to centuries of oppression are more likely to have a developed counter-frame because it usually has meant the only tool for their survival. For instance, resistance from African Americans can take the form of withdrawal, confrontation, humor, and sarcasm (Feagin 2006). For example, in the case of African Americans, they use elements of home culture such as family and religion to survive the experience of discrimination (Feagin 2010). As for Middle Eastern Americans, the counter-frame has probably not developed completely. However, in examining their ways of coping with racism they, like African Americans, rely on friends, community, religion, clothing, and speaking their home language. This means that the counter-frame for MEA includes those major elements of their home culture too. Withdrawal from the unpleasant situation was also the most reported answer of the respondents in cases of experiencing discrimination.

### **Summary**

This chapter described the findings of this research study on the types of coping strategies used by Middle Eastern Americans against discrimination in the health care setting as depicted through the perceptions of Middle Eastern American women. In this section, the model of coping strategies called multiple mediation models, developed by Villegas-Gold and Yoo (2014), was used for examining racial discrimination among MEA women. A description of different coping strategies used by the respondents and the meaning behind each one was presented. Based on these findings, those Middle Eastern American women who had experienced racial discrimination divided down the

middle in the type of coping strategies that they use for dealing with racial discrimination. Some chose disengaging coping strategies, including self-criticism, social withdrawal, problem avoidance, and wishful thinking. The other half of the respondents chose engaging coping strategies, including problem solving, expression of emotions, and social support. In general, many of the respondents who even reported incidents of racial discrimination at some point during the interview would identify them as non-race-related incidents, choosing to rely, even during the interview, on disengaging coping strategies such as wishful thinking or problem avoidance. The answers to the inventory questions presented in another chapter provide more evidence and a description for this argument.

## **CHAPTER VIII**

### **DISCRIMINATION OF MIDDLE EASTERN AMERICANS IN OTHER SETTINGS**

In the previous chapters, the discrimination faced by Middle Eastern American women as it pertains to a health care setting was examined. In many cases, respondents noted situations where they had experienced racial discrimination in a setting other than health care. In the existing literature on discrimination of MEA, other settings such as work places have received more attention compared to the health care system, but overall, there is very little concrete field research. Although this research study is not focused on the experience of MEA in other settings, those experiences are not of lesser value and can serve to demonstrate a similar pattern of racism to what respondents reported concerning health care services. Discrimination based on accent, language skills, religion, clothing, nationality, and names were reported for this category. This chapter provides the reader with those various encounters and adds a more general understanding of the racist ideology involved in the daily interactions of Middle Eastern Americans. Though some of the encounters are only briefly mentioned, they represent the negative image of Middle Eastern Americans in the minds of most whites and even some Americans of color. The images, narratives, stereotypes, and ideologies are, as mentioned before, only some aspects of the white racial frame that make up the anti-others framing in the minds of most white Americans, including health care practitioners when they are outside of health care settings. Reference by respondents to multiple

settings where they experienced racial discrimination is an indication that the existing structures of this society make it easier for this systemic racism to reproduce itself. In this section, some of the respondents explained the negative effect of media as one of the reproducing agents, and this study has devoted a chapter elsewhere in the study to discussing the absolute effect of media in discrimination against MEA. The following personal accounts are divided based on the type of discrimination.

### **Language and Accent**

Middle Eastern Americans experienced discrimination due to a foreign accent and difficulty with the language in other settings too. While it is relatively easy for children to learn a second or third language, the same is not true for many adults. The reason is that a person's distinctive intonation and phonological features (accent) are hard-wired in the brain and are difficult to change. That is why it is unrealistic to expect a person who learned to speak English as an adult to sound just like a native English speaker. This also means that learning to speak English with an American accent is not related to one's intelligence or motivation (Ingram 2009). While this is the reality that most Americans, as representatives of a nation that has many immigrants, should understand, the attitude of most of white Americans is discouraging. The white racial frame views a different accent as a negative and a reason for ostracization. Those whites who have never been exposed to an unfamiliar foreign accent particularly react in an odd and unwelcoming way. As a result, this type of discrimination remains a burden on the shoulder of first-generation immigrants who speak English with a different accent.

One Turkish respondent shared her experience of speaking with a supposedly “foreign” accent in places such as rural areas. She noted:

If you are on the campus or if you are living in the universities, people are already used to international students, so they can understand your English very well. But if you go to countryside or somewhere not many internationals are living there, you need to repeat it [your words] like two or three times at least. They are not used to your language. They are not used to meeting people.

Feagin argued that accents are racialized in the white racial frame as well.

According to the Pew Research Center (2013), whites in rural areas are more likely to fail believing in racism compared to whites in urban areas. For instance, rural whites are particularly likely to say that none of their community’s institutions treat blacks less fairly than whites—58 percent of rural whites say this compared with 49 percent of suburban whites and 43 percent of urban whites. Conversely, whites living in urban or suburban areas are more likely than whites living in rural areas to say that three or more of their community institutions treat whites and blacks differently. People in rural areas are usually white people, while minorities tend to reside in inner cities. White people who are older have always or mostly lived in their own community, never traveled, and never been exposed to other cultures or new places. They most probably have racial discrimination toward other Americans of color because their experience is unique in limiting their worldview to the other whites that they have known all their lives. It is no surprise that a Middle Eastern American would have difficulty communicating with this group because they see the world through the white racial frame, and their minds are highly influenced by the pro-white sub-frame. This group has a limited exposure to new

ways of life, so their discrimination extends beyond Middle Eastern people and may include people of their own culture or background.

One Lebanese respondent brought up the concept of fear and how she felt that people are scared of her or her accent when she talks. She said:

In Indiana there are people that have not left their state— not even the United States, the state. So when I present my name and I speak with my accent—yeah, I did feel there was...I get that feeling that there is fear, I wouldn't say rejection, but it's, oh, okay.

This respondent demonstrated the emotion of fear that sometimes whites experience toward minorities. According to Feagin (2010), the verbal elements of the dominant racial frame are linked to human emotions. Fear is an emotion that causes white people to avoid closeness or in some cases initial conversation with people of color. Blacks experience this framing more than other Americans of colors since there is more developed framing and stronger emotion toward them. In the case of Middle Eastern Americans, the emotion of fear can change dramatically over a political event or a terrorist attack. Naber (2000) reported on the attempt of the U.S. government to create fear toward the Arab American community in order to prevent them from gaining power in U.S. institutions. This study was done before the attack of September 11, 2001. After the attack, Americans developed more fear toward this population (Cainkar 2011). This is similar to the fear that whites have developed toward blacks throughout history by associating their dark skin with evil and negativity (Feagin 2010). This fear resulted in Americans viewing Middle Easterners as dangerous terrorists or threats to national security (Salaita 2005).

## **Discrimination in Educational Settings**

Schools have been reported as one place where Middle Eastern Americans experience discrimination. Teaching materials and attitudes toward those who wear Islamic clothing by teachers, staff, and peers have been the major topics of this discrimination. Aroian (2012) reported that seven out of nine discrimination incidents reported by Muslims occurred in school settings and were performed by teachers or classmates. The Muslim American girls who wear headscarves or other traditional clothing report more frequent discrimination. Also, this study suggested that Muslim youth frequently coped by doing nothing because they view taking action as ineffective in solving the issue (Aroian 2012). In regard to this type of discrimination, one respondent from Saudi Arabia shared a story related to her daughter's school:

My daughter was having—this is the most negative experience that I had here—[a class in] social studies when she was in sixth grade and she came home crying. I picked her up with my car, and we went to visit my parents in Houston; she was crying all the way to Houston. She said, “I did not feel comfortable because of the lesson. The lesson was about the Middle East and she [the teacher] was talking about terrorism, blah, blah, blah, Middle East is training base, things like this.” She [the teacher] said, “Actually, Saudi Arabia is the base for the training or something. All the people who did 9/11 were from Saudi Arabia—Saudi Arabian.” So she said, “I felt uncomfortable being there in the class... Muslims fighting each other,” things like that... so I emailed the teacher, she responded maybe like five minutes after that saying, “Okay, I can meet you tomorrow before the school.” You could feel she was very uncomfortable. I was the one [who said], “It’s okay, things happen. My daughter misunderstood something. I’m an educator, you’re an educator,” and, I mean, whatever... she [the teacher] said, “This was a lesson that we have to do and I did not mean to generalize,” but she [the teacher] was biased. Like [the teacher said], “I did not mean to do this, this was the first half of the lesson. Today, which was Monday, we’re going to continue with the lesson and I will make sure that I stress that not every Muslim is a terrorist or something.” I was like, deep in my heart, excuse me, it doesn’t make any sense to tell them on Friday, before they go home, those are terrorists, Middle East is the home. Sleep on those for the whole weekend and come on



Monday and say, “Well, you know what, we can’t generalize,” and keep going, it doesn’t make any sense to me.

