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The Adverse Effects of Stereotyping and Bias on Health in Low Socioeconomic Communities

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Abstract

Studies have shown that low socioeconomic status negatively affects health due to factors such as unstable access to secure environments, full-coverage healthcare, and quality of education. Members of these communities face further health adversities when confronting healthcare staff who are blind to these challenges, and more, that they experience. Several studies examined in this paper looked specifically at the intersects of low socioeconomic status and how they negatively affected the healthcare experience of individuals of these communities. Others demonstrate how having healthcare staff be knowledgeable of these adverse effects can lead to positive changes in the health of these community members. Examining these studies led to the conclusion that health and quality of healthcare of low socioeconomic patients are negatively affected as healthcare providers lack a phenomena known as cultural competence, and therefore it is through additional education and training on how to address these phenomena that healthcare staff such as physicians and Certified Child Life Specialists (CCLS) can help diminish the health disparities plaguing these communities and thus break them out of a cycle of oppression.

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Introduction

The relationship between socioeconomic status and health becomes more complex the more one begins to look at socioeconomic status as an intersectional umbrella term rather than a simple describing factor. In more recent years, socioeconomic status has been evolving from simply looking at income and poverty levels, but also into looking at aspects such as education level, the environment, race, and access to proper healthcare. These aspects are all interrelated in a way that adversely affect the health of community members, especially those of low socioeconomic status. Low socioeconomic status begins its effects on healthcare because of an exposure to unstable environments, subpar education, and unequal access to healthcare coverage (Adler and Newman, 2002). In turn, this leads to bias and stereotyping from healthcare staff. Communities plagued by low socioeconomic status face scrutiny from healthcare staff members who do not have what is known as cultural competency, or "the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients" (Georgetown University Health Policy Institute, n.d.). Healthcare staff members who are not trained to take into account the different factors that fall under socioeconomic status begin to improperly stereotype their patients and feel bias towards them. This bias and stereotyping is what leads low socioeconomic communities to feel less comfortable seeking healthcare, thus continuing to negatively impact health. Cultural competency has proven to be the factor that greatly helps improve the quality of health and healthcare of individuals in low socioeconomic communities. By being culturally competent, healthcare staff are able to thoroughly examine what specific community needs must be addressed to improve overall

health, whether it be forming local support groups or through providing education sessions specific to community standards.

Literature Review

Low socioeconomic status is known to have unfortunate effects on child health and cognitive development. In order to explain the ways in which low socioeconomic status affects child health and development, Aber, Bennett, Conley, & Li (1997) first began by delving into the central phenomenon of poverty. Poverty is achieved when household income reaches below a certain threshold held by the Federal government, and must reach two criteria: public acceptability and statistical defensibility (Aber et al., 1997, p.466). Aber et al. (1997) describe how an ecological framework that consists of macrocontexts and microcontexts of interactions between immediate family and their surrounding communities leads to several deficits such as high infant mortality rates, low birth weights, poor physical health, and delays/interruptions in cognitive development. Of course, Aber et al. (1997) also refer to the manner in which these negative effects on health tie in to race, as low socioeconomic status and race have a history of going hand in hand in the United States. However, there is still a methodological limitation that hinders the ability to properly tie in poverty to other variables that work hand in hand to affect health and cognitive development. Because of the work of these variables along with poverty, the unfavorable effects follow children into adulthood.

The interrelation of race, socioeconomic status, and health often creates health disparities that start at infancy and continue on to adulthood. It is known that African Americans have faced varying levels of social, political, and economic segregation that resulted in poor health since the

beginning of slavery. Because racism still occurs at the institutional level, members of color are at a disadvantage due to racial inequalities in education, employment, healthcare, housing, criminal justice, income, and wealth (Fiscella & Williams, 2004). Therefore, institutional racism causes health disparities due to the fact that it perpetuates racial disparities in poverty, education, and economic opportunities (Fiscella & Williams, 2004). Fiscella and Williams describe how, due to the interrelationship between institutional racism and low socioeconomic status, reverse causality and social causation affect members of low socioeconomic communities starting at infancy and throughout childhood, adolescence, adulthood, and elderly years. These factors, along with environmental components, further expose the destructive relationship between socioeconomic status and health.