I was very angry at the beginning. Like excuse me, this is a pre-teen girl, she’s already having problems with friendship here because of the stupid things, sorry. I mean really, she’s not being bullied or anything, but she’s isolated, and she wears hijab. I didn’t force her; I did not even want her to wear hijab here. So I mean if anything happened this is going to be, you’re just like adding salt to the injury. If anything happened, if she was bullied or anything, it’s going to be because of your lesson plan... [so we went to the class together] so even [in the class] she was like, “Okay now—tell me now, can we say all the Middle East are terrorists?” and the kids—some of the boys were saying, “Yes, yes, of course” and things like that. She was like, “No, I’ll ask the question again” [but] they would say yes. I was like, who on earth would say this, you are just making it...

Q: Worse.

A: Worse, and it sticks in their mind. So this was the worst experience ever. I mean my daughter came home once saying that “I don’t feel comfortable, blah, blah, teacher and I overheard some of the students talking that Muslims go and wear these explosive belts and explode themselves.”

Since this account was mentioned in another chapter of this dissertation, the explanation provided here is brief. The question that one might ask is what if the mother did not contact the teacher? The teacher acted out of the white racial frame and went so far as to label the entire people of one country as terrorists. That being said, the criticism should be pointed toward the curriculum that requires teachers to educate children about hate speech.

Research conducted among Muslim college-age students (Shammas 2009) and Muslim adolescent students (Aroian 2012) revealed similar problems related to hijab and negative verbal remarks. One Iranian respondent with a hair cover who has been in the United States for five years said:

I don’t feel any disrespect from people, but, definitely, I feel the difference. Even, for example, advisors, even the professors. Anyone I see that probably it’s

just the language or culture or whatever, but I feel that after all we are kind of second citizens here. And I don't have any problem with living like that because we try to, at least from the language, for taking benefits of, for example, education here but there are some times that I wish I was not [MEA]—I were an American.

The respondent explained the discrimination that she faces from even faculty members at a white-dominated college that she attends. She has come to believe that it is not only about culture, or language, or so forth, but about the reality that at the end of the day, she is a second-class citizen after whites. She is among the few respondents who honestly admitted her from time-to-time wish to be a white American. Understanding the benefits of being white in a white-dominated society has made minorities think about the implications of being white and opportunities that they would gain.

One Turkish respondent, a final-year PhD student, noted this about some staff on her campus:

I had somebody working in the university who deals with a lot of students telling me how that person actually doesn't like seeing these guys with long beards, you know, like very typical... The guys with the long beard and they wear loose clothes, etc. She disgusted them. She doesn't like them... I know that's like if you're a woman with some headscarf you might get some negative comments. Not to your face but behind you. Or if you're a guy with long beard they might think that looks like a terrorist. These people, you know, my blood freezes when I see them. Like words like this I've heard from white Americans.

The respondent explained the typical stereotypes of MEA. Most of them experience discrimination due to those racialized stereotypes. The respondent used the expression “my blood freezes when I see them” to separate herself from those who discriminate against this group for no reason. The stereotype toward clothing or facial expression is a product of the white racial frame. To be specific, the pro-white sub-frame in the center creates images of people who are “decent,” “beautiful,” and “trustworthy,” and the anti-

MEA sub-frame has negative images of MEA in its frame. For instance, a study by Horry and Wright (2009) showed that anxious white participants who were exposed to terrorism-related words showed a visual bias toward Middle Eastern **faces**. The study emphasized the role of media in transferring those negative images to white people and reproducing the white racial frame through those channels. The respondent's account about the staff member at the university who disliked Middle Eastern men is proof to the success of these channels in creating a sense of fear toward Middle Eastern people. This fear is similar to a sense of fear toward black people that Feagin (2006) explained in his book *Systemic Racism*. Shammass (2009) suggested that effective measures to expose subtle forms of discrimination on college campuses are needed, as is an analysis about denial of discrimination.

### **Discrimination in Public Places**

One respondent from Sudan, whose encounters have been quoted throughout this report, provided an extreme example of racism that was life-threatening to her. A white truck driver tried to run her over after 9/11. She said:

Walking in a small town with conservative people is the only time, really have the serious things, and I realized at that time that it had become threatening to me after 9/11. That was the only time I was really serious. I was in the school and I'm going across to the bus on the other side, so I'm going to take the bus to go to the main campus where I take my classes. So the guy, the light is green and I'm crossing. I am crossing, and I'm the only one crossing, and he's here, and I'm crossing, and he's here. There are a bunch of them Texans, and so he starts talking and cursing me, and he starts driving the truck even though he's red light. And he sound like, okay, you know they go to bump another car and he do that to me. Then, I said if I run, it will be more, so my brain said, "Okay." I stopped. I look at him and said you crazy. Everybody like, "What?" He almost hit me if I didn't do that. That was the only situation really seriously became life threatening.

This shows the extent of frustration and anger that Americans felt after the events of September 11, 2001. As mentioned in the literature review, many examples of these extreme practices have been documented throughout the literature. For instance, dozens of Middle Eastern Americans were violently attacked, and some killed, after September 11, 2001, including Sikhs (Marvasti and McKinney 2004).

One Kuwaiti respondent experienced direct verbal remarks as she was shopping for her children at a Toys R Us. She said:

I only experienced once that when we're in the store I found someone screaming at me, "Why are they coming to our country? I can't feel comfortable in my own home" and some stuff like that. I went shopping with my kids; that make really uncomfortable so this is the man, the only experience I have like...

Q: So what happened? You were talking to the man?

A: No, no, just shopping in the toys aisle and he was with his kids and wife and after we passed through the aisle he was in the next aisle and he just started talking like this and we didn't talk. We didn't do anything. We're just being in the store. I'm just upset because if someone did something bad, that doesn't mean that all the people of the same region are bad or have the same sort of ideas. Why making this so general that we are all the same and have the same terrorism thinking. The thing that I was with my kids and he was with his kids, what make our kids like violence than the other kids and why we have the thoughts? Why they thinking like this? We didn't do anything. We came looking for toys and the same thing he was looking for.

Direct negative remarks in a public place such as a toy store where there are many young children around is certainly setting a negative example for the next generation. Besides media, one of the other channels that reproduce and reinforce a white racial frame are white parents. The majority of white parents operate out of some version of the frame in their daily lives that makes the frame become embedded in their child's unconscious. Children watch the negative reactions, remarks, and attitudes of

their parents toward other people and pick up on those feelings without knowing the logic behind it. In the case of this respondent, the white person's statement about being uncomfortable was again based on the fear that he feels toward Middle Eastern people.

Another time she (the Kuwaiti woman) was sitting at the coffee shop when a white American woman asked her:

Don't you feel hot in the summer with wearing all those layers or something? I said, "No, I'm used to it because our country is much hotter than this." Sometimes they think we are wearing hijab or that we are women and we have to obey our husbands, and you wear it because of your husband, not for religion thing.

This respondent experienced direct remarks regarding her clothing in a public place from a stranger. This is against the white's support of the frame of liberty and justice that Feagin explained about. Respecting one's choice of clothing is probably one of the basic rights of anyone residing in the United States. Feagin argued that one of the elements of the counter-frame of minorities that is built against the white racial frame is relying on the frame of justice and freedom. Since whites claim that they are all for supporting justice and liberty, minorities use this disclosure to resist the racism that they experience based on inequality and a lack of justice. The Kuwaiti women argued that some people see her covering as a traditional way of life rather than her practicing her religion.

Regarding the effect of clothing on people's impressions, one respondent shared a story about a friend. The respondent was a second-generation Iranian. She said:

A few months ago I had a friend that wears the hijab and she told me that she went to a party with another girl that has a hijab and it was predominantly like a white, Caucasian party and, like, a Christmas party I think it was that they were telling me. They said there were even some people that wouldn't even greet them or acknowledge them, and even when they left, they didn't even say goodbye to them specifically. They asked me that question—like, "What do you think it is?"

I'm really not sure, I just think that a lot of times people are not understanding or they feel uncomfortable with something that's—I feel like human beings in general, with something that's unknown, they feel fear or uncomfortable with the unknown. Because this is so foreign, and maybe a lot of times they've been, like, taught that Middle Easterners, they think, like, they're barbaric and they fight and there's war always in the Middle East. It's just kind of that ingrained in their mentality. So I feel like sometimes it's out of fear or the fear of the unknown that they just won't approach you. I think that a lot of times, every human being has a center of compassion in them, where if they understood what the other felt, they would be more open. But I think that that fear or—just overpowers their thought process and makes them feel more uncomfortable with somebody with the hijab or with those cultural values.

This incident shows the possibility that these whites had some stereotypes in their mind about Middle Eastern people. Comparing the incidents of other settings with incidents in a health care setting demonstrates the differences in the forms of racial discrimination. In a health care setting, the health care providers cannot avoid having conversations with the patients since conversation is part of the medical procedure. However, they may have a negative attitude toward their patients and use inappropriate wording. In a setting where whites are not obligated to talk to the Middle Eastern people, such as a social gathering, the elements of the white racial frame are more visible. Whites may avoid eye contact, conversation, or make direct negative remarks to Middle Eastern Americans. The respondent in this case believes that fear of the unknown has been a reason of this avoidance. The fear of the unknown is again related to the discussion about fear and minorities.

As mentioned earlier, the white racial frame encourages whites to have a fear of minorities. Through this process, the “normal” is what whites do, which is framed through the pro-white sub-frame, and different is what minorities do, which is framed through the anti-sub-frame of people of color. The people in the party who avoided

acknowledging these MEA women saw their clothing as abnormal and not white. Then they—unconsciously—viewed them through the anti-MEA frame and used the negative stereotypes that they have known about Middle Eastern people to make a judgment about these two people. Based on their judgment they concluded that they are not safe enough to get connected with.

One respondent from Kuwait who had young children in school said:

Another thing, like, in my children's school some of them...they ask me why I'm wearing like? One time I was wearing a black scarf and one of the boys told me, "I don't like you." [I said] "Oh, why?" And he said, like, "You scare me." So I think the black color makes them—after that I decided not to wear black because the children like—

Q: Like bright colors?

A: Yeah, they connect with like Halloween because they only dress in black on Halloween or in sad occasions, so they don't see it often. So they feel scared.

This response shows the fear of this child of the black color. According to Feagin (2010), in the childhood socialization process, most whites learn to associate blackness with dirt, danger, ignorance, or the unknown. The comment of this young boy to the MEA woman shows the truth about the way he thinks about her without trying to be politically correct. Associating the images of those Muslims who wear black with negative emotion is rooted in the socialization process. The following account is also along the same lines. One Iraqi respondent, who covers her hair, said:

Even in the outside, some people get scared, especially when I, before, that I was wearing a black scarf because my mother passed away and I wear all in black around a year and a half. Then I know people is not comfortable, especially when they saw Iraq, and they saw the scary people who kill Iraqi, they wear black, therefore I decide to change my scarf. But I still wear the black [other than scarf] because I love my mom.

A respondent from Turkey, married to a white American man, mentioned some of the common stereotypes about MEA. She noted:

Before we moved to Texas everything was very good. People in ... Indiana they were very helpful and open-minded. But after we moved down here, I had an experience where the first year we moved to Texas, we just met a lady with two kids like myself and then, actually, at that time I had one. And we started becoming like friends, we see each other, we have play dates. And then a couple of times we met, and then we started talking more and more and she learned about [me being] Muslim. She stopped talking to me. Since then, she's not saying anything, and I'm not trying to get in touch with her because I tried, and then I kind of figured it out that because of my religion makes her uncomfortable.

But other than that, every time, you know, there are some questions that come up to me, like, "So you guys are not, you know, with the scarf or hijab?" yeah. Or they're like, "So you guys have regular like one husband one wife kind of thing?" Or, "Do you have four wives?" Those kinds of things, and I always implement this, as they do not have enough knowledge about the other parts of the world but just themselves as Americans... Especially in Champagne, they were asking questions about religion and preference for food. "Do you eat pork or no pork?" So they were, up north they were more open-minded than down in here. They are still good in here, but if you don't tell them what you don't want, they don't ask you.

This respondent was discouraged after she learned that the new American friend that she had made did not want to contact her after learning that she was Muslim. She compared her experience in Texas with her experience with living up north where people were more considerate of her cultural or religious restrictions, such as not eating pork. She also expressed her dissatisfaction in receiving questions that demonstrate the lack of knowledge of individuals about her religion (at least the modern form of religion that is practiced by most Muslims). Lack of cultural awareness and practicing out of an anti-MEA sub-frame are the causes for these behaviors.



One Egyptian respondent, who was a dentist and covered her hair, said this:

The last situation that bothered me a lot, I was at TJ Max—we were in Austin—and the woman [cashier] didn't answer my question, she just grabbed my stuff and just start [scanning]—and I'm asking her how much, and she answered everyone else, and she is talking to everyone nicely, it's not like a bad day for her. I found out that she is not answering my question, and she refused, and she treat me like she just take my card and finished the transaction—I don't know why she did this, and actually I told her that why you are not answering me, and she didn't answer. So something like this...I feel bad about it and I feel like it is because I'm different or you are not accepting me.

This account was significant because the cashier publicly disregarded the woman's questions and did not answer her. It is strange that none of the people in the store made any comments about that—probably because they knew the reason behind it—and the woman engaged in a confronting coping strategy by directly asking, “Why you are not answering me?” but the cashier was engaging in the discriminatory action to an extent that she ignored that question as well. The respondent felt bad and rejected after this incident.

The same respondent also shared this experience regarding her husband's first name:

There's something else that's funny, my husband's name is Osama—so for them they know Osama very well, so they say Osama. We sometimes get negative reaction; especially once we went to Fuddrucker's restaurant, you know, they call your name in your mic—so when they told [said], “Osama,” everybody looked and they—when they saw me wearing hijab they have this look on them, so yeah. But it's okay, just a name we use a lot in our country, so there is nothing to do about it.

The negative reaction of people to the name Osama is certainly associated with the negative memories of September 11, 2001. This is different from having a negative reaction to an unfamiliar name. This is a reaction that originates from the anti-MEA

frame that associates some names with terrorism and threats to national security. The white racial frame will make this negative association with un-white names, of course. If a white person engaged in some terrorist attack, his or her name would become associated with less negativity. The reason is that whites see themselves as moral beings due to virtuous whiteness. Based on that, whites see themselves and their community as decent and good while they may hold different views toward colored communities (Feagin 2010).

The same Egyptian respondent also shared the following:

In Macy's...it's a very simple situation, but I hate it also, that there was a promotion with Lancôme, and I saw two women came and they bought something and they take the promotion. When I bought my stuff, she told me, "No, the promotion didn't start yet." It was officially didn't start yet, but I told her, "I saw you giving it to other people."

The fact that this respondent had so many stories to share was interesting. She had a very bright skin color; she wore her hijab in a very common way and only covered her hair. Her husband, as depicted in pictures, had blue eyes and light brown hair. Her experiences of discrimination both in a health care setting and other settings demonstrated her ability to analyze the situations. Although she is considered a second-generation immigrant, she was able to see the difference between the treatment that she receives and the treatment that whites receive. She is very smart and independent and opened her house to me while she was taking care of a young toddler.

One Iraqi respondent shared her story about an incident that happened on Valentine's Day:

On Valentine, all the people who celebrate that day wear red or pink or something, but I was wearing all in black, and after I left the hospital with my

husband, who gets his infusion in the clinic, I wanted to put my child in the car. An old woman's car was parked right by mine. I opened the door. She said—she wanted to fight—she said, “You hit my car,” why I only want to open the door to put my child—I was far away, but she was like upset. She, like, came to fight with me. At that time I felt—I didn't, like, do anything...she came, like, very quickly, and she want to fight, and after that my husband said because we wear the black she get nervous because this is Valentine's Day. I said, “I don't care, I know I didn't hit her car, I know the door was very far from her car.”