Factors such as environmental exposures, social environment, and behavioral/lifestyle elements are other known aspects that further widen the health disparities within low socioeconomic communities. Adler and Newman (2002) specify how behavior and lifestyle account for half of premature mortality in these communities, with environmental exposures accounting for 20 percent and healthcare access for 10 percent. Environmental exposures include things such as exposure to lead, asbestos, carbon monoxide, fumes from local waste sites, industrial areas, highways, and more (Adler and Newman, 2002, p.66). Asthma rates for children in these communities is also higher than those of middle and high socioeconomic status. Social environment, which alludes to isolation and lack of social networks, are strong predictors of health as a result of urban planning and zoning dismantling long-standing social structures, rising housing costs driving community members away, and the lack of ability for communities to foster social ties between remaining members (Adler and Newman, 2002). Behavior and lifestyle

in these communities accounts for high levels of smoking, living a sedentary lifestyle, eating less fruits and high fiber foods, and high levels of alcohol consumption (Adler and Newman, 2002). Adler and Newman explain that having less access to education may explain why these factors have such an impact on health, as members may not have the proper education to know the risks of taking up such behaviors.

Health disparities exist in low socioeconomic communities because of a variety of factors that tie in to their access to quality healthcare. Despite the research on how life threatening these elements can be, members of these communities still face bias and stereotyping that further enhance the health disparities experienced. This is described as a lack of cultural competence, which is defined as "the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients" (Georgetown University Health Policy Institute, n.d.). Inability to provide services for individuals who, for example, have language barriers or have low literacy rates is an example of low cultural competency. People of color who disproportionately experience chronic illness require more healthcare visits (Georgetown University Health Policy Institute, n.d.). Healthcare providers who lack cultural competence are at risk of causing these patients to report less partnership with physicians, less participation in medical decisions, and lower patient satisfaction (Georgetown University Health Policy Institute, n.d.). As a result, health disparities in these communities is further established. Lack of this ability has also led to bias and stereotyping that has affected the quality of healthcare for community members, a phenomenon known as stereotype threat.

As stated earlier, an interrelationship between socioeconomic status, race, and health exists that begins its affect as early as infancy and as late as the elderly years. Aronson, Burgess,

Phelan and Juarez (2013) further emphasize this point as they explain that members of disadvantaged groups such as people of color, the poor, and others, are most at risk for unpleasant interactions in the healthcare system. Aronson et al. (2013) describe stereotype threat as a "disruptive psychological state that people feel at risk for confirming a negative stereotype associated with their social identity--their race, gender, ethnicity, social class, sexual orientation, and so on." Individuals of marginalized groups may feel too uncomfortable seeking healthcare from their providers for fear of being judged for their identity. If their healthcare provider upholds the stereotypes individuals are afraid of falling under, the quality of healthcare they receive is negatively impacted because stereotype threat results in lack of communication between provider and patient as well as a lack of adherence to medication and the overall avoidance of healthcare from the patient (Aronson et al., 2013). This further perpetuates the stereotype that people of marginalized groups are generally unhealthy and indifferent to health risks. In order to tackle the dismantling of these harmful biases and stereotypes, it is imperative that healthcare providers learn about practicing cultural competence and use this knowledge to create social support groups that tackle aspects of living in low socioeconomic environments.

Lack of quality education for low socioeconomic communities results in health disparities because it affects their capability of fully understanding medical terms, diagnoses, treatments, etc. Healthcare providers who lack cultural competence may not realize this and unfairly judge and stereotype members as being indifferent to their health, thus further damaging the level of trust in the relationship between provider and patient. Diener, Wright, Julian, and Byington (2003) examined the effects of literacy programs for low income families attending an urban pediatric clinic. The families examined were mostly immigrants, therefore they recognized

that certain barriers to their understanding of their child's health were that were language differences (as most were Mexican immigrants) and high school education not being completed. Diener et al. (2003) recognized that focusing on the "parents' favorite activities with their children, children's book reading experiences, and parents' own reading experiences... helped educate pediatricians about family strengths and obstacles in relation to literacy education on the children they serve" (p.152). Healthcare providers learned the best way to relay information to families of low socioeconomic status was by taking the time to get to know them and what works best to enhance their learning. Not only does this enhance the provider's cultural competence, but it also helps build relationships between families and providers that make for better healthcare experiences for both parties. Another way to strengthen the relationship between low socioeconomic families and providers is by creating support groups.