This is another example that shows the dislike toward black color. As mentioned earlier, whites associate this color with negative images and act more negatively toward those MEA who cover their hair or body with black colors.

Pertaining to the experience of discrimination, one second-generation Iranian explained that she usually does not experience discrimination using health care services but certainly at other places. She noted:

Number one experience is when it comes to airports, international travel, obtaining visas, and obtaining a high security level job.

Airports have been discussed as one of the major places where Middle Eastern Americans face discrimination. They get “randomly” selected for second screening by TSA (Transportation Security Administration) and most of the time receives a notice of baggage inspection upon their arrival at their destination. There is no doubt that being from the Middle East and obtaining a high security job adds a secondary inspection for Middle Eastern people, especially males. This is based on the stereotype of the anti-MEA sub-frame—that MEA men are terrorists—that reinforces the negative narratives about those MEA who were involved in terrorism and forgets that sometimes the terrorists were actually whites. According to systemic racism, one of the aspects of the white racial frame is virtuous whiteness. It is defined as whites perpetually continuing to

believe themselves to be a good and decent group. They do not have any memory of negative behaviors such as slavery. Additionally, whites believe in “symbolic racial capital,” which means that they share assumptions, understanding, and interactions in certain ways that are traditional to white families and community. Exercising these attributes gives the whites a chance to benefit from daily privileges associated with whiteness. One such privilege affiliated with symbolic racial capital is a lack of profiling by police or authorities (Johnson 2003).

### **Story of a Second-Generation Iranian**

Personal accounts of one second-generation Iranian on discrimination at other settings were so informative that this section focuses on her perspective and what she experienced growing up. She was a 21-year-old college student who grew up in Houston, and both of her parents were Iranian. Like the previous sections in this chapter, it is not related to discrimination in health care settings, but it is certainly worth inclusion in this research study because it is directly connected with the racism demonstrated toward this population and how even children have to face a lot of inequality and pressure growing up in a white-dominated society. This account also shows how whites exhibit this type of racism in all settings, thereby reinforcing what they may do in health care settings. This respondent shared stories about her time in school and interactions with neighbors and close friends. As mentioned in previous chapters, the experience of a second-generation immigrant is unique because this group understands the dynamics of racial discrimination and knows how it feels to be discriminated against. Even though they may not necessarily confront racism, they know

that it is there and have suffered from its physical and emotional pain. Although there are so many accounts, and some of them are related to settings that this research has not focused on, these accounts are only provided as examples of discrimination that this group faces on daily basis. In school, she experienced the following:

I've been told, "Is Osama bin Laden your cousin, are you related to Al Qaeda?" I mean, this goes on and on. People ask me, "Are you afraid when you go to Iran, they're all terrorists?" Growing up, it was very tough; I was very hurt... When they made fun of me, even up until high school, middle school, it wasn't trying to be harsh, they were trying to get a kick out of it, and we live in Texas—it's a very conservative place, people are bound to do that...it's the name calling and it was at that age. When you're between the ages of nine and fourteen, fifteen years old, it's a very sensitive age. Kids bully to put themselves higher.

In school, she experienced a teacher's negative reaction toward her non-American name. Teachers told her, "I've had that happen in class many times when like I'm not even go to try to pronounce this." This is similar to the experience of health care providers who discriminate based on foreign-sounding names.

Regarding receiving negative remarks, she remembered:

I don't feel anything negative now because I feel, like, you're proud, but I feel like growing up when I was younger, it's just harder because—especially where I'm from in Houston, it's all American people, like ninety percent of the population. So the kids grow up differently than you do. I think it's just, you feel a little left out. I don't know... just situations when you're younger and you don't feel as comfortable... just a feeling. I remember one time—I don't know why this always stuck with me—but I remember this little girl was like—whenever we were little, I think we were in, like, probably third grade or something. She was like, "Well, I'm white and you're not white, so that means you're my, like, slave." I was like, "What?" You know? There wasn't a lot, but there was some like that where you just—and then it's just you grow up differently.

Regarding her foreign accent, she said:

I remember my mom telling me about one of her clients—I don't remember the story exactly, but she said something like her client was like, "Oh, where's your accent from?" My mom said, "Iran," and then she's like, "Oh I thought it was

going to be like French or something. Oh, I don't think Iranians have that much of a pretty accent." My mom was like okay, I don't know what to say to that.

Concerning experiencing discrimination toward her religious background, she gave these remarks:

Like growing up in high school, my high school there was no one Middle Eastern. So they would see like—or when they would talk about Muslim they would be like, “Eeuw”—they would just automatically say “Eeuw” all the time. I didn't understand why, why is the religion eeuw? Everyone has different—I'm not Muslim, but I have family that is, especially those in Iran, so I would get offended—like you don't need to eeuw. Especially nowadays, I still hear people that I'm hanging around with and they're like—like this girl I know that is from Palestine, not one of my roommates, but it was another girl. Palestine is—the majority of them are orthodox and they get mistaken for being Muslim, she's like, “Eeuw, I'm not Muslim, I'm orthodox.” It's just like you don't really need to freak out about it. So I definitely always see negativity with Islam.

In response to the reaction of people to her national identity, she said:

Yeah, well, it just comes naturally to me to just say “Persian” and they're like, “Oh, what's that?” I'm like, “Oh, Iran.” Then some are like, “Do you mean Iran (pronounced as “eye-ran”)?” I'm like, “No, Iran (pronounced as ‘eeraan’).” Then they're like, “Oh, is that like Iraq?” I'm like, “No”—I feel like they just don't have a lot of knowledge about it. Then even one of my friends was asking me—“Do you get mad when people say Iran instead of Iran because it's pronounced Iran, right?” I was like, “I don't get made, I just think they don't have—they just need to be more informed, they don't have knowledge.” I mean my friends sometimes like—they like the culture and stuff and sometimes they think they're funny and they make like terrorist jokes. I'm just like, okay. I think a lot of people also try to hide it; they're like oh, cool—yeah. So you can tell, I don't think they've ever been negative to my face, but I can tell when they're just like, okay—you can tell they're hiding it. You can tell when some people are actually interested and some people just don't care.

Q: How does that make you feel when you know—because English is your native language, so you probably know better than a first-generation immigrant, that that expression means negative.

A: I mean, I do get offended, I try not to let it get to me, but I just try to think they're just not as—it's just kind of like I don't like their way of life not being open to other cultures. I'm Persian but I like being open to other cultures, like going to different countries and seeing different countries. I just think you're not

getting much out of life if you're not going to be open to the Middle East or any other culture. But I feel like people are more opposed to the Middle East just because of, like, terrorism and stuff like that. I just think it's dumb.

As for her interactions with close friends she stated:

Like I said, when I'm sitting around with my friends and something comes on TV about terrorists they'll say, "Oh, it's the Middle East again," or something like that. Especially all those shootings on TV—or recently you see in the news them going into schools and stuff, they automatically [unintelligible] terrorists from the Middle East and they'll say something about it. I'm just like, no. Most of the time the person turns out to be American or something else. So I think it's not right that people think terrorism is just a joke or that they can just put blame on Middle Eastern just because 9/11 happened and they associate them with that.

She described her coping strategy after hearing jokes about MEA this way:

I had to learn to laugh it off for my own sake. If I didn't, if I got upset, I would be that person sitting in the corner by herself. Socially, I had to accept, and it bothers me, and when I see people still doing it, I get very upset and I try to change their idea of that generalization and stereotypes, but this is Texas, you know?