Adler and Newman (2003) explained that certain aspects of social environment, such as the dismantling of social structures and the lack of ability for members to foster relationships amongst each other, affect the health of low socioeconomic community members. Therefore, another way to strengthen provider/patient relationships and encourage better health practices in low socioeconomic communities is by healthcare providers encouraging the establishment of support groups in and out of the hospital. Stewart, Reitzel, Correa-Fernandez, Cano, Adams, Cao, Li, Waters, Wetter, & Vidrine (2014) examined how social support arbitrates the association of health literacy and depression among racially/ethnically diverse smokers of low socioeconomic status. Stewart et al. (2014) found that among smokers who were ready to quit, low health literacy was associated with higher levels of depression and lower levels of social support. The authors also emphasized the need for providers to properly communicate the risk

factors associated with smoking and encourage treatments that don't require health literacy, such as visual education tools designed to be easy to understand and one-on-one education sessions. By providing social support to these group members at risk, physicians were able to foster a relationship that allowed members to not only learn about the risks of smoking, but also did so by using the members' strong points, thus demonstrating their high level of cultural competence.

Bias and stereotyping are known to have unfavorable effects on health and quality of healthcare of low socioeconomic patients due to a lack of cultural competence from healthcare providers. Having low socioeconomic status affects child health and cognitive development, causes racial disparities in health, and causes social and physical environmental risks to affect members' health. Members of socioeconomic communities and other minority groups state that stereotype threat and bias cause them to lessen how often they follow back with their providers as well as how often they participate in the upkeep of their care. Studies show that additional education and training on how to address these phenomena can help diminish health disparities plaguing these communities. Being culturally competent allows providers to come up with programs that increase health education, such as literacy programs that allow families to demonstrate their learning strengths that allow practitioners to come up with the proper tools for these families to be more involved in their child's care. Cultural competence also allows practitioners to learn about the importance of social support on health. As current research focuses more on the effects of social support on certain groups in low socioeconomic communities, future research should focus more on the effects of social support in communities as a whole.

Discussion

Socioeconomic Status Effect on Children

The effects of low socioeconomic status on health begins during infancy and continues on throughout early childhood and beyond by impacting overall child health and cognitive development. One specific factor of low socioeconomic status that causes these effects is poverty. Aber, Bennett, Conley, & Li (1997) describe poverty as when a household income reaches below a certain threshold upheld by the Federal government, which in 1995 was $12,258 for a family of three and $15,569 for a family of four. Most recent data shows that the Federal poverty threshold for a family of three is $21,330 and $25,750 for a family of four (Assistant Secretary for Planning and Evaluation, "Poverty Guidelines," 2019). Additionally, families must meet two additional criteria of public acceptability and statistical defensibility (Aber et al., 1997, p.466). Although these criteria exist, it's important to note that among poor families, a difference in resources exists as families may fall under extreme poverty, or households where incomes are more than half below the poverty line, or families that are above the poverty line but struggle to provide for their families because they are ineligible for certain programs, such as Medicaid, and must therefore pay out of pocket costs themselves. Children falling under any of these categories face many detriments to their health, or more specifically their "cognitive and socioemotional development" (Aber et al., 1997, p.468). Socioeconomic levels determine the quality of education that children receive; therefore, the lower the socioeconomic status, the lower the quality of education and the lower the chance they may pursue higher education. As a result, they continue to live in poverty well into adulthood.

Children in low socioeconomic households also face changes in the multiple ecologies of a child's life. Urie Bronfenbrenner presented the idea of human ecological models and described them as processes and conditions that "govern the lifelong course of human development in the actual environments in which humans live" (Bronfenbrenner, 1994, p.37). The environments described by Bronfenbrenner fall under the categories of microsystems, mesosystems, exosystems, macrosystems, and chronosystems. Poverty is seen to affect microsystems and macrosystems of children ranging from interactions between their parents and other adults to the neighborhood they live in and the access to educational and health services (Aber et al., 1997, p.470). Other additional impacts of low socioeconomic status begin at infancy and affect birthweight and infant mortality rates due to the exposure to harmful environments and prenatal risks. These infants also face being at risk for neurological deficits and abnormalities, as well as detriments to their psychological and intellectual development. In order to fully understand the impacts of low socioeconomic on children and adult health, one must begin to look at it through an intersectional lens.