### **Summary**

Experiences of discrimination in settings other than health care facilities were more extreme for some respondents. This might be associated with several factors. First, health care providers are more likely to be called to account for the practice of racial discrimination. Even those respondents who reported being discriminated against by health care providers had the right to follow up and file a racial complaint case, although it may not have the desired outcome. In some other settings, though, such as stores, streets, and schools, whites may be likely to engage in more discriminatory actions because they have the chance to walk away from the scene. Also, this might be due to the practice that Feagin (2010) described that pertains to front stage and back stage. He said that whites are more likely to speak out blatantly against people of color when they

are back stage and know that they do not have to be politically correct. The last encounter depicted above of the second-generation respondent provided an example of this wherein the respondent was hanging out with some white friends and the friends felt safe enough to share some of their thoughts about minorities with her. The front stage can be a health care setting, where providers tell their customers that it is “cool” that they are from the Middle East, as one of the respondents described it, but in reality do not feel comfortable with the idea of having patients from that part of the world. Based on another respondent’s account, behavior such as that indicates that whites do not become “friends” with the Middle Eastern people. They are “keeping face” because that is polite and maintains white virtuousness.



## CHAPTER IX

### CONCLUSION

The quote from a Lebanese respondent in this study summarizes the major findings of this research project. This respondent had certainly fought her way through life in the United States. During her life as an immigrant, she went through divorce, raising her children, graduating from college, sickness, and finding a job before she became financially independent.

Being from Middle East is not easy because we always going to be labeled, and there are some who are going to try making us uncomfortable. Some people make you uncomfortable, make you feel like you're not a good person or you're not whole, you're lacking something, or you're bad. I feel like some [Middle Eastern] people will not embrace their culture, they will try to hide it; they will try to turn more into white people—become more “white” than being proud of their culture. So I would like to tell those people that no, they should be proud. We should educate people about us—more education. We should teach Americans that there are bad people, fanatic people, and good people [in Middle East]. It's not only in Middle East—turn around, there is a lot of people everywhere like that. We have more—there is no media here, the media here shows you only the bad stuff about the Middle East. They don't show you our generosity, they don't show you how smart we are, how educated we are. Most people think that we're not educated. They don't know that we are more educated—we put value in education before other part of the world did—education is very important to us.

The respondent's quote demonstrates the experiences of Middle Eastern Americans in the United States. Being labeled, feeling uncomfortable, and not feeling good about one's self results from experiencing discrimination on daily basis. To become more “white” in order to fit into an American culture is a daily struggle of many MEA in response to discrimination. The Lebanese woman criticized the process of assimilation. She passionately explained how she thinks assimilation is not a way to cope with

discrimination. The quote also emphasized the role of education in changing how minorities are treated. She believes that lack of knowledge about Middle Eastern countries and culture is a leading cause of discrimination. Americans tend to treat MEA based on stereotypes. This respondent explained how Americans may fail to see that there are good people and bad people everywhere in the world. A lack of knowledge and stereotypes are the major elements of the white racial frame, a major component of systemic racism. Media, as repeatedly mentioned throughout this project, has a role in reproducing this white racial frame by only portraying the negativity, which is the anti-MEA sub-frame. The respondent fluently discussed the lack of a presentation of positive aspects of Middle Eastern culture (for instance, the high value that MEA put on education).

The respondent's belief is in line with the research conducted by Erickson and Al-Tamimi (2001). According to their study, the marginalization of MEA is a result of the current foreign policy in the Middle East, the inability of most Americans to distinguish between those few who commit terrorist acts and the remaining population, the small amount of accurate information that many Americans receive about life in the Middle East, and negative images and misinformation. Basically, Erickson and Al-Tamimi examined the systemic racism that uses stereotypes and generates the negative images and narratives of terrorists to all Middle Eastern people, the small amount of information that is due to lack of understanding the history and lives of Americans of color, and negative images and disinformation that are elements of the white racial frame, and the anti-MEA frame specifically.

This final chapter summarizes the main findings of the current study of discrimination of MEA in the health care system and then offers some solutions to the discrimination and suggests some areas for future research. The experience of MEA in the United States is complex and needs much more evaluation. As discussed in the introduction of this project, the MEA exists as an invisible minority in the United States; as a result, the literature is only focused on the experiences of Arab or Muslim Americans. The following conclusion addresses the issues that this group faces during their use of health care services. First, this report provides an outline of the findings of the study by reviewing them through the lens of systemic racism theory. Then, it provides solutions, areas of future research, and limitations of the study.

#### **Discrimination Reported by MEA Women in the U.S. Health Care Setting**

More than half of the respondents believed that they were discriminated against in health care settings. Most of those who did not report any discrimination in the health care setting reported experiencing discrimination in other settings. This may reflect unfair treatment toward this population in some other settings more than in health care settings. The evidence of discrimination against MEA is in line with other research studies that focused on the experience of Arab Americans or Muslim Americans. However, most of those research studies focused on religious identity while this research focused on immigration and national identity. MEA women reported different types of discriminatory behaviors in the health care setting. A negative attitude of health care providers that resulted in ignoring patient's needs and questions and a lack of pain management were the most frequent type of discrimination reported. Along with the

negative attitude of health care providers, most patients reported feeling excluded and rejected. For first-generation immigrants, discrimination against their foreign accent and English language skills was the most commonly reported occurrence. Most respondents provided examples of the incidents where they had faced discrimination because of their accent. Other discriminations were related to disrespectful verbal comments directed toward one's nationality, religion, or cultural practices. Muslim clothing or wearing a hijab created many issues for women who chose this practice. This may suggest that those who do not wear this clothing can pass as non-Middle Eastern and not experience discrimination as frequently as those women who cover their hair or body. Some of the negative remarks or questions were attributed to lack of information about Islam or Middle Eastern culture. Issues such as respect for privacy or same-sex caregiver were the ones that initiated the conversation about more needed awareness from health care providers. Experiencing discrimination resulted in patients' lack of compliance with their follow up appointments or medication. Those who experienced mistreatment at the physician's offices reported feeling unenthusiastic about going to see that physician again or taking their medication. Some ended up switching their physicians or took their medication but never went back for future visits.

Different factors affected the extent of experiencing discrimination. The time of immigration (i.e., first vs. second generation), religious involvement, national origin and self-identification, clothing, and media were identified as the major factors that can change the experience of MEA in the U.S. health care setting. The first-generation immigrants reported discrimination toward their accent and English language skills,

while second-generation immigrants reported discrimination in different settings and with more details. Second-generation immigrants were able to identify discrimination and understand the mindset behind people's actions and conversations. Also, some of the more recent immigrants were more concerned about their essential needs, such as insurance, job, or immigration paperwork, than their daily interactions in the host country. We might conclude that while whites engage in racial framing in one institutional area, such as health care, they tend to do it in other areas as well. This repetition causes the reinforcement of this practice in their heads. Also, the respondents exposed the structural and systemic racism that is the context of their lives by sharing the negative aspects of the structure of the United States today.

Those who were more religious than others (even non-Muslims) were less likely to report discrimination compared to others, suggesting the effect of religion as a buffer against the experience of discrimination. Also, those who have migrated from less developed countries in the Middle East are less likely to report or be annoyed by discriminatory actions. This provides evidence for arguing that a comparison point of reference makes a difference in how patients report discrimination. Furthermore, those with stronger ethnic identity are more likely to become the victims of discrimination compared to others who have become more assimilated. The more traditional clothing of the women resulted in more discriminatory behaviors of health care providers, suggesting a religious discrimination toward this minority. All of the respondents expressed their concern and dissatisfaction with the way that mainstream media portrays

Middle Eastern people or their countries. They identified it as a major factor that can affect the extent to which health care providers engage in discrimination.

A great deal of research documents the coping strategies of minority populations in response to racism. For Middle Eastern Americans, the literature is mainly focused on Muslim Americans and religious identity. Comparing the coping strategies used by the respondents with other Americans of color provided a clearer picture for the strategies employed by this population. Denial of racism, using ethnic or religious identities, confrontation, and social support were recognized as the main ways of coping with racism. Due to their strong religious background and immigration status, this population, like some other Americans of color, benefited from involvement in their religious gatherings or from support of their community or friends. Confrontation was usually not a common coping strategy for first-generation immigrants, which might be explained by their low self-confidence in English language skills. Wishful thinking and denial were common since many of the respondents who even reported incidents of discrimination preferred to label it as a random misunderstanding. Some of the respondents engaged in self-criticism for either not speaking the language fluently or for a lack of knowledge about American culture.