The Intersectionality of Socioeconomic Status and Race on Health

Low socioeconomic status through an intersectional lens looks at how other factors of identity affect the livelihood of individuals. In this case, socioeconomic status and race must be observed as a high correlation between the two factors exists. The interrelation of race, low socioeconomic status, and health create even higher disparities between populations. Although the Civil Rights Movement fought for the equal treatment of black people in the United States, they are still experiencing varying levels of social, political, and economic segregation in the public sphere. Racism is still occuring in the institutional level, and as a result members of color

are experiencing discrimination in the many sectors. Members of color are at a disadvantage due to racial inequalities in education, employment, healthcare, housing, criminal justice, income, and wealth (Fiscella and Williams, 2004). To this day, African Americans are still experiencing dramatically worse health as a legacy of oppression, such as higher adult and infant mortality rates. According to Fiscella and Williams (2004), African Americans "have significantly higher mortality rates from cardiovascular and cerebrovascular disease, most cancers, diabetes, HIV, unintentional injuries, pregnancy, sudden infant death syndrome, and homicides than do whites" (p.1140). Black women are most likely to die post-birth because of complications, a phenomenon almost experienced by athlete Serena Williams after the birth of her daughter. Studies have shown that these experiences occur because of racial differences in socioeconomic status. These instances where an interrelation of race and socioeconomic status impacts health exists are not only seen at adulthood, but at childhood as well.

As stated earlier, health disparities because of socioeconomic status begin at infancy and follow throughout adulthood. This is especially the case for individuals of color living with low socioeconomic status. Health disparities begin in utero because the health of the fetus relies on the health of the mother. A mother's low socioeconomic status opens the door to many risk factors ranging from smoking to unplanned and unwanted pregnancies (Fiscella and Williams, 2004, p.1140). Adolescent health is also highly related to parental socioeconomic status. Studies have shown that low socioeconomic Black adolescents report worse health, ranging from teen pregnancies to asthma. Of the 6.2 million adolescents living with asthma, "Black children not only have the highest rates but are more likely to be hospitalized and die" (Muhammad 2019). This is because of factors such as exposure to poor air quality and other bleak environmental

factors, lack of access to quality healthcare, and racism. A study published in Annals of Allergy, Asthma, and Immunology "shows an association between Black parents and guardians who experienced chronic stress associated with exposure to racism and poor asthma control in their young children" (Muhammad 2019). In other words, acts of racism towards Black parents can negatively impact their child's Asthma. And because of a correlation between race and socioeconomic status, aspects affected by low socioeconomic factors can also trigger a Black child's asthma, such as financial and household instability. Lastly, the interrelation between race and low socioeconomic status follow the adolescent into adulthood and into their elderly age as they experience greater disability, limitations in activities, and a more frequent and rapid cognitive decline (Fiscella and Williams, 2004, p.1141). This comes to show how necessary it is to look at socioeconomic status through an intersectional lens, as it demonstrates the different factors that come into play for the development of health disparities. A further look into what specific factors of living with low socioeconomic status arise gives additional insight into the existence of health disparities.

Environmental Impact of Living in Low Socioeconomic Communities

There are environmental factors of living in low socioeconomic communities that cause an increase in health disparities. These factors include environmental exposures, social environment, and behavioral/lifestyle elements. Environmental exposures refers to the exposure to damaging forces in the environment, such as asbestos, lead, carbon dioxide, and industrial waste (Adler and Newman, 2002, p. 66). Because low socioeconomic communities tend to be located near areas such as highways, toxic waste sites, and industrial areas, individuals are more exposed to said damaging agents than wealthier communities. Low socioeconomic households

also have the tendency to experience higher amounts of crowding, causing for higher exposures to noise, which can cause poorer long-term memory and reading deficits in children (Adler and Newman, 2002). Pollution in low socioeconomic communities is also plaguing. Childhood asthma in low socioeconomic communities is on the rise, especially in urban communities, further demonstrating the negative effects on the health of children living in low socioeconomic communities.

Social environment refers to social networks formed amid members of a community. Individuals who face isolation and lack of engagement in social networks risk higher mortality rates than those with extensive communal connections (Adler and Newman, 2002). Socioeconomic status is a big determinant of the extent at which social institutions encourage and foster social ties. According to Newman and Adler, "those with greater social cohesion and social capital have lower rates of homicide as well as lower overall population mortality" (2002, p.67). Low socioeconomic status impacts social environment because of aspects such as urban planning, zoning dismantling long-standing social structures, rising housing costs driving community members away, and the lack of ability for communities to foster social ties between remaining members. Therefore social cohesion and trust becomes difficult for members of low socioeconomic communities, resulting in poorer overall health. Other factors such as architectural features of communities and institutions promote social integration and cohesion that promote health. Although it is fairly unknown why these factors are so detrimental to health, it is still an important element that must be addressed when talking about the causes of health disparities in low socioeconomic communities.

Behavior and lifestyle account for half of premature mortality in low socioeconomic communities, with the greatest behavioral risk for premature mortality being tobacco use. Adler and Newman (2002) point out that the lower the education level and income, the higher one is likely to smoke (p.68). On the other hand, the more educated one is, the more likely they are to try to quit smoking. Low socioeconomic status is also correlated to a sedentary lifestyle, a lower consumption of fiber, fresh fruits, and vegetables, and a higher risk of heavy drinking (Adler and Newman, 2002, p.69). The exposure to these risks, tied in with a lack of education, means that there is a lack of information readily available for the community to learn about them. As a result, individuals continue partaking in acts that adversely affects their health. Information on the risks of smoking, a sedentary lifestyle, and lack of healthy diets is not easily available in low socioeconomic communities. Instead, health promotion efforts are more available to those with the resources available to make those changes, such as information on walking, bicycling, nutritional information campaigns, and an emphasis on the cessation of smoking (Adler and Newman, 2002, p. 69). This information demonstrates how lack of access to information about the risks of certain actions and the resources necessary to tackle them increases the presence of health disparities in low socioeconomic communities. Healthcare professionals working in these communities should therefore be taking the initiative to gather and provide this information to community members. Firstly, however, in order to do so, the healthcare community must tackle the issue of bias and stereotyping and its damaging effects on the health of low socioeconomic communities.

Effects of Bias and Stereotyping on Health

Health disparities exist in low socioeconomic communities because of a variety of factors that tie in to their access to and quality of healthcare, such as education, environment, and race. Although there is plenty of research depicting how life threatening these factors can be, members of low socioeconomic communities are still experiencing bias and stereotyping that further augment the presence of health disparities. This phenomenon is known as stereotype threat. As stated earlier, the interrelationship between socioeconomic status, race, and health begins at infancy and expand throughout a lifetime, ending as late as the elderly years. According to Aronson et al (2013), members of disadvantaged groups such as people of color, the poor, and others, are more at risk of having unpleasant interactions in the healthcare system. This is due to an anomaly known as stereotype threat, which is a "disruptive psychological state that people feel at risk for confirming a negative stereotype associated with their social identity--their race, gender, ethnicity, social class, sexual orientation, and so on" (Aronson et al., 2013). This phenomenon has mostly been studied in the education field; however, stereotype threat has also demonstrated to have harmful effects on the health of individuals.

Stereotype threat is a process that begins with patients' recognition that they belong to a group that is negatively stereotyped. This recognition leads to patients/potential targets of these stereotypes to be cautious of cues that the stereotype is relevant. If the cues corroborate the relevance of the negative stereotype, then stereotype threat is provoked (Aronson et al., 2013). Healthcare professionals who uphold negative stereotypes against their patients, whether implicitly or explicitly through interactions, put their patients at risk from suffering from stereotype threat and thus negatively affecting their healthcare experience. Targets of stereotype

threat may also feel “devalued by their interaction partners merely as a function of interacting across racial, ethnic, or other social identity divides” (Aronson et al., 2013), thus showing just how impactful stereotyping can be.

Stereotype threat has three major impacts on health of target individuals. Firstly, stereotype threat causes individuals to avoid healthcare. Individuals who perceive discrimination and stereotype threat are “most likely to miss medical appointments and delay needed or preventative medical care” (Aronson et al., 2013). Targets of stereotype threat are aware of the negative stereotypes that follow them, and thus are more likely to feel unwelcome and devalued when facing healthcare professionals who uphold these stereotypes. Therefore, because they avoid interactions with their healthcare providers, they are at risk of failing to relieve medical conditions before they turn serious and will be less likely to receive proper care (Aronson et al., 2013). The second major impact of stereotype threat on health is a lack of clear communication with healthcare providers. Knowing medical histories, habits, and symptoms is important for healthcare providers to know in order to offer the best course of treatment. However, patients who feel stereotype threat lose trust in their healthcare providers, influencing what they may choose to share with them (Aronson et al., 2013). Subsequently, the healthcare experience of these individuals is hindered. Patients may also alter details to project an image that is the opposite of what their perceived stereotype might be. For example, individuals may not want to share certain dietary styles because they may not want to be perceived as living up to a negative stereotype. Accordingly, this kind of miscommunication negatively affects the healthcare experience of individuals. Lastly, stereotype threat affects a patient’s willingness to adhere to a treatment plan. If patients at risk of stereotype threat who misinterpret an interaction because of