### **Findings Related to the Literature**

Findings of this study add to the existing literature by extensively explaining the experience of Middle Eastern American women in health care using qualitative research methods. The extensive field research shows the negative attitude of health care providers and a prevalence of foreign accent discrimination as the two major

discriminatory actions demonstrated toward Middle Eastern Americans. This is different than previous research studies that focused on the experience of Muslim or Arab Americans and identified clothing (hijab) as the most reported reason for discrimination (Aroian 2012; Ghumman and Jackson 2010; Ghumman and Ryan 2013; Kulwicki, Khalifa, and Moore 2008; Scott and Franzmann 2007). The experience of Middle Eastern Americans is complex and contains similar elements to the experience of other Americans of color. It is similar to the experience of other minority (especially immigrant) groups as it pertains to accent or language, but it is also similar to the experience of Muslim Americans due to their common religious practices. It is parallel with the experience of African Americans because Middle Easterners might have dark-colored skin and face discrimination because of that. Finally, another element that adds to this complexity is the instability of the political and social situation of Middle Eastern countries and the ongoing war with terrorism. Although not all countries are involved with this crisis, all Middle Eastern people have to deal with the negativity associated with it. A terrorist attack by two masked gunmen in the offices of the French weekly newspaper *Charlie Hebdo* in Paris by the Islamic extremists who fired up to 50 shots while shouting “*Allahu Akbar*” (Arabic for “God is [the] greatest”), killing 11 people and injuring 11 others during their attack. The horrifying actions of extremists Muslims, results in stereotyping Middle Eastern people as dangerous beings. This attack, similar to previous ones (the major one being the events of September 11, 2001), will certainly contribute to more humiliation and marginalization of this group.

## **Findings Related to the Theoretical Framework**

As discussed previously, much of the theoretical work for working with a minority population in the health care system is related to the statistical research on health care disparities and the effect of discrimination on minorities' health status. While these contributions are important in creating a base for the research on discrimination in health care settings, they tend to overlook the racialization of these institutions and the white-dominated health care setting. Throughout this study, the common theme that continued to be the major element of respondents' narratives was negativity toward Middle Eastern Americans. The systemic racism theory provides explanations for this negative feeling of health care providers—mostly whites—toward Americans of color, which includes Middle Eastern people. The frequency of discriminatory actions in this research shows that experiences in the health care setting cannot be viewed as random acts of discrimination but as events that are experienced by many of American of colors and that need comprehensive evaluation. This research connects the micro-level interactions that are being reported as incidents of racism with macro-level racism that is explained by systemic racism. By using systemic racism and its dominant white racial frame to interpret and explain these negative micro-level interactions, this study offers means of understanding the white racial frame in a more explicit way.

The findings of this research on Middle Eastern American women suggest that there are many more factors that may affect the relationship between patients and health care providers. The literature that focuses on barriers of effective communication between the two fails to recognize racism as one of the leading factors. This research



study concluded that cultural or racial dimensions affect communication between the Middle Eastern American patients and health care providers. If patients are MEA first-generation immigrants, the foreign accent adds to the difficulty of the communication. As mentioned in previous chapters, the negative attitude toward language, accent, national identity, religious practices, or clothing of the respondents is the result of the white racial frame. Part of the white racial frame is a middle-class, white-standard media accent. Any different accent creates a negative reaction toward the individual who speaks it. The result of this study showed that when patients of Middle Eastern origin who speak English with an accent go into the physician's offices, then, if for no other reason, they will still experience discrimination based on their different accent or their foreign names. According to the inventory question, other types of discrimination are reported as occurring less often than discrimination due to an accent and foreign name. To briefly explain this through the systemic racism, it should be noted that systemic racism has many different components. One important rationalizing feature is the white racial frame. Two features of this frame are the pro-white sub-frame and the anti-MEA sub-frame. The discrimination that MEA patients experience in health care systems shows some combination of the anti-MEA sub-frame and dominant white frame. The pro-white frame is normative. Anything outside of that normality is subject to discrimination. Health care settings, which have been historically white and male-dominated spaces, have acted out of this frame for a long period of time. As a result, health care providers are very likely to discriminate against people of color, including MEA. Their discrimination is connected to the white racial frame in that they treat

anyone with a different accent, clothing, skin color, nationality, and religion in a way that conveys the message of abnormality and strangeness to the patient. Health care providers seem to be unaware of the mental and physical toll of this discrimination on their patients. Lack of compliance and pain management were identified as the two major issues that arise from these negative behaviors.

### **Implications for Practice**

The findings in this dissertation focus attention on the discriminatory practices of health care providers and issue a call to them to change their perspective toward Middle Eastern Americans. Culturally sensitive care recommendations might be needed to address the lack of cultural awareness reported by the patients.

I don't think that when you, for instance, go through medical school education, or other routes like even allied health care providers—I don't think that you should just be taught the didactic sciences, I think that somewhere along there should be classes like this—like cultural classes. Not just like one, like maybe two or—I don't know like two or three or something, some other related or relevant classes where they teach you that not all people are alike, not all people grow up the same. Especially with different cultures, there are certain things like this, like shyness or there are certain attributes to the culture that the patient, when they come and they interact with the physician or the health care provider that there are barriers to that communication.

As mentioned earlier, the literature has suggested cultural competence education as a means for addressing the issues of minorities and health care in the hope that such training could resolve the problem of cultural differences. For instance, some researchers have argued that it might be beneficial to learn the values that Middle Eastern people embrace. According to Kulwicky et al. (2000), Arab Americans highly value certain behaviors, such as the presence of family members during times of family crisis, nurture and support toward family members who are experiencing illness, and protection related

to honor and shame by male family members toward female family members. Modesty of dress is valued for both males and females. Removing clothes in public, even in a hospital environment, should be done in a way that leaves almost no part of women's skin exposed. This is because female modesty is held in such high regard by the Arab culture.

Although learning about these values might positively affect the experience of MEA in health care, the negative attitude of health care providers toward this group cannot be merely explained by the lack of cultural understanding. The reported issues are far beyond a simple case of cultural misunderstanding that can be solved by learning about one's cultural values or common customs and traditions. Of greater and more disturbing concern is the attitude of whites toward those who are seen on the lower part of the racial spectrum and the framework that tends to look down at those who are not white.

A research study conducted by Taylor (2003) criticized the common cultural competence education in medical schools. The assumption that health care providers do not have a culture, even though patients do have one, is wrong in the first place. Taylor stated, "The institutional culture of medicine and medical education, which sees itself as a 'culture of no culture' systematically tends to foster static and essentialist conceptions of 'culture' as applied to patients" (p. 814). This research argued that medical students do not take cultural competence education seriously since they think that it is far removed from the real competence that needs to be acquired. Physicians' medical knowledge is no less cultural for being real, just as patients' lived experiences and

perspectives are no less real for being cultural. Taylor's study criticized the reality that physicians may rely on their own cultural values during a patient's treatment because minority patients have real experiences and do not need to be racialized at all times. After examining the findings of my study, my research proposes that the solution to this problem is challenging the idea that a physician's knowledge is accompanied by their cultural values, and while learning as much as possible about a patient's culture is important, changing the health care providers' perspectives are critical too. The same study suggests that the best way to resolve the issue is to put away the cultural competence curricula, which promotes the idea that physicians are not cultural.

The most important concept missing from the cultural competence education, as mentioned throughout these chapters, is straightforward and realistic anti-racism training. Real change requires deframing and reframing. The process of reframing and deframing, as systemic racism theory suggests, should be incorporated to remove the negativity of the white racial frame and replace it with the justice frame, which would encourage treating everyone equally. For white health care providers to implement this anti-racism training in their treatment, two things must happen. First, they should become aware of the anti-MEA and other anti-sub-frames of Americans of color and the pro-white sub-frame in the middle of the white racial frame. The whites that run the system operate out of this frame. The deframing process for them means giving up some of that unjust enrichment because of unjust impoverishment of people of color. Anti-racism training requires learning about the history of slavery and domination of whites over different minorities throughout history. Medical/nursing students and practitioners

need much historical competence (learning U.S. racist history, for example, about Francis Scott Key the slaveholder, data on white unjust enrichment over the generations, more on Middle Eastern American history and their current status), much contemporary racial/racist data competence (white families with at least eight times the wealth of blacks, blacks earning only 59 percent of white income—even after 20 generations), as well as a realization that they are part of a white racist system (Feagin 2010).