the anxieties of stereotype threat, they may "misunderstand the nature or importance of recommendations, or, alternatively, have difficulty later recalling vital information" (Aronson et al., 2013). In addition, "because stereotype threat engenders mistrust, minority patients may hear, understand, and recall information and feedback, yet discount it because it is seen as biased or threatening" (Aronson et al., 2013). A mixture of miscommunication and mistrust causes for health disparities as patients are more reluctant to seek and follow through with proper care regimens. In order to dismantle the effects of stereotype threat in the healthcare community, it is imperative that healthcare professionals eliminate prejudice and descrimination in their treatment. This is possible through the help of a concept known as cultural competence.

Cultural Competence and How it Helps Reduce Health Disparities

Health disparities exist in low socioeconomic communities because a variety of factors relating to education, environment, and access to quality healthcare. Despite the research in how these factors negatively affect health, members of these communities continually face bias and stereotyping. Healthcare providers who fail to realize this lack a quality called cultural competence. Cultural competence is described as "the ability of providers and organizations to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of patients" (Georgetown University Health Policy Institute, n.d.). Cultural incompetence would be the inability to provide services for individuals who may have language barriers or have low literacy rates. Healthcare practitioners who fail to see how culture impacts the way an individual may interpret the healthcare system and/or a medical diagnosis also demonstrate cultural incompetence, therefore driving up the occurrence of health disparities. According to the Georgetown University Health Policy Institute (n.d.), people of color, which are targets of

stereotype threat, who disproportionately experience chronic illness require more healthcare visits. A healthcare provider who lacks cultural competence would be unaware of such a fact and put their patients at risk for generating less partnership with physicians, less cooperation in medical decisions, and lower patient satisfaction (Georgetown University Health Policy Institute, n.d.). These outcomes result in the upholding of stereotypes that healthcare providers abide by their patients, consequently culminating further stereotype threat. Cultural competence therefore holds a strong key towards helping eliminate stereotype threat, as it allows healthcare providers to look into the background of their population to determine how to best help their patients best maintain their health.

A lack of quality education and available resources causes health disparities in low socioeconomic communities because it affects community members' ability to fully understand medical terms, diagnoses, treatments, etc. (Aronson et al., 2013). A lack of cultural competence causes healthcare professionals to misjudge and stereotype members of low socioeconomic communities as being indifferent to their health, thus further causing a scarcity of trust in the relationship between patient and provider. A culturally competent healthcare provider is able to determine that in order to help educate a low socioeconomic community on aspects of healthcare, they must look at the specific social, cultural, and linguistic needs of the community and create a solution with those needs in mind. A study by Diener et al. (2003) examined the effects of literacy programs for low income families attending an urban pediatric clinic. The families investigated in this study were majority immigrants, which allowed the researchers and healthcare providers to recognize the certain barriers to their understanding of their children's health, which were language differences as most immigrants were of Mexican descent, and a

lack of education past high school. Diener et al. (2003) identified that focusing on the "parents' favorite activities with their children, children's book reading experiences, and parents' own reading experiences... helped educate pediatricians about family strengths and obstacles in relation to literacy education on the children they serve" (p.152). In this case, healthcare providers exemplified cultural competence by observing families with known barriers using methods that focused on literacy in order to identify the literacy needs of their population. As a result, not only were physicians able to develop literacy programs to help better the developmental needs of the children served, but they also helped in providing literacy information and referrals to other community organizations for the adults involved as well (Diener et al., 2003). By focusing on bettering the literacy needs of their population, healthcare practitioners in this study introduced the population to the necessary access to information and resources they needed to maintain their healthcare and developmental needs all while strengthening patient and provider relationships. Another way to strengthen this relationship is by focusing on the social aspect of cultural competency through the use of community support groups.

According to Adler and Newman (2003), social environmental factors such as the dismantling of social structures and the inability to nourish relationships amongst community members are key elements of causing negative effects on the health of low socioeconomic community members. Culturally competent healthcare providers realize that this is a social need that must be addressed when looking for ways to better the health of their community. Addressing the social needs of these communities also aids in strengthening the patient/provider relationship necessary to ensure optimal healthcare experience for both patient and provider.

Encouraging the establishment of support groups in and out of the hospital is a proven way to stimulate better health and stronger patient/provider and community relationships. A study by Stewart et al. (2014) examined how social support mediates the association of health literacy and depression among racially/ethnically diverse smokers of low socioeconomic status. They concluded that among smokers who were prepared to quit, low health literacy was associated with higher levels of depression and lower levels of social support (Stewart et al., 2014). In other words, although smokers were ready to improve their health, low levels of health literacy and social support were detrimental to their mental health, thus affecting their overall ability to truly quit. Stewart et al. (2014) also emphasized the need for healthcare providers to accurately communicate the risk factors associated with smoking and encourage treatments that don't require health literacy, such as using visual education tools designed to be quick and easy to understand and one-on-one education sessions. These are culturally competent examples of ways healthcare providers can help their community reach and interpret information pertaining to their health in proactive ways. Providing social support hand-in-hand with tools for improving health literacy allows physicians to foster a relationship which allow members to learn about health risks, therefore decreasing the health disparities existing in these communities. Highlighting healthcare providers who are emphasizing the importance of cultural competence in the fostering of patient/provider relationships is necessary to understand just how impactful cultural competence is in at-risk communities such as those impacted by low socioeconomic status.

When discussing cultural competence in the healthcare community, it's important to discuss how child life specialists in clinics and hospitals are helping bring the concept to light. According to the Association of Child Life Professional's Child Life Competencies, which is the

minimal level of acceptable practices as defined by the Child Life Council, child life specialists must have the ability to "initiate and maintain meaningful and therapeutic relationships with infants, children, youth, and families" (2019). In order to do so, child life specialists must have a knowledge of identifying values related to sociocultural diversity and the educational opportunities and resources responsive to the needs of the child and family in order to ensure mastery and learning. Child life specialists who identify these values and needs relating to sociocultural diversity and education are therefore able to create appropriate plans of care for their patients to ensure their wellbeing. Child life specialists are also able to deflect stereotype threat through the language they use and by creating safe environments free of judgement, as another competency states that child life specialists must provide a "safe, therapeutic, and healing environment for infants, children, youth, and families" (Association of Child Life Professionals, 2019). In addition to the Child Life Competencies, the Child Life Code of Ethics principle three states that "child life professionals shall have an obligation to serve children and families, regardless of race, gender, religion, sexual orientation, economic status, values, national origin, or disability" (Association of Child Life Professionals, n.d.). Child life specialists are trained to respect children and families regardless of identity, hence explaining why they are advocates for cultural competency in their work and the work of other healthcare providers. Child life specialists will continue to be advocates for cultural competency in the healthcare system so long as bias and stereotype threat continue to be a downfall to the health of individuals at risk.

Conclusion

Bias and stereotyping continue to have long lasting detrimental effects on the health and quality of healthcare of individuals in low socioeconomic communities as a result of a lack of cultural competency from healthcare providers. The effects of bias and stereotyping, or more specifically stereotype threat, begin at infancy by affecting child health and cognitive development, and continue on throughout childhood, adolescence, and adulthood. Because of the interrelationship between socioeconomic status and race, bias and stereotyping additionally cause racial disparities in health. Lastly, social and physical environmental aspects of living in low socioeconomic communities further disrupt the health of individuals in these communities. Members in low socioeconomic communities and minority groups state that stereotype threat and bias further affect their health because it discourages them from following up with their providers in terms of treatments, keeping up their level of care, and nourishing the relationship between patient and provider. Studies have shown that programs devoted to the social, cultural, and linguistic needs of their patients can help diminish health disparities in these communities. The phenomena that is responsible for the emergence of these programs is cultural competence. Culturally competent healthcare providers create programs that increase health literacy and education, and culminate support groups that help spread resources and support necessary for individuals to learn about and adhere to treatment. Child life specialists are key examples of healthcare professionals who acknowledge the importance of cultural competence when creating plans of care for patients and their families. By encouraging the learning and incorporation of cultural competence into their care, healthcare providers can properly address and tackle the health disparities plaguing at risk communities.

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