After learning about the history of racism and receiving anti-racism education, it is then time for health care providers to become more exposed to the world outside of the United States. A few of the respondents talked about how this is needed and about how it will expedite a solution. One Turkish respondent said:

If health care providers are traveling, if they are having interaction with many people and they are very close to other cultures, they will know everything, maybe more than you know about your country and your culture. Because they are better observer about your culture, because they are coming from outside and they see things clearly...

Another Turkish respondent expressed a similar opinion. She said:

Well, with the latest in the news and everything else, people are becoming more like, wow, you know, it's a very difficult place, you know, a dangerous place with ISIS and the new government. But overall, you know, they aren't too much negative about it; they were just curious whether we have electricity in the houses, whether we have cars or still using donkeys. Or we have well water or city water, you know, those kind of things that—I'm like, this is just a regular democratic country, you know? It's just—all of those stupid questions for me because that shows them they know little about the world.

After adding the anti-racism training to the current cultural competence training, then it is time to revise the cultural competence education in a more beneficial way. The major role of cultural competence education is based on informing health care personnel. Most of these programs proceed on the assumption that the more an individual knows

about a minority group, the less likely they are to feel hostility toward them. Evidence suggests that this assumption is true. Those who know most about other races tend to have favorable attitudes toward them. This is especially the case for groups who are regarded as a potential threat. Also, the way of receiving the information can also make a difference. Self-acquired knowledge gained through firsthand experience helps more in avoiding prejudice and negative feelings compared to knowledge gained via information obtained through books or media (Allport 1979). This is one element that cultural competence education should consider. Hiring more minority personnel can help the dominant white staff to learn more about different cultures and minorities instead of only relying on reading materials. A survey about cultural competence done of physicians showed that physicians preferred learning about these issues through continuing medical education, seminars, and newsletters (Klein et al. 2012). Many nursing and medical schools are incorporating these ideas in their curriculum, but research has yet to look at the effect on the overall health of patients (Smith 2012).

### **Limitations of the Study**

The fact that respondents were only women might have caused both benefits and limitations to the study. One benefit was that the experience of women who cover their hair was compared to the experience of those who do not in more detail. Also, due to the experience of annual OB/GYN visits, pregnancy, and delivery, all of the respondents had the experience of using health care services, while MEA men might have not used health care services at all. Women in general have better analytical skills when it comes to explaining the attitudes, looks, or comments that carry discriminatory behaviors. In other

words, they might be better in detecting the covert discrimination due to the nature of their more intuitive nature (Bertakis et al. 2000). However, choosing only women created some limitations for the study too. Although some of the respondents provided examples of times when their male acquaintances were subject to discrimination in a health care setting, this study mainly focused on women and their experiences. Also, as mentioned throughout this study, the general stereotype of Middle Eastern or Muslim women is that their husbands dominate them, and they have no choice or say in how they live their lives. Being seen as powerless or as victims might have served them well when health care providers treated them. Anger or negative feelings might be directed more toward Middle Eastern men, who are seen as the potential agents of terrorism or dominant over women (Harris 2002). Another limitation of the study was that the law prohibits racial discrimination in a health care setting. This means that even if health care providers want to discriminate against people of color, some of them may not engage in the action for fear of losing their job or license. One of the respondents said:

I haven't felt like they openly discriminate because obviously they know the laws and that's against the law to discriminate. Especially openly and say, "Oh, I can't treat you." There's never been any case like that, and I'm sure they know that it's illegal to do something like that, to discriminate.

This limitation, however, did not prevent this research study from finding several examples of discriminatory behaviors, but a setting with fewer laws and regulations addressing racial discrimination might have resulted in more examples.

### **Conclusion**

Middle Eastern Americans have been a minority population in the United States for a long time. Their experiences in terms of obtaining education and high-ranking jobs

have been documented throughout the years. Their interactions with health care providers and general experiences of health care services have also been documented by focusing only on the religious identity of this group. As clearly shown throughout this project, the experiences of Middle Eastern Americans in health care cannot be fully examined without using a theory that would evaluate the structure of the health care institution. Since health care institutions are still mostly dominated by whites, there are issues with treating minority patients and the process of racialization. Health care providers tend to think through the white racial frame, which results in whites seeing their world through the pro-white sub-frame. This sub-frame makes them see anything related to the lives of whites as normal and decent. The anti-MEA sub-frame, like other anti-minority sub-frames, encourages seeing Middle Eastern Americans through images, stereotypes, narratives, and other elements that are completely negative and downgrade the social status of this population. Whites, who have access to a great deal of power, tend to reproduce this frame through the use of media. Recall those accounts provided in this dissertation and note that MEA face discrimination in terms of the attitude of the health care providers and the lack of pain management. They get discriminated against based on their language and accent, foreign names, national origin, religious identity, and clothing. They cope with racism through different strategies, but the discrimination may result in them not following up with their health care providers for future visits or even in a lack of compliance with the medical instruction they were given. Factors such as ethnic identity, time of immigration, type of clothing, and religious involvement can affect the experience of discrimination. In summation, this current research advances the



literature on the experience of Middle Eastern Americans being seen as a minority group with different national origins instead of being seen as one large group with only a religious identity. In spite of these negative experiences, the Middle Eastern Americans interviewed in this project shared positive experiences of interactions with some Americans who made them feel visible and important. Although the number of those with a negative attitude might be more than those with a welcoming one, it gave them the hope and confidence to stay and try to win this struggle.

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## **APPENDIX**

### **INTERVIEW SCHEDULE**

This interview consists of a few introductory questions in the beginning, then questions related to general experience of living in the United States. The next section focuses on health care and asks questions about experiences with health care system. It includes questions regarding verbal or non-verbal interactions, compliance issue, and coping strategies through the end. The final portion of the interview will conclude with brief vignettes focusing on issues relate to the research. At the end of interview the respondents will be asked to answer some inventory questions with marking “Yes” or “No.” Below a list of interview questions can be found.

#### **Introduction:**

1. Tell me a bit about yourself and your family? When did you or your family move to the United States? From which country?
2. Are you a first- or second-generation immigrant? If you are a first-generation immigrant, did you move here with your family? What do you do for living?
3. How often do you visit your home country? Do you have difficulty visiting your home country due to visa situation?
4. Do you have a lot of family members in the US? How about Middle Eastern friends? Do you prefer to form friendships with Middle Eastern Americans?
  - a. If so, what makes your friendships stronger?
  - b. If not, why not?
5. The term “Middle Eastern American” can sometimes have a vague definition. If you were to define this term, how would you do it? Can you explain to me the most important element of your definition?



6. People usually have some sort of self-identification. Do you identify yourself as Middle Eastern American? Or by your (or your parents') country? In any case can you explain to me the reasons behind it?

**General Experiences:**

7. Do you use health care services "on regular basis"? Have you used health care services at least once in the past year? If you need to see a family medicine doctor due to sickness or medical check up (not a specialist) are you more likely to go to physician's offices, clinics, or emergency rooms?
  - a. If you have a doctor that you regularly see what are some of the characteristics of the doctor that encouraged you to choose him/her as your health care provider?
  - b. Are there things that you like about the receptionist, nurses, or other staff members?
8. Can you share with me some of your positive and negative memorable experiences as a MEA in the US? How about MEA friends or family members? Can you give me a general sense of their experiences following their immigration to the US?
9. Has it been specific times when being MEA made things difficult for you? Have you ever felt that Middle Eastern Americans experience mistreatment because of their race or nationality?
  - a. If so, can you name some of the settings where MEAHs experience this mistreatment?
  - b. Do you think the health care system is one of the settings where MEAs experience this mistreatment?
10. Have you ever filed a formal complaint because of racial discrimination?

**Health Care System:**

11. How do you usually choose your physicians? Do you ask other Middle Eastern Americans about their experience and choose the doctors that they recommend?
12. Did you have any particular expectation before visiting your physician for the first time?
  - a. If yes, what were some of your expectations? Did you have an expectation that your doctor understands your different culture and background and give you more attention as a minority patient?
  - b. Do you think the physician fulfilled your expectation? What makes you say that?

13. Some people may switch their doctors because of a negative experience at the physician's office. Has this ever happened to you?
  - a. If yes, can you explain to me what happened? What was the racial background of the doctor?
  - b. If no, has this happened to any of your family members or friends? If it has happened do you know the details?
  
14. What are some of the things that you dislike about going to the doctor? Have you ever thought that you don't want to go because the last time you went in the doctor was not comfortable with your racial background? If this has happened, can you share with me some of the details?
  - a. If yes, can you explain to me what happened? What was the racial background of the doctor?
  
15. Do you feel that your physician and his/her staff provide any additional support to you as a minority patient to make you feel more comfortable?
  - a. If yes, what was the racial background of the doctor or staff?
  - b. If yes, what are some of the things that they did?
  
16. Have you ever felt discriminated by the doctor or staff at your doctor's office in the way they pronounced your name or listened to you while you were speaking to them?
  - a. If yes, can you explain to me what happened? What was the racial background of the doctor and/or staff person?
  - b. If no, has this happened to any of your family members or friends? If it has happened to them, do you know the details?
  
17. Have you ever felt any changes in the attitude of your doctor or staff after they notice that you speak English with a different accent?
  - a. If yes, did their facial expression change? Did they give you an impression that it was difficult for them to understand you? Can you explain more what happened and how it made you feel?
  - b. If you have a negative experience with this can you remember the racial background of the doctor or staff?

**Discrimination at Health Care System:**

**A. Verbal Interaction with Physician:**

18. Has it been times when you felt that your physician did not understand (or ignored) the level of your pain and discomfort?
  - a. If yes, can you explain to me what happened? What was the racial background of the doctor?
  - b. Has this happened to anyone that you know?

19. During your doctor's visits has it been times when you wished you were White European American? During that time did you ever imagine how physician would treat you differently if you were White European American?
20. Has it been times when you felt you couldn't describe your pain due to lack of English proficiency or knowledge of Western culture?
  - a. If yes, did the doctor make any attempt to assist you? Can you explain to me what happened? What was the racial background of the doctor?
  - b. Has this happened to anyone that you know?
21. Some Muslim women choose to clothe differently than others. Do you feel that your clothing affected interactions in the doctor's office or with any of the staff? Do you feel that your physician might feel uncomfortable by the way you dress? Have you ever felt that your doctor is curious to ask you some questions about the reasons behind covering your hair (for those respondents who cover their hair)?
  - a. If yes, do you think the curiosity was a sign that the doctor found this practice strange and unusual? What was the racial characteristic of that doctor?
  - b. If no, has this happened to any of your family members or friends? If it has happened do you know the details?
22. Have you ever seen any negative reaction from your physician after you told him/her where your home country is? Have you been asked some follow up questions? How about others in your family or among friends? Do you know anyone who had a negative experience with this? If yes, what was the racial characteristic of your doctor?

**B. Non-verbal Interaction with Physician:**

23. There might be times when people experience a medical condition that they are embarrassed about. Talk to me about one time when you felt embarrassed about your medical condition (you do not need to explain the actual condition), share your feelings with me. Did you have difficulty explaining or expressing it to the doctor? Do you think your doctor understood your embarrassment? Do you think being from a different culture made a difference in your situation? If you remember such incident can you identify the racial characteristic of your doctor?
24. Have you ever felt that your physician believes in the common stereotypes about Middle Eastern Americans? For example that they might be dangerous or not clean? If you can remember a time can you distinguish the racial characteristic of your doctor?

### **C. Compliance:**

25. Has it been times when you did not go in for a follow up visit because you felt that the doctor is treating you differently due to your race?
  - a. If yes, can you tell me what happened?
  - b. What was the racial background of your doctor?
  
26. Do you generally think that the way doctors treat you has an effect on how you follow their orders? Have there been times when you felt motivated not to follow your doctor's orders? Was this because you felt disappointed and discouraged by the way your doctor treated you or was there some other reason?
  - a. If yes, can you tell me what happened?
  - b. What was the racial background of your doctor?
  - c. Do you know of any other MEA who had the same experience?
  
27. Have it been times when you even filled your prescription but did not trust your doctor enough to take your medicine?
  - a. If yes, can you tell me what happened?
  - b. What was the racial background of your doctor?
  - c. Do you know of any other MEA who had the same negative experience?
  
28. Do you think you can trust your doctor to give the same treatment to you as if you were White European American? Have you ever wished to be white at the doctor's office? Have there been times when you did not fill out your prescription because of the negative experience that you had at the doctor's office? Have there been times that you felt that the doctor was in a rush to treat you and go to the next patient because you and the doctor did not have a same racial background?
  - a. If you have any experiences with this scenario can you tell me the racial background of your doctor?
  - b. How about anyone else that you know? Can you explain the situation to me?

### **D. Coping:**

29. In case of experiencing mistreatment at your doctor's office what were some of the things that you did to help yourself feel better? (Coping strategies) Did you talk to someone about your experience? Did you stay quiet? Did you try to react at the moment? Have you heard any of others' reactions to these situations?
  
30. If you were to give advise to a Middle Eastern American about what they should do following mistreatment at the health care system, what would you say?

## E. Vignettes:

31. A 55-year-old Middle Eastern woman, who covers her hair, is in a lot of pain and goes to see her doctor (Middle Eastern female). Since she has been in a constant pain for a long period of time she bursts into tears as she starts to explain her medical condition. After a few minutes of crying she puts herself together and describes the pain that she's suffering from. However, the doctor refuses to give her any pain medication thinking that she is exaggerating the level of her pain. The doctor tells her that she is fine and becoming too emotional about pain and sickness may only make it worse for her. She suggests that the patient should be more positive and control the level of her emotions. What do you think about this incident? Has anything like this happened to a friend or relative? Has anything like this happened to you?
  - a. If yes, can you explain to me what happened? How did that make you feel?
  
32. A 28-year-old Middle Eastern man with black hair, dark skin, and no facial hair is at the doctor's office. A nurse (White European male) comes into the room before the doctor's examination. The man notices that the nurse attempts to avoid any conversation or eye contact with him and looks scared and uncomfortable. When it comes to asking what has brought him into the doctor's office, he makes the questions brief and does not ask any additional questions about his health condition. When he wants to put on the blood pressure monitor, he avoids touching any part of his skin. What do you think about this incident? Has anything like this happened to a friend or relative? Has anything like this happened to you?
  - a. If yes, can you explain to me what happened? How did that make you feel?
  
33. A 40-year-old Middle Eastern man with light skin color, and light brown hair goes to see his doctor (White European male). The doctor acts friendly and normal following his entrance to the examination room. As soon as the patient starts explaining his medical condition, the doctor notices his different accent. The doctor looks puzzled and has a facial expression that makes the man think that the doctor can't understand what he's saying. The doctor does not ask the patient any follow up questions. At the end he gives him some general advice about taking some pain relievers and getting enough rest. The patient is certain that the doctor did not understand his medical issue but is too shy to ask him. What do you think about this incident? Has anything like this happened to a friend or relative? Has anything like this happened to you?
  - a. If yes, can you explain to me what happened? How did that make you feel?

34. A 31-year-old Middle Eastern woman, who does not cover her hair, is at the doctor's office waiting for the doctor to come in. She is a second-generation immigrant (born in the US) and speaks English with the common US accent. The TV is on and broadcasting a program related to terrorism, Middle East, and Islam. The doctor (White European female) comes in and pays attention to the program for a second. She then mumbles a racial slur about Middle Eastern people as she is sitting down on her chair. What do you think about this incident? Has anything like this happened to a friend or relative? Has anything like this happened to you?
- a. If yes, can you explain to me what happened? How did that make you feel?

Anything else you would like to add to the interview? Thank you so much for your time and patience. I greatly appreciate your participation. Please answer this short inventory on paper.

#### **Inventory Questions at the End:**

35. Have you ever experienced mistreatment because of your race in the following situations:
- As soon as the physician entered the room and saw your face
  - When the physician wanted to pronounce your name
  - When you were explaining to the nurse about your health condition
  - When you were explaining to the doctor about your health condition
  - During your physician's examination
  - When he/she was talking to you about your diagnosis
  - When he/she was prescribing something for you
  - When you had some additional questions to ask

**If you answered, "yes" to any of the above questions can you briefly explain to me what happened? Do you think the situation happened due to race/nationality or other factors?**

**Please feel free to write or talk about any other situation where you experienced racial discrimination at your doctor's office.**